NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Annual Report 2018-19

Pride in our care

Cambridgeshire and Peterborough NHS Foundation Trust

Annual Report and Accounts 2018 – 2019

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

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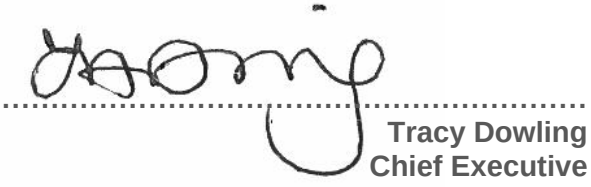
About this report

Cambridgeshire and Peterborough NHS Foundation Trust's Annual Report 2018 - 2019, 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 *23 May 2019*. 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.



Tracy Dowling
Chief Executive

23 May 2019

Statement from the Trust Chair

Integration and innovation have been key themes for CPFT over the past year.

As the Trust responsible for mental health services and community healthcare services for older people and those with long-term conditions, we are extremely proud of the specialist role we have within the local health system.

But we cannot operate alone.

To ensure we continue to provide the very best care for our patients and service-users, we must ensure we work side by side with our colleagues from our local acute hospitals.

After all, the people we support and serve just see "the NHS", and any thoughts for individual organisations are far down the list of importance.

There has been considerable progress in this area over recent years, but the announcement of a new children's hospital, which will be based in Cambridge but will serve the East of England, affords us the opportunity to make a ground-breaking leap forward. In partnership with Cambridge University Hospitals NHS Foundation Trust (CUH) and Cambridge University, this will be a true integration of mental and physical health.

While there is still further funding to secure, it will allow the children and young people's services operated by both CPFT and CUH to be based under one roof.

Through the involvement of the University of Cambridge, it will also be the home for ground-breaking science and research and will attract some of the world's top scientists.

Increased integration of mental and physical health services is a major part of the NHS Long-Term Plan, which was published in January 2019.

The Long-Term plan heralds significant investment in mental health and community services and it is vital that, in this most financially constrained health system, we prioritise developing out-of-hospital and mental health services when making strategic decisions about our limited investment resources. I and the Board will ensure that the voice of those we support is heard.

Julie Spence, Trust Chair

The strategy is certainly a challenging one, but it was pleasing to see some of the developments we have in place and demonstrated to NHS Chief Executive Simon Stevens when he visited our Trust last summer – the development of a 24-hour mental health crisis helpline and mental health staff embedded within A&E departments – being rolled out across the country.

We were also proud that our Primary Care Mental Health Service – which has seen specialist mental health staff based within every GP practice in Cambridgeshire and Peterborough giving people simpler and easier access – feature as a case study within the Long-Term Plan.

The Long-Term Plan also pledges major action in the prevention and treatment of physical health issues such as respiratory conditions and diabetes, which is a major boost to our dedicated teams working in those key areas.

The recognition for our services in the Long-Term plan followed the Trust retaining its "good" status after our latest inspection by the Care Quality Commission.

This was especially welcome because it was carried out following the introduction of the CQC's new inspection standards. Indeed, the CQC found several areas where services were judged as "outstanding".

As part of their new inspection procedures, the CQC will return again this year and we must ensure the examples of "outstanding" practice continue to permeate across all parts of the organisation.

The work of our Trust continues to be recognised on a national level.

At the Royal College of Psychiatry's annual awards, our Recovery College East team, along with honorary consultant psychiatrist Professor Paul Fletcher, won the Psychiatric Communicator of the Year title for their work in helping Cambridge games company Ninja Theory develop the international best-seller Hellblade: Senua's Sacrifice. In the game, the lead character, Senua, has psychosis. At the same awards, consultant psychiatrist Dr Christopher O'Loughlin was named Psychiatric Trainer of the Year.

A number of other services and individuals were also finalists at the awards. The Gynae Psycho-oncology Service, which supports women with their mental health following cancer treatment, (Psychiatric Team of the Year - all-age specialist category), Dr Graham Murray, honorary consultant psychiatrist, was shortlisted for the Researcher of the Year prize, while Konrad Wagstyl was nominated in the Medical Student of the Year category.

Amid the successes of the past year, I and many others were saddened by the death of Elizabeth Mitchell. Elizabeth, who had continued to be a governor of the Trust after stepping down from her role as lead governor in May last year, died following a long illness.

Liz was passionate about the work of the Trust and it is without doubt that her persistence drove the advancement of carers being involved in our day-to-day work.

She understood how mental health and other long term conditions can impact on the lives of individuals, far better than many of us ever will, and I know she would want us to continue to be at the forefront of delivering compassionate care for people living with these conditions.

Liz was always going to be a hard act to follow, but Keith Grimwade, who took over as Lead Governor, has been excellent in his role and I would like to thank him and 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 Chair is to lead the Board of Directors, which is made up of the Trust's Executive Directors and eight Non-Executive Directors (including two advisory NEDs). I would also like to thank them all for their support and contribution to the organisation over the past year.

Over the course of the last year, CEO Tracy Dowling, Keith and many other Directors, Non-Executive Directors and Governors have stood alongside me at our Pride Awards which recognise the work of our staff and teams across the organisation.

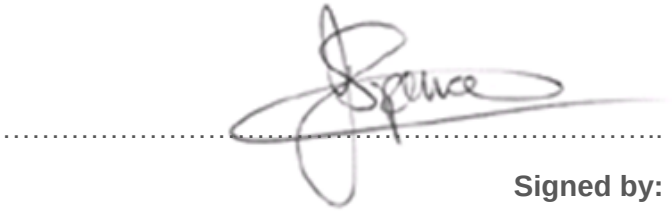
It is always great that colleagues nominate their fellow team members, but it is the submissions from patients, service-users and carers that always mean so much both to me and to the staff members they wish to see honoured.

This time last year we were getting ready to mark the 70th anniversary of the NHS and the events which were held gave everyone a chance to reflect on the part the National Health Service has played in everyone's lives.

There have been enormous changes over that time, and as we look towards the 80th anniversary there will be further changes and challenges to face.

But everyone who has an interest in our work and how the whole system is delivering healthcare across the area should be assured CPFT, working with our partners, will continue to provide services to those who need them the most.

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



Signed by:

Julie Spence

Trust Chair

23 May 2019

SECTION 1: Performance Report

This section provides information on Cambridgeshire and Peterborough NHS Foundation Trust, its main objectives and strategies, and the principal 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 second performance report since becoming CEO and I would like to thank all our staff for their continued hard work and dedication. Within the last year we have published four strategic goals that underpin our central purpose. They are:

- Delivering the best care
- Being a leading innovator in healthcare and research
- Demonstrating best value
- Improving the experience of working at CPFT

We have made very good progress in these areas as we continue to aim to become an "outstanding" organisation. This is not just in terms of our CQC rating which is "good" - and we will be welcoming back Care Quality Commission inspectors this year – but also in how our staff rate us as a place to work. If we can get that right, then the CQC rating we aspire to will follow.

In January we saw the publication of the Long-Term plan which sets what the £20.5bn real terms uplift will mean for NHS services and for us as a Trust. The proposals are significant and exciting and will have a major contributory factor in each of our four goals.

Delivering the best care

Patients and service-users – along with carers – continue to be at the very centre of everything that we do. Their involvement and enabling them to co-produce services we deliver is an essential area of our work.

Certainly, patient and service-user involvement has been key to the development of the Long-Term Plan which sets out proposals for major investment in our core areas of community and mental health care. It details very clear direction for increasing support for out-of-hospital care, long-term conditions such as diabetes and respiratory conditions, adult and children's mental health, and integrating children's physical and mental health.

This clearly has major implications for our Trust – and also very much matches our ambitions. Through our work in the care of older people and those with long-term conditions, we are leading the way in much of this work already.

I am proud that the impact of our First Response Service, a 24/7 mental health crisis support team, has been recognised and will now be rolled out across the country, and that our Primary Care Mental Health Service – mental health staff based within all GPs surgeries – was highlighted as an example of pioneering excellence in the Long-Term Plan.

Leading innovator in healthcare and research

The use of technology is vital. We have it in our lives on a daily basis, but the use of technology in healthcare has not been embraced in the same way. To support the NHS Long-Term Plan, that will have to change, and my ambition for our Trust, given our links to research and the Quality Improvement programmes that we have in place, is that we can use technology and the supporting data to be at the cutting edge of enhancements to patient care.

Demonstrating best value

We constantly look to ensure we are providing the most cost-effective ways of delivering care. But it is also about how we work with our partners to provide truly joined-up care for our local population. The proposed East of England Children's Hospital announced in January provides a ground-breaking opportunity to provide physical and mental health services under one roof alongside our partners from Cambridge University Hospitals Trust and the University of Cambridge.

Improve the experience of working at CPFT

We will only do this if we can continue to recruit and retain the best staff for our organisation. Indeed this is echoed in the Long-Term Plan, and we continue to look for innovative and creative ways to attract people to CPFT and the NHS. But once we have welcomed people to our organisation, we must continue to look after their health and wellbeing. Over the last 12 months, we have put in place a number of new initiatives to ensure colleagues are looking after themselves as much as they do our patients and service-users, and ensure they have the support they need. This continues to be one of my personal goals. We will only be an employer of choice if we look after our staff, help them to stay healthy and give them exciting and fulfilling – and modern – roles for the 21st century.

Overall, these remain challenging but exciting times at CPFT, and the National Health Service.

We do, however, remain in one of the most financially challenged health economies in the country.

We must continue to work alongside our partners to lobby at the highest level for increased funding if we are to deliver the significant changes that we want to, and the Long-Term Plan demands.

Whilst not underestimating the challenges, I remain confident of our ability to continue to provide really good care – in a way that fits with our values – and believe that, through the ongoing commitment of our staff that I witness on a daily basis, we will become a truly outstanding organisation across all areas of our work.

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 Cambridgeshire and Peterborough Mental Health Partnership NHS Trust.

We provide a wide range of mental health, physical health, specialist, learning disability and neuro-rehabilitation community and hospital services to a population of around 950,000 people in the east of England. CPFT is a health and social care organisation, providing integrated older adult physical and mental health services, adult mental health and learning disability services and children's mental health services, across Cambridgeshire and Peterborough, and children's community health services in Peterborough.

We employ more than 4,000 staff. Our main bases are at The Cavell Centre, Peterborough, and Fulbourn Hospital, Cambridge, with staff based in more than 50 locations across the county. CPFT is a designated Cambridge University Teaching Trust and a member of Cambridge University Health Partners; one of only eight Academic Health Science Centres in the UK.

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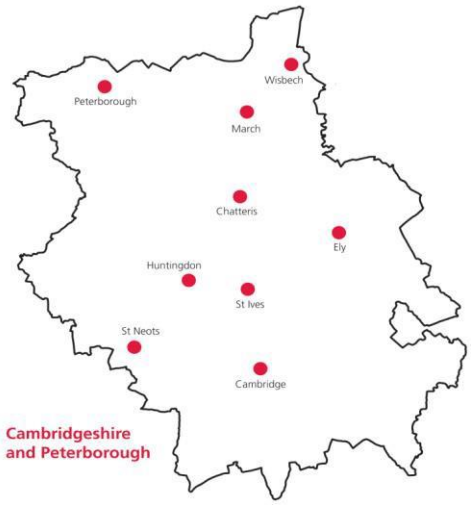


Our strategic ambitions

Our Three-Year Strategy for 2018-2021 sets out our **Statement of Purpose:**

'CPFT strives to improve the health and wellbeing of the people we care for, our staff and members, to support and empower them to lead a fulfilling life.'

We have set ourselves four goals to achieve this purpose, each delivered through a series of strategic objectives setting out what we need to do to work effectively with partners to improve the health and wellbeing of the people we care for, and how success will be measured. Our goals are to:

- Deliver the best care,
- Be a leading innovator in healthcare and research – nationally and internationally;
- Demonstrate best value, and
- Improve the experience of working in CPFT.

The full plan is available to view via this link to our website, with updates on progress submitted regularly to our Board of Directors.

A number of enabling strategies are under development and in place to support the delivery of the three-year strategy, around:

- Workforce and organisational development;
- Information management, technology and estates
- Clinical strategies
- Research and development
- Patient experience and involvement
- Communications and engagement,
- Nursing and Allied Health Professionals.

Further details are available from the Trust Secretariat on 01223 219475 or e-mail trustsecretariats@cpft.nhs.uk

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

Head to Toe Charity

Head to Toe, the Trust's charity, has continued its excellent work this year to raise 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.

The charity has entered into partnership arrangements with the following organisations to strengthen its offer to the local community and increase its fundraising opportunities:

- **Living Sport** – Living Sport works to raise the profile of sport and to increase participation across Cambridgeshire and Peterborough. Head to Toe has built a strong relationship with Living Sport over the past year and has again been chosen as its partner charity for 2019, donating a percentage of its profits to Head to Toe. In 2019 Living Sport is organising five mass sports events; four in Peterborough and one in Cambridge.

- **Enchanted Cinema** – Enchanted Cinema is an outdoor cinema company based in Cambridge that has grown substantially over the past five years. Head to Toe and Enchanted Cinema will work closely over the next year with the aim to cross-brand events and share audiences. Enchanted Cinema has also committed to running an event for staff and patients at Fulbourn Hospital by the end of 2019, as well as planning some bigger fundraising events throughout the next couple of years.

- **Ninja Theory** – Ninja Theory has shown continuing support for the Trust's Recovery College East and has agreed to provide an annual donation to cover all costs relating to the provision of a scholarship programme named 'Senua's Scholarship'. The aim of the scholarship is to enable one student each year in the Recovery Collage to receive training and mentoring to become a qualified adult education tutor.

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 2018-2019 that help to enhance the experience of patients and service users plus their families, carers and staff. These have included:

- **Christmas meals for patients in Fulbourn and Cavell -** Charitable funding enabled 93 patients across the Trust to enjoy a top-quality Christmas meal

- **Schwartz Rounds -** Pilot Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. Charitable funding enabled two staff members to receive training that enables them to lead Schwartz Round sessions within the Trust. It is hoped that this safe space will help the wellbeing of staff members, in turn enabling them to provide the best care possible to their patients.

- **Hearing Voices Group facilitator attendance at International Congress -** The Hearing Voices Network (HVN) is a world-wide organisation. A central part of HVN's work is the provision of self-help groups, also known as 'hearing voices groups,' which endeavour to offer safe and accepting spaces to share one's experiences, exchange coping strategies, and develop a positive identity as someone who hears voices. Charitable funding gave two staff the opportunity to attend the 10th Hearing Voices Congress Living with Voices: A Human Right in the Hague. The conference gave them insight into the practices of groups around the world, which they could feed back into their local sessions.

- **Mulberry 1 History Walk –** many patients are interested in the rich history of Fulbourn and the wards that operate here. Charitable funding enabled staff from Mulberry 1 to frame their history projects so they can share the knowledge with patients and families that use the service.
- **Pride Awards –** The Pride Awards celebrate and recognise those who go above and beyond in the work they do in the Trust to help improve care. Charitable funding has enabled the Trust to hold a quarterly event to give these people a stage where their achievements can be shared with their family and colleagues.

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 commercial opportunities in line with our Trust Strategy 2018-21. We have a dedicated Business Development Team with the necessary systems in place enabling us to respond to commercial developments both regionally and internationally.

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 Trust Leadership Team each month, and subsequently by the Board and Board sub-committees.

The BAF reflects the top organisational risks that have the greatest impact on the delivery of the Trust's strategic objectives, and risks scoring 15+ (Based on an analysis of likelihood versus impact, each on a scale of 1-5).

The ORR reflects risks that threaten delivery of operational goals and risks with a mitigated risk score of more than 12 that 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: 4655 – Discharge to Assess
Sustainable Discharge to Assess Model
Lack of clear commissioning for Discharge to Assess (D2A)/Intermediate Care Model. No decision on future model has been agreed, presenting ongoing operational risks

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, particularly consultant psychiatry

The top three risks recorded on the ORR at the time of writing, are:

Risk Ref: 4465 – Approved Mental Health Professionals (AMHPs)
Risk of not having enough AMHPs to fulfil our statutory duties under the Mental Health Act 1983.

Risk Ref: 4586 – SBS (formerly Serco) Contract
There is a risk that the scope and delivery of services within the SBS (formerly Serco) contract may be compromised as a result of changes to the contract before the end of its term.

Risk Ref: 4250 – Section 75 Agreement between CPFT and Local Authorities
The S75 Agreement between CPFT and Peterborough City Council expired in August 2018 and between CPFT and Cambridgeshire County Council in March 2018. There is no contract extension in place. There is therefore a risk that PCC/CCC staff are working to CPFT with no formal contract in place.

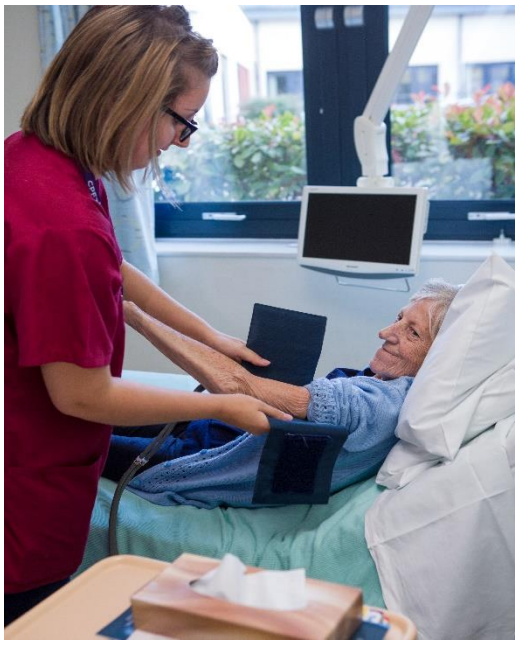
Overview of going concern

The accounts have been prepared on the basis that the Trust continues to operate as a 'going concern', reflecting the on-going nature of its activities. 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

The Trust has had a successful year financially delivering an operational surplus of £0.370m for the year, in line with our Control Total set by NHSI. As a result of this we earned Provider Sustainability Funding of £3.7m, resulting in an overall surplus of £4.1m for the year. The Trust's Finance and Use of Resources Risk Rating for the year was a "1", which is the best possible rating. The Trust also invested £2.9m in developing its infrastructure and estate.

A key financial focus during 2018-19 has been continuing to support the work being developed through the STP and to ensure that the agreed service developments we have been responsible for are implemented and delivered to support the system-wide savings plans and the reduction in admissions to our local acute hospitals. This has included a key role in the evaluation process for each STP supported and funded development to ensure that the new services are providing a positive benefit to both patients and the system financial position.



Internally, the Trust has focused on ensuring that planned efficiencies are delivered recurrently wherever possible, and that income is sustained or extended through conservative growth within existing or related service areas.
In the financial year 2018-19 we generated income totalling £224.4m, including £3.7m of Provider Sustainability Funding following achievement of our Control Total for the year. Our income is earned largely from contracts with NHS commissioners for activities relating to the provision of health and social care services. Most are block contracts where the income is fixed, irrespective of changes in activity levels, with our main commissioner being Cambridgeshire and Peterborough Clinical Commissioning Group. Income is linked to activity or outcomes for some services, including those specialist services commissioned by the local NHS England Specialist Commissioning Team. In 2018-19 staffing and other pressures in these services, particularly our Child and Adolescent Mental Health (CAMH) Tier 4 in-patient units, resulted in an adverse variance against plan of £1.6m for these services.

In common with other Trusts, our most significant area of spending is pay costs. Our total pay costs for the year were £157.5m and represent 72% of total operating expenses. The comparative figures for 2017-18 were £149.1m and 69%.

The financial position in 2018-19 has been supported by several non-recurring measures, with mitigating savings and utilisation of contingencies helping to offset funding pressures in core mental health services and under-achieved CIP targets in the year. As a result of this there is a recurring shortfall in the delivery of CIP savings in 2018-19, which has been brought forward to be addressed as part of the financial plan for 2019-20.

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 2018-19 of £2.9m. Improvements in the year included investment in technology to improve IT resilience and performance, and investment in mobile working to support clinical staff in the community. Estates and facilities investments were made to relocate teams and support improvements 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 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 that is currently under review.

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

- Improving the energy metering infrastructure. The Trust has installed a 'smart' meter network that 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 that may benefit from LED lighting have been identified.

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 other delegated areas of responsibility under the S75 agreements and delivery of services, despite continuous pressures on resources. This year has seen the embedding of the new senior management structure across social work. This has strengthened the delivery of social work services.

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, such as the Local Counter-Fraud Specialist, Equality and Diversity Officer and Guardian of Safe Working Hours, to provide a joint framework or approach to promoting and embedding the practice of ‘Speaking Up’

Further information about the role of the Freedom To Speak Up Guardian is set out in the Voluntary Disclosures section of this report.

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

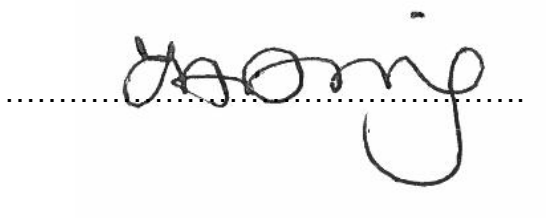
We continue to have an interest in potential European and international opportunities where we could offer research expertise, mentorship, training and service and strategy development.

The Trust was successful in being awarded a tender in Qatar to support a research and fellowship program. We anticipate the implementation of this tender will take place during the coming year (2019 - 2020), subject to the conclusion of a final contractual agreement being reached.

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

23 May 2019

SECTION 2: Accountability Report

The Accountability Report comprises:

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. Its 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
- Manage resources to maintain financial sustainability

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

The Board comprises eight Executive Directors and nine independent Non-Executive Directors (NEDs), including two Non-Voting Advisory NEDs. The Director of Transformation and the 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 2018 – 2019.

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 an appropriate balance of skills and experience. The Board of Directors also evaluates its own effectiveness on an annual basis, with the results presented to the private Board meeting in March 2019.

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, NEDs and Executive Directors are outlined in the Annual Remuneration Report. NEDs are appointed for a term of three years and are subject to an annual performance appraisal. NEDs 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 subject to any reappointment being reviewed on an annual basis.

Removal of NEDs, including the Trust Chair, requires the approval of not less than 75 per cent 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, in addition to providing annual declarations, are given the opportunity to declare any new interests at the beginning of every Board and sub-committee meeting.

The Trust's Register of Interests 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 2018 - 2019

Julie Spence OBE
Trust Chair

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

Julie has more than 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 chaired the Police Mutual Assurance Society during 2018-19 and is 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 (until January 2019)

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. In addition to his role within the Trust, Julian serves as Vice-Chairman of Diabetes UK and as a Non-Executive Director at Settle Group (formerly North Hertfordshire Homes).

Joanna Lucas
Senior Independent Director

Chair of:
Charitable Funds Management Committee

Joanna has more than 40 years' experience working in mental health services in the UK and internationally. She served as a Board member for a number of organisations that 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 more than 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. She is an Education Associate for the General Dental Council and 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 sectors. 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 Cambridgeshire 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 Advisory Non-Executive Director

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 an advisory Non-Executive Director 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). 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.

Angela Single
Advisory Non-Executive Director

Angela initially joined the Board as part of the national NExT Director Scheme, which supports women and people from black, Asian and minority ethnic communities to become non-executive directors in the NHS. Angela started her career as a registered nurse and subsequently qualified as a district nurse. She was general manager of all acute services at Hinchingbrooke Hospital and then Deputy Chief Nurse, North Middlesex Hospital.

Angela has worked in the heath technology market for more than 20 years. She was Global Business Development Director at BT Health and has advised several health tech start-ups. She chaired a joint Department of Health and Industry initiative in the UK *3millionlives* whose aim was to enable 3 million users to use technology in the home. She also launched a similar imitative (*1in4 lives*) in conjunction with the Australian Government.

Following the successful completion of her NExT traineeship, Angela was appointed as an advisory Non-Executive Director in March 2019

Executive Directors 2018 - 2019

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 more than 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.

Kit Connick
Director of Corporate Affairs

Areas of special interest and / or responsibility: Corporate projects, Trust secretariat, governance, communications and marketing, charitable funds, equality, diversity and inclusion, risk management, emergency planning, medical devices, Recovery College East, partnership engagement and chaplaincy services.

Kit has worked in a number of NHS corporate leadership roles in Cambridgeshire for 17 years, 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.

Melanie Coombes
Executive 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
Executive 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
Executive 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 more than 30 years' experience in senior management roles and more than 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 Cambridgeshire 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
Executive 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 more than 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
Executive Director of Operations

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

Julie has more than 22 years' operational experience within the NHS across the full Trust portfolio of services. 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 redesigns.

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.

The table overleaf details attendance at Board of Director meetings during FY 2018 – 2019

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 18	18th July 18	25th Sept 18	28th Nov 18	29th Jan 19	27th Mar 19		
Julie Spence, OBE	Chair (Non-Executive Director)	Full Year	✓	✓	✓	✓	✓	✓	Jan 2013	May 2020
Julian Baust*	Non-Executive Director	Full Year	✓	✓	✓	✓	✓	✓	April 2013	Jan 2022
Jo Lucas	Non-Executive Director	Full Year	✓	✓	X	✓	✓	✓	Oct 2014	Sept 2020
Sarah Hamilton*	Non-Executive Director	Full Year	✓	X	X	✓	X	X	Jan 2016	Jan 2022
Mike Hindmarch	Non-Executive Director	Full Year	✓	✓	✓	✓	✓	✓	May 2015	June 2021
Prof Peter Jones	Advisory Non-Executive Director	Full Year	✓	✓	✓	X	✓	X	Mar 2017	Feb 2020
Brian Benneyworth	Non-Executive Director	Full Year	✓	✓	✓	X	X	✓	Jan 2018	Jan 2021
Geoff Turral	Non-Executive Director	Full Year	✓	✓	✓	✓	✓	✓	Jan 2018	Jan 2021
Angela Single*	Advisory Non-Executive Director	Full Year	✓	X	X	✓	X	✓	Mar 2019	Mar 2020
Tracy Dowling	Chief Executive Officer	Full Year	✓	✓	✓	✓	✓	✓	Sept 2017	Exec Director
Melanie Coombes	Executive Director of Nursing and Quality	Full Year	✓	X	✓	✓	✓	✓	Nov 2012	Exec Director
Dr Chess Denman	Executive Medical Director	Full Year	✓	X	✓	✓	✓	✓	Jan 2012	Exec Director
Scott Haldane	Executive Director of Finance	Full Year	X	✓	X	✓	✓	✓	Jan 2015	Exec Director
Stephen Legood	Executive Director of People and Business Development	Full Year	✓	✓	✓	✓	✓	✓	Sept 2015	Exec Director
Julie Frake-Harris	Executive Director of Operations	Full Year	✓	✓	✓	✓	✓	✓	Oct 2018	Exec Director
Sarah Warner	Director of Service Transformation	Full Year	✓	✓	X	✓	✓	✓	March 2018	Director
Kit Connick	Director of Corporate Affairs	Full Year	✓	✓	X	✓	✓	✓	Oct 2018	Director

Removal of a Non-Executive Director requires the approval of not less than three quarters of the total members of the Council of Governors.

Angela Single joined the Board as an Associate Non-Executive Director under the national *NeXT Director* scheme. The appointment to an Advisory Non-Executive Director became effective on 25 March 2019

Julian Baust and Sarah Hamilton had their contracts extended to January 2022, with Julian Baust's appointment, for a third term, being subject to annual review, in accordance with the Trust's constitution.

Meeting dates for 2019 – 2020 are:

23 May 2019
24 July 2019
25 Sept 2019
27 Nov 2019
29 Jan 2020

Board of Directors' Sub Committees

The work of the sub-committees and their Terms of Reference are reviewed annually to ensure they remain 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 at least 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 is required to have relevant and significant financial expertise. A nominated governor lead also attends.

Meeting dates for 2019 - 2020:
15 May 2019
10 July 2019
9 October 2019
16 January 2020

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 three Executive Directors. A nominated governor lead also attends.

Meeting dates for 2019 - 2020:
24 April 2019
26 June 2019
28 August 2019
23 October 2019
18 December 2019
26 February 2020

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, and efficient processes and controls are in place across the Trust. The committee also provides assurance to the Board in relation to workforce matters.

Membership of the committee consists of four Non-Executive Directors, one of whom is appointed to the role of committee Chair, and three Executive Directors. A nominated governor lead also attends.

Meeting dates for 2019 - 2020:
24 April 2019
26 June 2019
28 August 2019
23 October 2019
18 December 2019
26 February 2020

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, two Executive Directors, the Director of Corporate Affairs, an operational director and up to a maximum of three Fund Advisors. The Head to Toe Charity Manager and the Deputy Director of Finance of the Trust are both permanent, non-voting members of the committee. There is also a nominated governor lead who attends.

Meeting dates for 2019- 2020:
12 June 2019
5 September 2019
4 December 2019
12 March 2020

The table overleaf details committee membership and meeting attendance during FY 2018 – 2019.

Sub-Committee Membership and Attendance

Name	Membership				Meeting Attendance																			
					AAC					B&P						QSG						CFM			
	AAC	B&P	QSG	CFM	18 April 2018	16 May 2018	11 July 2018	10 Oct 2018	17 Jan 2019	2 May 2018	4 July 2018	5 Sept 2018	7 Nov 2018	23 Jan 2019	6 March 2019	2 May 2018	4 July 2018	5 Sept 2018	7 Nov 2018	23 Jan 2019	6 March 2019	13 June 2018	6 Sept 2018	6 Dec 2018	13 March 2019
Julian Baust*		Chair	✓							✓	✓	✓	X	✓	✓	✓	✓	✓	X	✓	✓				
Jo Lucas			✓	Chair												✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Sarah Hamilton		✓	Chair							X	✓	X	✓		X	X	✓	X	✓	✓	✓				
Mike Hindmarch	Chair	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓	X
Brian Benneyworth	✓		✓	✓	✓	✓	✓	X	✓							✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Geoff Turral	✓	Chair			✓	✓	✓	✓	✓	✓	✓	✓		✓	✓										
Melanie Coombes			✓		✓											✓	✓	✓	✓	✓	✓				
Dr Chess Denman																✓	✓	✓	✓	✓	X				
Scott Haldane	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							✓	✓	✓	✓
Stephen Legood		✓	✓							✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Julie Frake-Harris		✓	✓							✓	✓	X	✓	✓	✓	✓	✓	X	✓	✓	X				
Sarah Warner		✓								X	X	X	✓	X	X										
Kit Connick				✓																		✓	✓	✓	✓

The Board appointed Geoff Turral to replace Julian Baust as Chair of the Business and Performance Committee on 28th November 2018.

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 Executive 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 NHSI guidelines, the Board and Committees completed annual reviews of their effectiveness. Results were collated and considered to form the basis for continuous improvement.

Better Payment Practice Code

Public Sector Payment Policy - unless other terms are agreed, we are required to pay our creditors within 30 days of the receipt of goods or a valid invoice, whichever is the latter. This is to ensure that we comply with the Better Payment Practice Code. The Trust's performance against this metric is shown in the table below:

Better Practice Payment Code Summary 2018 - 2019	No. of Invoices	Value (£000)
NHS Payables		
Total NHS trade invoices paid in the year	1,631	12,452
Total NHS trade invoices paid within target	864	6,538
Percentage of NHS trade invoices paid within target	53.0%	52.5%
Non-NHS Payables		
Total non-NHS trade invoices paid in the year	36,420	56,044
Total non-NHS trade invoices paid within target	25,346	37,105
Percentage of non-NHS trade invoices paid within target	69.6%	66.2%

The Trust paid £0.005m (2017-18 nil) interest under the Late Payment of Commercial Debts (Interest) Act 1998. Section 113(7) of the Public Contract Regulations 2015 requires the Trust to disclose the amount of interest that the Trust may be liable to pay in respect of late payment. The total potential liability to pay interest on invoices paid after their due date during 2018/19 would be £0.322m (2017-18 £0.340m). There have been no claims under this legislation and liability is only included within the accounts when a claim is received. This legislation does not apply to inter NHS invoices.

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 Treasury 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 disclosures relating to NHS Improvement's Well-Led Framework have been included within the Annual Governance Statement.

Patient care

Due to our size and level of autonomy, 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
- Integrated, intermediate care service
- Joint Emergency Team expansion
- Forensic Child and Adolescent Mental Health Service

These are already detailed within the Directorate information on pages 55-61 of this 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 and other relevant metrics. 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.

Building on previous investments, performance analysis processes have evolved during 2018-2019. Improvements in data quality and the enhancement of available data sources has increased the range of insight available to service managers and clinicians. At Trust, directorate, service or clinician levels of granularity, the Trust can monitor the capacity and demand associated with clinical activity, and also triangulate analysis across a range of clinical, HR and finance variables. These developments ensure that whilst maintaining compliance with NHS Improvement targets, the Trust can develop further business insight. Using national benchmarking data, Trust services use this data to investigate efficiencies and opportunities to enhance service provision.

The table below shows the performance of the Trust against the mandated NHS Improvement indicators, as defined in the Single Oversight Framework. Additionally, for completeness legacy indicators are reported, showing positive results maintained:

Measure	Type	Data Frequency	Measure Source	2016 / 2017 Full Year	2017 / 2018 Full Year	2018 / 2019 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	69.5%	72.5%	↑	71.4%	71.8%	69.9%	71.5%	**71.0%**
Community scores from Friends and Family Test – % positive (% of those categorised as extremely likely or likely to recommend)	Caring	Quarterly	NHS England	52.7%	76.9%	↑	86.1%	87.6%	89.2%	87.8%	**87.7%**
Finance - Use of Resources	Effective	Monthly	CQC	2	1	<=2	2	1	2	1	**2**
Written complaints – rate	Caring	Quarterly	NHS Digital	174	214	-	53	50	48	54	**205**
Inpatient scores from Friends and Family Test - % positive	Caring	Monthly	NHS England	92.9%	93.2%	>60%	80.6%	82.7%	81.6%	82.2%	**81.8%**
Mixed Sex Accommodation breaches *(Count of number of occasions sexes were mixed on same-sex wards)*	Caring	Monthly	NHS England	0	0	0	0	0	0	0	**0**
% clients in employment (on CPA, aged 18-69)	Effective	Monthly	NHS Digital	Measured differently	13.0%	4.50%	13.4%	11.8%	13.5%	14.6%	**14.6%**
% clients in settled accommodation (On CPA, aged 18-69)	Effective	Monthly	NHS Digital	79.6%	80.0%	75%	80.7%	78.6%	79.8%	79.9%	**79.9%**
Admissions gate kept by CRHT	Effective	Monthly	CPFT	99.4%	99.8%	95%	99.5%	100.0%	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	96.0%	95.8%	95%	95.9%	95.8%	95.2%	96.1%	**95.7%**
CPA patients having formal review within 12 months	Effective	Monthly	CPFT	96.1%	96.9%	95%	95.7%	95.4%	94.9%	95.3%	**95.3%**
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	2677	3294	↓	97	95	286	76	**554**
Minimising delayed transfers of care	Effective	Monthly	CPFT	2.9%	2.3%	<=3.5%	2.4%	1.5%	1.0%	2.8%	**1.9%**
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	7.8%	7.9%	-	4.8%	4.4%	4.6%	4.3%	**4.6%**

Measure	Type	Data Frequency	Measure Source	2016 / 2017	2017 / 2018	2018 / 2019	Q1	Q2	Q3	Q4	Full Year
Staff sickness	Organisational health	Monthly	NHS Digital	4.9%	4.1%	<4.35 %	4.0%	4.5%	5.2%	4.8%	**4.3%**
Staff turnover *(cumulative 12 month rolling)*	Organisational health	Monthly	NHS Digital	14.8%	12.2%	<10.5 %	12.0%	11.0%	11.1%	11.3%	**11.9%**
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	**0**
Admissions to adult facilities of patients who are under 16 years old	Safe	Monthly	NHS Digital	-	0	0	0	0	0	0	**0**
Clostridium difficile - Infection rate	Safe	Monthly	PHE	0	2	0	0	0	0	0	**0**
MRSA bacteraemias	Safe	Monthly	PHE	0	1	0	0	0	0	1	**0**
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	100.20%	53%	95%	95%	85.7%	94%	**91.9%**
% Compliance Overall Mandatory Training (core modules)		Monthly	CPFT	N/A	99.10 %	90%	93.4%	93.8%	94.0%	94.2%	**93.8%**
Safe Staffing Levels (Registered and Unregistered)	Safe	Monthly	CPFT	100.9%	88.2 %	80%	102.5%	100.9%	101.2%	102.4%	**101.7%**
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%	99.2%	99.25%	**99.2%**
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%	88.1%	87.0%	88.0%	87.3%	**87.6%**

The performance measures within the Trust are monitored through a robust governance structure. An active and effective performance management framework hierarchy exists, from service line reporting within individual teams, through to monthly Performance and Risk Executive meetings, the Board subcommittees (Quality, Safety and Governance and Business and Performance committees) and then to the Board itself. At each stage of this cycle, data driven performance discussion and challenge is undertaken.

This established and effective process ensures the Trust remains assured of performance and confident any issues are identified and addressed in a timely manner

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 are 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 Patient Safety Manager to determine whether there are safeguarding issues or whether the concerns 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 team provides monthly data on complaints to the Directorates, and at a Trust Board level within the Integrated Quality and Safety Report which is discussed at the Quality Safety and Governance Committee and Board.

The Trust has seen a slight decrease in the number of formal complaints for 2018-2019. The complaints team deals with formal and potential complaints, sign posts service users/complainants to the Patient Advice and Liaison Service (PALS) and other NHS / Social Care organisations and registers and responds to all health professional feedback.

The complaints team 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 207 formal complaints between 1 April 2018 and 31 March 2019. This is a 4% decrease from the number of complaints received in 2017/18 (n=216). The average response rate across the Trust has seen an increase from 47 working days in 2017/18 to 51 working days in 2018/19. The response rate is based on 227 formal and reopened responses being sent between 1 April 2018 and 31 March 2019. The Trust's average response time increased. The number of responses sent to complainants has seen an overall increase of 7%.

The Complaints Team reviewed the action module within the Datix system and have been using this to monitor action plans for formal complaints since April 2018.

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 Involvement and 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.

Statement as to Disclosure to Auditors (S148)

To the best of their knowledge, 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 and Deputy Chair
Sarah Hamilton, Non-Executive Director
Joanna Lucas, Non-Executive Director and Senior Independent Director

There were two Remuneration Committee meetings during 2018 – 2019, and attendance was as follows:

Name	Meeting Attendance *(There were two Remuneration Committee meetings during 2018 – 2019)*	
	17 May 2018	5 Dec 2018
Julie Spence	✓	✓
Julian Baust	✓	☒
Sarah Hamilton	✓	☒
Joanna Lucas	✓	✓
Mike Hindmarch		✓

Other attendees may be co-opted from time-to- time in accordance with agenda items. During the course of 2018 - 2019 the Committee was supported in its work by Tracy Dowling, Chief Executive and Stephen Legood, Executive 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.

It is the policy of the Trust to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience to effectively run the Trust, whilst also having due regard to the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances.

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 Executive 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

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

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

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

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

Julie Frake-Harris
Executive Director of Operations
Date in Post: October 2018
Unexpired Term: Permanent
Notice Period: Six Months

Kit Connick
Director of Corporate Affairs
Date in Post: October 2018
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

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 2019						Year Ending 31 March 2018					
	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	50 - 55	0	0	0	0	50 - 55	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
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
Brian Benneyworth, NED *(Note 1)*	10 - 15	0	0	0	0	10 - 15	0 - 5	0	0	0	0	0 - 5
Geoff Turral, NED *(Note 2)*	10 - 15	0	0	0	0	10 - 15	0 - 5	0	0	0	0	0 - 5
Professor Peter Jones, NED	0	0	0	0	0	0	0	0	0	0	0	0
Angela Single, NED *(Note 3)*	0 - 5	0	0	0	0	0 - 5	0	0	0	0	0	0
Tracy Dowling, Chief Executive (Note 4)	160 - 165	0	0	0	0	160 - 165	95 - 100	0	0	0	30 - 32.5	125 - 130
Dr Chess Denman, Executive Medical Director	120 - 125	0	0	0	0	120 - 125	155 - 160	0	0	0	60 - 62.5	215 - 220
Melanie Coombes, Executive Director of Nursing and Quality	130 - 135	0	0	0	0	130 - 135	130 - 135	0	0	0	70 - 72.5	205 - 210
Sarah Warner, Director of Service Transformation *(Note 5)*	90 - 95	0	0	0	5 - 7.5	100 - 105	0 - 5	0	0	0	40 - 42.5	45 - 50
Stephen Legood, Executive Director of People and Business Development	115 - 120	0	0	0	27.5 - 30	145 - 150	115 - 120	0	0	0	42.5 - 45	155 - 160
Scott Haldane, Executive Director of Finance	150 – 155	0	0	0	32.5 - 35	180 - 185	150 - 155	0	0	0	42.5 - 45	195 - 200
Julie Frake-Harris, Executive Director of Operations	120 - 125	0	0	0	30 - 32.5	155 - 160	120 - 125	0	0	0	130 - 132.5	250-255
Kit Connick, Director of Corporate Affairs	90 - 95	0	0	0	27.5 - 30	120-125	85-90	0	0	0	25 - 27.5	110-115

Note 1 – Appointed January 2018
Note 2 – Appointed January 2018
Note 3 - Joined as an advisory NED on 25 March 2019
Note 4 – Appointed August 2017
Note 5 –Sabbatical during 2017 – 2018, returned March 2018

Disclosures required by the Health and Social Care Act 2012:

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 2018/19 was £160,000 - £165,000 (2017/18 £155,000 - £160,000). This was 5.8 times (2017/18 5.7 times) the median remuneration of the workforce, which was £28,050 (2017/18, £27,635).

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 £25,911 in expenses to Directors (2017/18 £21,985) and £2,680 to Governors (2017/18 £702). 11 of the 17 Directors posts made claims for expenses and 11 of 27 Governors claimed expenses.

During the year the Trust also made one payment to a past Senior Manager of £514 in respect of reimbursement for travel expenses relating to their period of employment. No further payments were made to past Senior Managers and no payments were made for loss of office.

Pension Benefits 2018 – 2019 *(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 2019	Lump sum at aged 60 related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 1 April 2018	Real increase in CETV at age 60	Cash Equivalent Transfer Value at 31 March 2019	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
Tracy Dowling, Chief Executive	0	0	50 - 55	140 - 145	982	96	1,110	67
Dr Chess Denman, Executive Medical Director	0	0	65 - 70	205 - 210	1,554	0	0	0
Melanie Coombes, Executive Director of Nursing and Quality	2.5 - 5.0	0.0 - 2.5	45 - 50	115 - 120	777	108	928	76
Sarah Warner, Director of Service Transformation	0 - 2.5	0.0 – 2.5	35 - 40	90 - 95	583	86	699	60
Steven Legood, Executive Director of People and Business Development	0 – 2.5	0	20 - 25	40 - 45	300	51	378	36
Scott Haldane, Executive Director of Finance	2.5 - 5.0	0	15 - 20	0	197	37	261	26
Julie Frake-Harris, Executive Director of Operations	0 – 2.5	0.0 – 2.5	30 - 35	75 - 80	431	79	541	55
Kit Connick, Director of Corporate Affairs	0 - 2.5	0.0 - 2.5	20 - 25	40 - 45	257	50	329	35

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.

Following a late adjustment to the Greenbury disclosure guidance, the real increase in CETV for 18/19 has been adjusted as per the requirement however the 17/18 comparators have not in order to present the table as was published last year.

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	Real increase in CETV 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 31 March 2018
	(bands of £2500) £000	(bands of £2,500) £000	£000	(bands of £5000) £000	(bands of £5000) £000	£000
Tracy Dowling, Chief Executive	0 -2.5	10-12.5	74	50 - 55	140 - 145	982
Dr Chess Denman, Executive Medical Director	2.5 - 5.	10 – 12.5	148	65 - 70	205 - 210	1,554
Sarah Warner, Director of Transformation (Note 1)	0 – 2.5	(2.5) - 0	54	35 - 40	90 - 95	583
Stephen Legood, Executive Director of People and Business Development	2.5 - 5.0	0 - 2.5	49	15 - 20	35 - 40	246
Melanie Coombes, Executive Director of Nursing	2.5 - 5.0	5. – 7.5	100	40 - 45	110 - 115	774
Scott Haldane, Executive Director of Finance	2.5 - 5.0	0	53	10 - 15	0	195
Julie Frake-Harris, Executive Director of Operations	5 - 7.5	12.5-15	95	30 - 35	70 - 75	431
Kit Connick, Director of Corporate Affairs	0 – 2.5	0 – 2.5	27	15 - 20	40 - 45	257

Note 1 - Sabbatical during 2017/18, returned March 2018

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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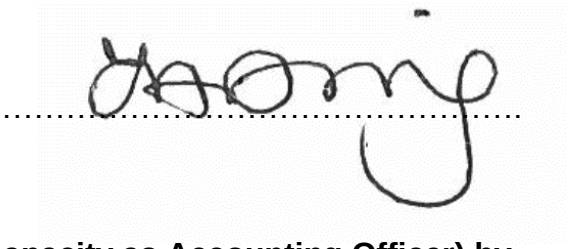
Following a late adjustment to the Greenbury disclosure guidance, the real increase in CETV for 18/19 has been adjusted as per the requirement however the 17/18 comparators have not in order to present the table as was published last year.

The Remuneration Report has been signed by the Chief Executive:



Signed (in her capacity as Accounting Officer) by:

Tracy Dowling
Chief Executive

23 May 2019

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	2018-2019	2017-2018
Medical and Dental	72	106	178	160
Ambulance Staff	-	-	0	0
Administrative and Estates	60	783	843	706
Healthcare Assistants and other support staff	161	871	1,032	881
Nursing, Midwifery and Health Visiting Staff	14	1,233	1,247	1,051
Nursing, Midwifery and Health Visiting Learners	-	-	0	0
Scientific, Therapeutic and Technical Staff	169	473	642	601
Healthcare Science Staff	-	-	0	0
Social Care Staff	-	-	0	0
Agency and Contract Staff	-	-	0	0
Bank Staff	-	189	189	179
Other	-	-	0	0
Overall Average	**333**	**3,719**	**4,052**	**3,404**
Of Which: Number of Employees (FTE) Engaged in Capital Projects	-	-	0	1

Workforce Gender Breakdown

Role / Category	Staff Numbers		
	Female	Male	Total
Board of Directors	10	7	17
Other Employees	3,384	673	4057
TOTAL INDIVIDUALS	**3,394**	**680**	**4,074**

Board of Directors

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

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

Staff Costs

			2018 - 2019	2017 - 2018
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	123,572	7,533	131,105	121,625
Social security costs	10,972	561	11,533	10,691
Apprenticeship levy	612	-	612	567
Employer's contributions to NHS pensions	15,703	-	15,703	14,698
Pension cost - other	-	-	-	-
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	114	-	114	194
Temporary staff	-	6,880	6,880	9,558
Total gross staff costs	150,973	14,974	165,947	157,333
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	150,973	14,974	165,947	157,333
Of which				
Costs capitalised as part of assets	284	100	384	453

Average Number of Employees (WTE basis)

			2018 - 2019	2017 - 2018
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	94	66	161	156
Ambulance staff	-	-	5	0
Administration and estates	691	57	733	702
Healthcare assistants and other support staff	762	158	794	955
Nursing, midwifery and health visiting staff	1084	12	1095	1,165
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	408	164	644	626
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Agency and contract staff	-	-	103	163
Bank staff	-	-	218	146
Other	204	-	2	9
Total average numbers	**3243**	**316**	**3755**	**3,628**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	5	5

Union Facility Time

Facility time is paid time off for union representatives to carry out Trade Union activities. The information below relates to Trade

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
1	0.6

Union facility time within NHS England.

The Trust is currently working in partnership with recognised Trade Unions to ensure that a full disclosure, stating information relating to the percentage of time spent on facility time and percentage of pay bill spent on facility time and paid trade union activities in line with the Trade Union Regulations 2017 (Facility Time Publication Requirements) is published on its website.

Developing a skilled and engaged workforce

To support the ambitions laid out in the NHS Long Term plan the Trust recognises the need to create an engaging 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 have completed the following:

- Developed and implemented a comprehensive training needs analysis that focusses on competencies, behaviours and roles. This is being delivered across seven different locations across Cambridgeshire to improve accessibility for our staff and increase the amount of time they spend with our patients.
- Launched our Talent Leadership and Organisational Development Strategy to further strengthen our commitment to retaining and developing CPFT talent through strategically planning our workforce and how they are developed. This has included embedding a compassionate and collaborative leadership culture and our values and behaviours across our leadership and personal development programmes.
- Strengthened our leadership development programmes by investing in and leading the facilitation of a Cambridge and Peterborough system wide leadership programme.
- Developed robust organisational development plans to support the ongoing change programmes that enable staff to meet the ongoing ambitions to integrate our health and social care services.

Information on NHS sickness data

The average percentage sickness rate for the Trust was 4.62% across the 2018 calendar year which was above our set target of 4.35%.

Sickness Analysis (2018 - 2019)

Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE Days Available	FTE Days Lost to Sickness Absence
3,559	-	7.7	1,299,035	60,265

The sickness analysis figures shown above are for the 2018 calendar year.

Staff policies

Staff policies and procedures reviewed and/or developed for 2018/2019 are:

- Capability policy
- Dignity at Work
- Flexible Working policy
- Mandatory training cancellation process
- Obtaining and providing references
- Social Media policy
- Temporary Employment policy
- Uniform and Dress Code
- Roster management
- Managing violence and aggression against staff

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 works 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

CPFT continues to take a number of steps to ensure slavery and human trafficking is not taking place in any of its supply chains or in any part of its own operations. We do this by:

- working towards full compliance with the relevant legislation and regulatory requirements;
- working to promote the requirements of the legislation, making our approach known to our suppliers and service providers;
- building on our existing workforce awareness of human trafficking and modern slavery, through our safeguarding policies/ protocols and commercial learning; and
- considering human trafficking and modern slavery issues when making procurement decisions.

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

- A new Onboarding process and guide has been developed for new employees and managers. This provides contact and support between an offer being made and a new employee commencing with the Trust to enable a positive start to employment with the Trust.
- A new recruitment system (TRAC) was launched which provides enhanced technical ability along with a streamlined process to support and improve the recruitment process and experience for managers and new employees. This has seen an improvement with time to fill. Along with this a new streamlined internal recruitment process has been developed and implemented.
- The Trust commissioned developments to the E-Rostering system (Health Roster) which are underway. This will result in the implementation of Safecare modules and HealthMedics module which will bring all medical staff onto the rostering system supported by robust job planning.
- The Trust continues to participate in the NHSI Retention Programme and has published updated Recruitment and Retention Strategies to support retaining high quality staff. There has been a reduction in turnover and increase in stability throughout the year.
- An updated and revised appraisal and supervision system was implemented to enable better recording of supervision.
- Improving data quality was a priority over the last year which has resulted in improvements to the accuracy.

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), and CPFT EMBRACE Campaign, 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: https://www.england.nhs.uk/about/equality/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://www.cpft.nhs.uk/about-us/equality.htm

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 Director of 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 2018/2019 include:

- 97.54% staff compliance with mandatory training, including Equality and Diversity training covering Equality Act Legislation
- Launch of the Diversity Network
- Engagement with staff through a series of Staff Wellbeing & Inclusion Roadshows; total of four at Doddington Hospital, Newtown Centre, Cavell Centre and Ida Darwin. At each event, staff were encouraged to update their Electronic Staff Record and a number of workforce team member were on hand to provide support.
- Development of Diversity Champions (50+) across the whole organisation to support the ED&I work at directorate/service level.
- The Trust's first Diversity Conference (October 29th, 2018) showcased the Trust's work and celebrated staff and EDI achievements.
- Transgender Embrace Guidelines co-produced and launched- next Embrace guidelines will be around reasonable adjustments.
- Comprehensive suite of training programmes co-produced and co-delivered with the recovery college and Diversity Champions, for example: Understanding LGBT+, Understanding Culture, the Power of Language, Understanding Resilience, 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 and weekly staff bulletins.

Education and training activities

As a Trust we remain highly committed to improving patient experience and care by providing opportunities for our staff to learn in a variety of ways to improve not only their academic knowledge, but also their practice and competency. This is being linked to clear career pathways to ensure that staff are developed to support their own personal development goals and future needs to support our patients. Despite challenges in funding arrangements we have maximised opportunities to have a robust professional development programme across all roles in our Trust to develop leaders at all levels.

We continue to work closely with educational providers to support work-based learning programmes and work experience with local schools and colleges. Despite salary pressures we have invested in apprenticeships to support career pathways across a range of disciplines including our nursing career pathways. The Trust has continued to support the Nursing Associate programme with our first cohort of this new workforce graduating in the early months of 2019. We have further invested in three more cohorts.

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 fund CPD activity through a substantive budget. This approach strengthens the CPD opportunities for our staff and complements the external funding received via the Learning Beyond Registration pool via Health Education England. This has included ongoing support for a number of staff undertaking degree or masters level programmes and modules during the year, Advanced Clinical Skills; mentorship, preceptorship in-house CPD events for specific roles and developmental workshops to strengthen our research and development skills

Health, Safety and Occupational Health

The Trust's Sickness Absence and Wellbeing Policy details support available to staff in relation to their health and working environment.

A health and wellbeing strategy has been developed and ratified by the Trust Board. This links to the NHS Employers framework and focuses on:

- Leadership and management
- Data and communication
- Healthy working environments
- Mental health
- Musculoskeletal support
- Healthy lifestyles- which is being developed to support our staff activities

The Trust's pilot Staff and Wellbeing Service was successful and has been commissioned on a permanent basis. This supports 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
- Mindfulness courses continue to be provided to staff

A number of other support channels include:

- Occupational health service provided by Optima via SBS
- 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 53% of Trust staff, which equates to 2,000 individuals, an increase from 51.8% in the previous year. Overall, the Trust is comparable to similar mental health, learning disability and community organisations. For 2018, results are organized into ten themes.

The below table highlights the Trust's top five scores:

No.	Question	2017	2018	National Average	Trend
Q22b.	I receive regular updates on service user experience feedback in my department.	63%	67%	61%	↑
Q10b.	On average, how many work additional PAID hours in a week?	80%	81%	78%	↑
Q18b.	I would feel secure raising concerns about unsafe clinical practice.	77%	78%	73%	↑
Q28b.	Has your employer made adequate adjustment(s) to enable you to carry out your work?	81%	80%	77%	↓
Q20.	Have you had any non-mandatory training or development in the last 12 months?	75%	77%	72%	↑

While most scores stayed stable, two overall themes showed a more statistically significant change, these were: Health and Wellbeing and Safe Environment (Bullying & Harassment). These dropped from 6.1 to 5.9 for Health and Wellbeing and 8.4 to 8.1 for Safe Environment (Bullying & Harassment). However, this does match the national trend and the average theme scores for 2018 are 5.9 and 8.0 respectively. It has continued to be a challenging year within the NHS, with increasing demand for services and the impact of growth in some teams.

The Trust action plan will focus on the following themes:

- Health & Wellbeing
- Safe Environment (bullying & harassment)
- Engagement
- Morale
- Quality of appraisals

The Trust's bottom 5 scores are:

No.	Question	2017	2018	National Average	Trend
Q21c.	I would recommend my organisation as a place to work.	54%	54%	59%	→
Q11c.	During the last 12 months have you felt unwell as a result of work-related stress?	43%	46%	41%	↓
Q19b.	The review or training helped me to improve how I do my job.	21%	19%	21%	↓
Q19d.	The review or training left me feeling that my work is valued by my organisation.	24%	28%	31%	↑
Q23a.	I often think about leaving this organisation.	N/A	32%	30%	N/A

The results continue to be analysed and the Workforce Executive will oversee the development of an appropriate action plan in response to the survey results. Draft action plans will continue to be developed with Staff Side, Directorates and staff, and will link to both the Workforce Strategy and the Organisational Development strategy and other work taking place within the Trust. These will be shared with Staff Governors for feedback and input.

Current activity and performance

CPFT's clinical audit and research activity was recognised as an area of 'Outstanding' practice in the Care Quality Commission's 2018 inspection report. CPFT is currently ranked as the top performing trust for mental health research in the east of England, and one of the national top five in the mental health category highlighted by the National Institute for Health Research (NIHR) Research Activity League Table for 2017/18.

Record numbers of people are taking part in NHS research, and since it opened in 2012, the Trust's Windsor Research Unit has recruited over 10,406 participants to studies in dementia, mental health and community healthcare. Each year CPFT delivers over 150 studies with over 1,500 people taking part, and 2019 is set to be another record-breaking year for recruitment and increasing access to new therapies and treatments through research. Research underpins NHS services by building the evidence base and changing practice, so we find the most effective and efficient ways of delivering care, achieving better health outcomes and recovery for patients.

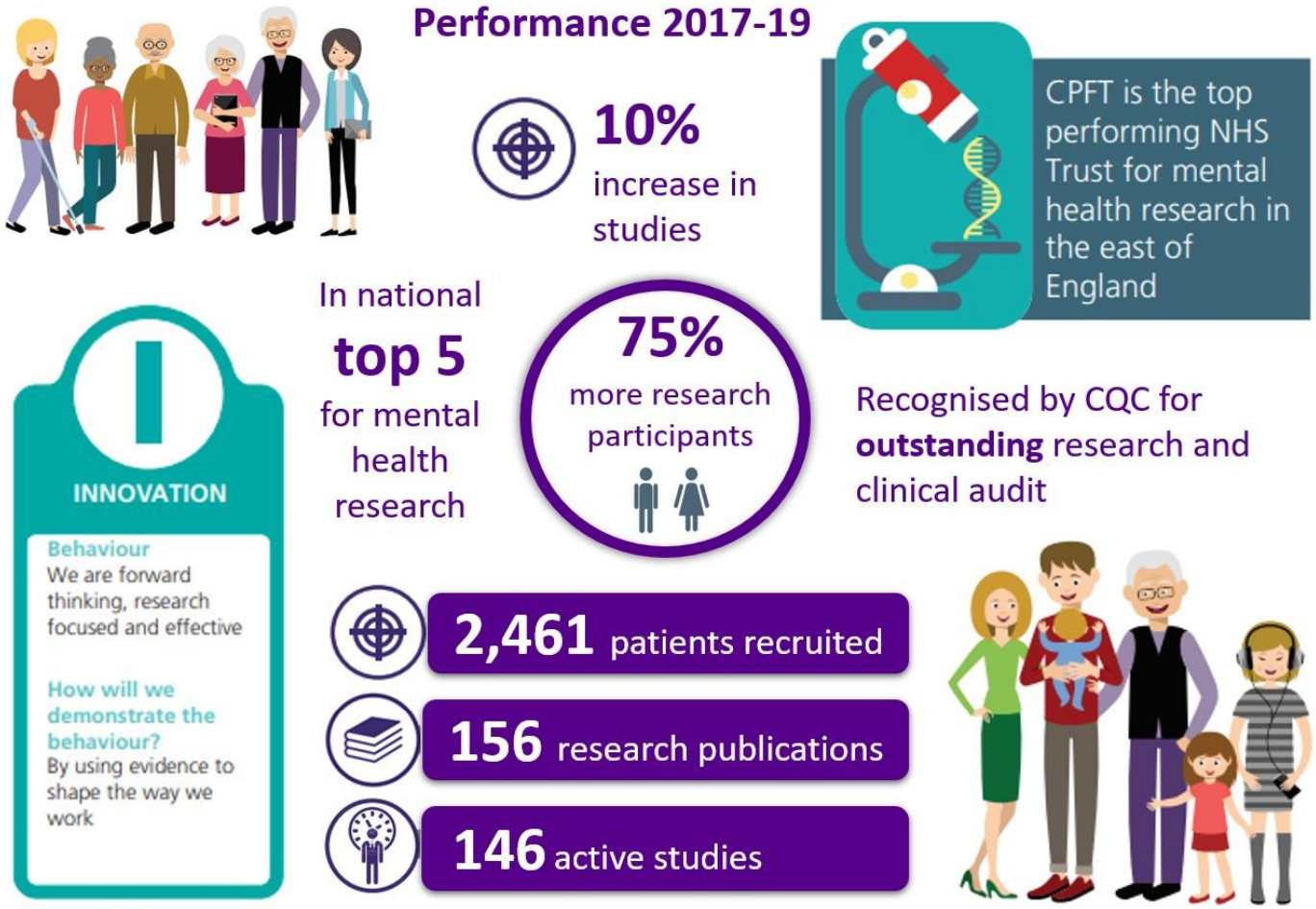
Growing NIHR and commercial portfolios

Research teams across the Trust continue to grow the number of projects and increase the number of research participants, working collaboratively with patients, carers and members of the public to improve care and treatment for mental and physical illnesses. Working closely with the Clinical Research Network Eastern to plan budget for delivering portfolio studies, the Trust's successful track record in recruiting to time and target also attracts major investment to deliver commercial studies.

Building research capacity and capability

CPFT hosts the National Institute of Health Research Collaboration for Leadership in Applied Health Research and Care East of England (NIHR CLAHRC EoE). This is a collaboration of academics, clinicians and managers who undertake high quality applied health research focused on the needs of patients and service users, supporting the translation of research evidence into practice in the NHS and social care.

The infographic and summaries below provide highlights of research and development activity 2018-19:



Changing care practice for dementia

CPFT research has driven a major update in guidance to improve diagnosis, management and care for dementia. Studies conducted by our clinicians and researchers, working closely with people living with dementia, have contributed to the knowledge base behind the new 2018 guidelines from the National Institute for Health and Care Excellence (NICE). Research informed best clinical practice through several studies looking at how to best use anti-dementia drugs, and the effectiveness of antidepressants in treating depression that occurs in dementia. Professor John O'Brien, Honorary Consultant in Old Age Psychiatry at CPFT and NIHR Specialty Lead for Dementia, was a member of the group that helped to formulate the new NICE guidance to improve the diagnosis, management and care of all those with dementia. CPFT is a top performer in the region and UK for recruitment to dementia studies, and in recognition of this significant contribution, NICE recommends that all people with dementia should be provided with information on research studies they could participate in.

Finding new treatments for depression

CPFT Research and Development director Professor Edward Bullmore leads the NIMA consortium – funded by the Wellcome Trust – which is a large academic-industrial consortium, investigating the role of the immune system in depression and Alzheimer's disease and how this could lead to new drug treatments for these disorders. In 2019, CPFT is leading as co-sponsor on a clinical trial of an investigational medical product (CTIMP), a new anti-inflammatory drug that is being tested as an anti-depressant for the first time. This is an important milestone for the NIMA consortium and also for CPFT, because it is the first time that CPFT has sponsored a CTIMP study.

Tailoring new therapies for recovery

Major funding was awarded from the NIHR Programme Grants for Applied Research (PGfAR) for the TYPPEX programme (team pictured), co-led by Professor Jesus Perez, CPFT consultant psychiatrist and Lead Clinical Director of the Eastern Clinical Research Network and Professor Peter Jones, Director of CLAHRC EoE and CPFT Advisory Non-Executive Director. TYPPEX is developing a new form of talking therapy for people with common mental health disorders and unusual experiences. Supported by frontline NHS staff in Psychological Wellbeing Services in CPFT, Norfolk and Suffolk NHS Foundation Trust and Sussex Partnership NHS Foundation Trust, the research team have beat data collection targets for this year with over 1,150 questionnaires measuring the prevalence of psychotic experiences in people using IAPT services, and the first therapy training module is being delivered for frontline staff.

Improving mental health assessments for young people

CPFT is s part of a new £1.5m study to help children and adolescents receiving care by improving diagnosis of emotional disorders. Consultant child and adolescent psychiatrist Dr Anupam Bhardwaj (pictured) is leading the study for Cambridge and Peterborough, working with national lead Professor Kapil Sayal from The Institute of Mental Health. They will be evaluating an assessment tool used by mental health clinicians working with children and adolescents to diagnose emotional disorders like anxiety and depression, working closely with health professionals and patients. The STADIA study (STAndardised DIagnostic Assessment for children and adolescents with emotional difficulties) is funded by the National Institute for Health Research and aims to evaluate whether the Development and Well-Being Assessment (DAWBA) standard assessment tool is clinically effective and good value in diagnosing emotional disorders in children and adolescents (aged 5-17 years), referred to Child and Adolescent Mental Health Services (CAMHS) with emotional difficulties. By evaluating different approaches to assessment within CAMHS, and publicising the findings, this research will help improve care and inform clinical guidelines. Study results will help the NHS decide how to ensure diagnosis of emotional disorders is effective and value for money.

Helping more people take part in research

CPFT is currently ranked as the top performing trust for mental health research in the East of England, and one of the national top five in the mental health category highlighted by the National Institute for Health Research (NIHR) Research Activity League Table for 2017/18. Record numbers of people are taking part in NHS research, and over the last 12 months, the Trust's Windsor Research Unit has recruited over 2,349 participants to studies in dementia, mental health and community healthcare, and continues to exceed monthly delivery targets. Each year CPFT delivers up to 150 studies on the NHS portfolio, with 2019 set to be another record-breaking year for recruitment and increasing access to new therapies and treatments through research. Clinical director Dr Ben Underwood and his team at the Windsor Research Unit won the 2018 Clinical Research Network Eastern Celebration Award for their work to improve the patient research experience – Putting Patients First.

Research innovation using data to improve healthcare

Dr Rudolf Cardinal, university lecturer in clinical informatics and honorary consultant liaison psychiatrist at CPFT, secured a £1.5 million Medical Research Council (MRC) pathfinder grant from the Medical Research Council for mental health clinical informatics. The programme focuses on how best to collect, link, anonymise, select, and analyse data to improve diagnosis and predict outcomes in mental health conditions. The research group is helping to build the systems, infrastructure, and insight to help make the best secure use of NHS data to improve healthcare. Academic teams are working collaboratively with industry partners in preparation for a future Mental Health Research Platform. CPFT is investigating ways to expand the use of the Trust's innovative research database – CRATE and reviewing opportunities to forge collaborations with academic and industry partners to further optimise the clinical and research potential of our data, using technologies such as artificial Intelligence.

Building research careers and expertise

Dr Mary-Ellen Lynall, a young psychiatrist supported by an NIHR Academic Clinical Fellowship in CPFT, won the 2017 Core Trainee of the Year award from the Royal College of Psychiatrists and, in 2018, was awarded a 3 year PhD Fellowship from the Medical Research Council. Her individual success is indicative of the overall strength of CPFT's medical training programme, also demonstrated by consultant psychiatrist Dr Chris O'Loughlin's recognition as 2018 Trainer of the Year, awarded by the Royal College of Psychiatrists at their prestigious annual celebration of excellence in psychiatry. We also have a growing programme for clinical research training which is attracting some talented young psychiatrists to work in CPFT and bringing an ethos of enquiry and research excellence into the medical workforce.

Supporting LGBTQ young people in care (NIHR CLAHRC EoE)

This NIHR CLAHRC EoE funded work aimed to co-produce and deliver accessible, impactful training materials for professionals working with LGBTQ young people in care. Scoping of currently available training for foster carers, social workers, residential workers was carried out. Working with two local authorities and two voluntary agencies, interviews with key strategic managers and focus groups allowed the research team to develop training materials that met the needs of key stakeholders. These training materials were co-produced with a team of seven young researchers, care experienced young people who identify as LGBT+. The resulting half day and full day training packages were piloted in Norfolk, Suffolk local authorities, National Fostering Agency and Break charity. An animated film was made with the young researcher team working with Creative Research Collective. The SpeakOut film was launched at Norwich Pride in July 2018. It has been picked up and used in training by National Fostering Agency and Three Circles Fostering, as well as a project run by Stonewall and Young Minds aimed at improving the mental health and emotional well-being of LGBTQ young people.

Supporting the transition of young people into adult services

The Child and Adolescent Mental Health Services (CAMHS) Transition Preparation Project funded by NIHR CLAHRC EoE brought together young people service users and leavers, as well as NHS practitioners and researchers, to explore what CAMHS transition preparation might involve and to co-devise a practical Transition Preparation Programme (TPP). The young people's primary recommendations to improve preparation for transition were: dedicated transition peer support workers, a personalised transition workbook, and a range of information including virtual 'podwalk' tours of mental health clinics.
The 12-month project officially concluded in March 2016, but work has continued since then.
In the 2 years following the end of the initial study, lead researcher Valerie Dunn has continued to work closely with staff and young people to provide support for transferring learning from the project, and further develop the young people's ideas. In CPFT, three peer support workers and two Band 6 transition workers were employed and continue to support the transition of young people into adult services, young people have filmed and published a virtual tour of Adult Mental Health Services.
A transitions booklet has been developed and published (April 2018) and interface meetings between CAMHS and adult teams have been introduced to discuss individuals' transitions.

Reducing out of area placements

Dr Roland Casson (clinical psychologist) undertook a 2015 NIHR CLAHRC EoE Fellowship project.
It focussed on school exclusion of children and young people (CYP) with learning disabilities and/or autism and behaviour that challenges others, a significant challenge of the Transforming Care agenda.
Such children are often placed in 52 week residential educational provision, far from their families and/or others who are able to monitor their progress and wellbeing. Such placements are hugely costly (approx. £300,000 per annum) and it's argued that locally invested money has more impact. Dr Casson examined data around these young people, aiming to understand how decisions about these CYP were made. Through interviews with practitioners, managers and commissioners of services (as well as examining individual trajectories to residential school), he established that the process was hard to understand, and that there was limited systematic support to enable these children to remain in local provisions. With two years of funding secured from Cambridgeshire Social Care, a small multi-disciplinary intensive support team was established. They used evidence-based Positive Behaviour Support to minimise exclusion from local provisions and the subsequent use of out-of-area residential school placements.
In December 2018, Cambridgeshire County Council committed a further two years of funding to a) develop the team and b) work with colleagues in Peterborough to implement a similar approach.
As the costs are split between social care, education and CPFT, the cost savings will inevitably benefit CPFT. Furthermore, this approach should reduce future demand on MH and intellectual (learning) disabilities services within CPFT.

Transcutaneous vagal nerve stimulation (tVNS) study

Aggressive behaviour is difficult to treat and has a major adverse impact on the lives both of those who present such behaviour and of their families and other care-givers. Professor Tony Holland and Dr Howard Ring found, serendipitously, that vagal nerve stimulation, approved to treat epilepsy, had a beneficial impact on the mood and behaviour of people with Prader-Willi Syndrome. Since then, a technical development has enabled the use of transcutaneous vagal nerve stimulation (tVNS) so a surgical implant is no longer required. Supported by the Foundation for Prader-Willi Research and CPFT, Professor Holland developed his study and found that, for some people with Prader-Willi Syndrome, tVNS has a dramatic impact on their behaviour. At the same time, Dr Isabel Clare, Dr Howard Ring, and Dr Fergus Gracey, funded by the CLAHRC and CPFT, have investigated whether tVNS may be helpful to people with developmental conditions (intellectual disability and/or autism) or acquired brain injury who present with aggressive behaviours. They are now developing collaborations with clinicians in in-patient services for people with intellectual disabilities/autism or acquired brain injury. The researchers are linking closely with MedTech work in CPFT and hope to involve patients whose lives are restricted because of their aggressive behaviour.

Strengthening service user and carer involvement in research

Involvement of people with lived experience of mental health issues in research is a key priority area within our R&D programme.

The Trust aims 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. CPFT service users and carers have supported research projects throughout 2018-19 and contributed to a number of training and showcase events.

Examples of research with patient and carer involvement:

- Pathways to care in at risk mental states and first episode psychosis
- Studying resilience after individual stress exposure
- Evaluation of Brief Psychological Interventions
- An investigation of the use of psychological formulation in ward settings to reduce restraint
- CBT to Reduce Insomnia and Improve Sleep in Early Psychosis (CRISP)
- Involvement of Experts by Experience in identifying mental health research topics and priorities: a scoping review
- Genetic determinants of common clozapine-induced side effects
- Dementia Care, Research and Technology funding application
- ENtorhinal CoRtex Structure and Function in PREVENT (ENCRYPT)
- Development and evaluation of Compassion Focused Group Therapy
- A more efficient journey: improving the autism pathway for adults
- Clinical Informatics for Brain and Health Research (CLIMB), MRC Mental Health Data Pathfinder Award

Service User and Carer Research Group (SUCRG)

The Trust runs a virtual group where people with lived experience of mental health issues or dementia are supported to be involved in the developing and running research, as well as sharing results and findings to facilitate learning.

During 2018/2019

- **48** Experts by Experience (EbEs) were supported to be involved in **34** research or research-related activities
- **26** researchers received advice and support
- **18** EbEs were involved for the first time
- **11** Lived Experience Advisory Groups (LEAG) were set up to help researchers with their projects - 10 were coordinated by CPFT R&D

Key achievements in 2018-19

EbE representation at CPFT R&D Strategic Funding Allocation Committee

Engaging with EbEs at all levels of decision-making is a priority for CPFT Research and Development, to strengthen relevance, responsiveness and accountability, and to build trust. To maximise patient leadership in R&D an EbE was recruited to join the CPFT R&D Strategic Funding Allocation Committee. The role of the EbE Representative is to bring a patient and/or carer perspective to the discussions and decisions made at the meetings.

Research on involving EbEs in identifying mental health research topics and priorities

As part of a CLAHRC Fellowship project the PPI Lead and four members of the SUCRG conducted a scoping review to gain a better understanding of the strengths and weaknesses of different approaches and assess whether any could be used to identify patient focused research topics and priorities in our area, or if better results may perhaps be achieved through combination of strengths of several methods. This work was built on the Department's recognition of the benefits of PPI at early stages of research and the recommendations of the PPI Strategy/Task and Finish Group (2017) on the way we can enhance person-centred research at CPFT.

Strengthen interdisciplinary team working and research

Members of the SUCRG and the PPI Lead supported researchers from the Department of Geography (University of Cambridge) to develop a successful funding application to carry out a conference on "Social Power and Mental Health", a topic of particular importance to EbEs.

Successful continuation of a PPI training programme

Approximately 120 researchers attended 12 teaching sessions which were co-delivered with experts by experience. Examples include:

- The 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. All sessions (9) were well attended and received excellent feedback. The CEbE programme was presented at the "International Perspectives on Evaluation of PPI in Research" Conference on 15th November 2018 in Newcastle (oral presentation given).
- A workshop delivered in collaboration with Recovery College East and focused on the way we can develop a recovery environment in mental health research by using recovery language.

LEAP/PPI Case Study: Randomised Study of Web-based CBT Intervention (Sleepio) to Reduce Insomnia and Improve Social Recovery in Early Psychosis (CRISP)

Camice Revier is a PhD Student who has special interests in sleep disruptions in mental health and social recovery in psychosis.

This research was initially motivated by conversation with experts by experience on sleep at a service user led teaching session called Conversations with Experts by Experience in 2015. The discussion prompted the analyses of sleep and social recovery in psychosis within the National EDEN cohort data that has ultimately led to the current study.

A Lived Experience Advisory Panel (LEAP) was set up in February 2017 to help shape the study during its development. Two members of the LEAP had contributed to the original conversation that prompted this research path. Since then the LEAP research partners have provided key input on the study design, recruitment strategies, surveys on sleep and its treatment, the Patient Information Sheets (PIS) and consent forms.

Five members of the LEAP participated in a practice run of the study and gave meaningful and real-world feedback on each component of the study process. This has provided an important opportunity to work out practical challenges in the design, assessment methods and survey wording, reinforce the acceptability and feasibility of the study and increase the likelihood that the full study process runs smoothly and is comfortable for participants.

Ideas were exchanged with members of the LEAP via email, phone conversations, texts and in person. Input was considered and ideas implemented before taking the protocol further. This allowed us to achieve our aim of ensuring that the experiment design and goals were established and developed in a way that is participant focused.

Members of the LEAP have expressed enthusiasm at their thoughts and opinions being translated into action and research. The majority of the original LEAP members have maintained involvement in the study development over the last two years and have been an integral part of the progress to date. Members will be encouraged to maintain involvement throughout the research and dissemination of findings.

As a researcher I've received validation from my LEAP partners that the ideas I've developed aren't just important to me but to the people they impact most during their recovery path. The collaborative team we've built together has kept me motivated and focused on who really matters in the research.

Expenditure on consultancy

During the year CPFT spent £0.149m on consultancy to support strategic reviews of service provision, emergency preparedness and actuarial support.

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 2019	**12**
Of which…	
No. that have existed for less than one year at time of reporting	8
No. that have existed for between one and two years at time of reporting	1
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	2
No. that have existed for four or more years at time of reporting	1

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 2018 and 31 March 2019	**8**
Of which…	
Number assessed as within the scope of IR35	8
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 2018 and 31 March 2019:

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.	17

Exit packages

There were three exit packages agreed in 2018/19 totaling £0.114m (4 in 2017/18 totaling £0.194m).

Reporting of Compensation Schemes: Exit Packages 2018 - 2019			
	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	-	2	2
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	1	1
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total Number of exit packages by type	**-**	**3**	**3**
Total resource cost (£)	-	£114,000	£114,000

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

Exit packages: other (non-compulsory) departure payments				
	2017 - 2018		2017 - 2018	
	Payments agreed	Total value of agreements	payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	2	100	1	120
Mutually agreed resignations (MARS) contractual costs	-	-	1	12
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	14	2	62
Exit payments following employment tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	3	114	4	194
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

Acs: 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)

The Adult and Specialist Mental Health Directorate was created three 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.

Over the last 12 months the Adult and Specialist Mental Health Directorate has seen an expansion of its *front door* services, the embedding of Primary Care Mental Health Services (formerly PRISM), witnessed a significant increase in activity within its First Response Service and the expansion of the Psychological Wellbeing Services and 24/7 Liaison Psychiatry. A perinatal service was launched during November 2018.

The main areas of development over the last year include:

First Response Service (FRS)
The service operates 24/7, providing much quicker access to urgent assessment and treatment for people of any age in a crisis situation living in Peterborough and Cambridgeshire. In the 2 years since it was fully launched there have been significant increases in demand with the service having handled 43,489 calls between October 2017 and December 2018. Anyone can call the team and receive advice, support or an assessment of needs. In addition, the team also undertakes face-to-face contacts. The service links to two out-of-hours 'safe havens' run by mental health charity Cambridgeshire, Peterborough and South Lincolnshire Mind. The Trust is committed to the continued development of the service which has received additional funding to guarantee its future for the next 12 months.

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.

Primary Care Mental Health Service
The Primary Care Mental Health service (formerly PRISM) **provides mental health support input into all GP surgeries** across Peterborough and Cambridgeshire. We have piloted drop-in clinics at some Cambridge-based GP practices and a *Managing Me* group in the Huntingdon area.

Perinatal Mental Health Service Launched
The Perinatal Mental Health Team is a multi-disciplinary mental health service for pregnant and post-natal women with complex or severe mental health illness. The team works collaboratively with women, their families and other professionals to detect, prevent and treat perinatal mental health problems. Since it launched in November 2018, the service has seen 138 women.

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)
The service celebrated its 10th anniversary during the year. The service continued to build on the links made with the Diabetes, Cardiovascular and Chronic Obstructive Pulmonary Disorder physical health teams. Since the expansion of the service in April 2017, 3602 of the 4,104 referrals resulted in patients entering treatment.

Dual Diagnosis Street Team
Since the introduction of the Dual Diagnosis Street Team (DDST) in 2017, 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, 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 signpost, support and offer guidance and advice to those who do not meet the criteria and to other non-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.

24/7 Liaison Psychiatry Service (Pilot) Launched

This service is available to anyone attending A&E or who requires mental health care on acute wards. The service operates on a 24/7 basis at Peterborough City and Cambridge University Hospitals and on a weekday 9-5 basis at Hinchinbrooke Hospital. The 12 month pilot was funded by a £1.1m contribution from NHS England.

Out of Area Treatment Services (OATS)

The number 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 2019, there were seven out of area patients. All of these patients need services that are currently not provided by the Trust. Work continues to develop services ensuring that all patients receive their care as close to home, friends and families as possible.

Integrated Mental Health Team

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 the 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."

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

2018/19 has been a busy, challenging and exciting time for Older People's and Adult Community Services (OPAC). The directorate has remained focused on delivering the **quadruple aim** for our population of older people in our community, striving to:

- **enhance** the **experience** of each of our **patients**
- be sensitive to the wider health needs of our **local populations**
- deliver high quality services in **an efficient and cost-effective** way and
- ensure we **support our staff** in maintaining their own health and wellbeing.

Highlights:

- OPAC services ended 2018/19 with a caseload of 40,574 patients (live referrals as at 31st March 2019)
- We delivered 818,639 contacts against 809,643 contacts in 2017/18
- There were 40,427 Minor Injury Unit attendances
- OPAC inpatient units delivered 50,714 inpatient bed days
- 97% of referrals were seen within 18 weeks
- There were not any *Never Events* and 22 Serious Incidents (compared with 39 in 2017/18)
- We had 4 'Stop the Lines' (2017/18: 3)
- We had 4 avoidable pressure ulcers compared with 14 in 2017/18
- We received 68 complaints compared with 88 in 2017/18

Neighbourhoods and community integration

We have continued to refine neighbourhood team services by enhancing clinical staff alignment to their local GP practices. The creation of a new patient flow co-ordinator role supports each of our 14 neighbourhood teams to focus on the co-ordination and tracking of complex patients on neighbourhood team caseloads across the system, ensuring patient flow, in to, through and out of the system, working closely with GP practices and acute trusts.

Looking ahead, the directorate continues to be a key partner across the system in the development of primary care networks and integrated care systems.

Sustainability and Transformation Partnership (STP)

Throughout the year, the directorate has consolidated its STP funded services including dementia, falls prevention, diabetes, early supported discharge for stroke, respiratory, heart failure, Joint Emergency Team (JET) and intermediate care services (discharge to assess).

Evaluation for each STP scheme was carried out throughout 2018, offering detailed analysis and indicating excellent patient outcomes and return on investment of each of the schemes.

Excellence in care
The directorate has implemented a range of initiatives to enhance the care we provide. In addition to the appointment of a Head of Nursing and Quality, we have implemented service improvements at Denbigh ward, our dementia inpatient unit in Cambridge.

Service Line Reporting combined with regular Quality Improvement Visits (QIV) process, local governance and team meetings and Patient Safety and Quality forums provides a robust process across the directorate to ensure we deliver safe and effective care.

We have also established our Safe to Care Group, End of Life Steering Group and Technology Group. The directorate now has a nursing practice development lead role for both physical health and mental health, working with our nursing teams and staff to drive forward clinical audits, quality improvements and support the development of our wider nursing workforce.

Transformation and cost improvement
Transformation and service improvement became one of the key focuses for the directorate in 2018 with the creation of a monthly Transformation Board and a programme of transformation and cost improvement schemes for 2018/19.

Unplanned care services
In addition to the expansion of STP funded emergency response services including the Joint Emergency Response Teams (JET) and Older People's Mental Health Crisis response teams, the directorate has continued to embed its Intermediate Care teams across Cambridgeshire and Peterborough.

We have driven forward the development of a community-based operations hub, running a virtual operations centre function coordinating up to date daily situational awareness for unplanned and planned care services within OPAC.

The scope of services will expand in 2019 to include both the Adult and Specialist Mental Health and Children, Young People and Families directorates.

Our Staff

The directorate has focused on leadership and engagement with our staff, driving forward a co-creation approach to delivering local service improvements.

Use of feedback from local questionnaires along with the national staff survey results is helping us to shape our future model for staff engagement, ensuring our staff feel valued and supported to do the basics well, empowering them to make decisions and ensuring communication channels are efficient, effective and supportive.

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 2018–2019, 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.

Transition
During the year the Trust introduced mental health transition workers to work alongside young people to help and support them during the transition from Child and Adolescent Mental Health services. In addition, Peer Support Workers were also engaged in specifically supporting young people during this transition process.

Joint transformation
A key focus of work during the year was the joint work with Cambridgeshire Community Services NHS Trust to bring together children's mental and physical health services across Cambridgeshire and Peterborough. During the year the Joint Transformation Board agreed that it would prioritise 0-19 services which led to the development of a joined-up service model. The implementation of this new service model, together with enhancements to occupational therapy physiotherapy will be key in the forthcoming year.

First Response Service
The First Response Service provided by the Adult & Specialist Directorate expanded its remit during the year to include children and young people. Additional staff have been recruited to support this and a pilot operating from 4 pm to 12 pm implemented in December 2018 in Peterborough. The objective of the pilot is to inform the development of services to be provided to children and young people in 2019/20 and beyond.

East of England Community Forensic Child and Adolescent Mental Health (FCAMH) & Complex Cases
The Directorate introduced two new services in 2018/19, commissioned by NHSE; FCAMHS and complex cases. The East of England FCAMHs is part of a nationwide service and there was a phased implementation during the year, initially opening to Cambridgeshire and Peterborough and more regionally by the end of April. In additional to its primary clinical objectives, the service also provides training to staff working in a variety of settings across the region wishing to enhance their skills in working with this complex cohort of children and young people.

The Complex Case Management Service is a small project commissioned through the Clinical Commissioning Network. The service operates across Cambridgeshire and Peterborough offering advice, advocacy, assessment and at times interventions for young people who are at significant risk of offending, are struggling with their mental health and for whom engagement with mainstream services is challenging.

Phoenix Unit
As a result of recruiting difficulties experienced during the year, the Trust took the difficult decision to temporarily 'pause' the service. Following a recruitment drive and a redesign of the service in conjunction with commissioners, staff, young people and their families, Phoenix was reopened in October and phased new admissions to the unit should ensure a sustainable model is maintained.

East of England Children's Hospital
In December, the Department of Health announced that Cambridgeshire and Peterborough would be allocated up to £100m of capital funding to support plans to build a new East of England Children's Hospital. The Trust has been working alongside Cambridge University Hospitals NHS Foundation Trust on the options for relocating the three tier 4 inpatient units by 2023. The new hospital presents an exciting opportunity to integrate children and young people's mental and physical health services and research.

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 Council of Governor'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 2018–2019, are outlined below:

COG RESPONSIBILITY	ACTIONS IN FY 2019
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 Angela Single as an Advisory NED.
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.
Appointing, reappointing or removal of the Trust's External Auditors	At the Council of Governors' meeting in December 2018.
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 in September 2018

CoG Meetings, Governor and Board Involvement

The CoG met in full four times during 2018-2019. 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

Development of strategy and forward plans

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 Governors

Representing the interests of the Trust's members and the public

Four Governors currently serve as membership leads. This year, the membership Recruitment and Engagement Strategy was refreshed due to the introduction of the General Data Protection Regulations. A Governor membership working group was set up to look at ways in which Governors can support the delivery of the refreshed strategy. The membership working group meets every quarter and 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 representation and engagement with the Trust membership.

The Trust's website provides details of our Governors' work and how to contact them – www.cpft.nhs.uk/about-us/council-of-governors.htm

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 2018 - 2019, these were held on: 25 April, 20 June,13 September and 5 December.

NAME	CLASS OF GOVERNOR	DATE ELECTED	DATE(S) OF RE-ELECTION	CURRENT TERM ENDS	MEETINGS ATTENDED of 4
Elizabeth Mitchell (Note 1)	Public (Cambridgeshire)	July 2012	May 2014, May 2017	Deceased May 2018	**1 out of 4**
Fiona Kerr	Public (Cambridgeshire)	June 2018		June 2021	**2 out of 2**
Clare Tevlin (Note 2)	Public (Cambridgeshire)	June 2018		June 2019	**2 out of 2**
Margaret Johnson	Public (Cambridgeshire)	July 2011	July 2014, May 2017	May 2020	**4 out of 4**
Stephen Mallen	Public (Cambridgeshire)	June 2018		June 2021	**2 out of 2**
Adrian Howson	Public (Cambridgeshire)	June 2018		June 2021	**1 out of 2**
Paul McGhee	Public (Cambridgeshire)	June 2017	-	May 2020	**3 out of 4**
Eric Revell	Public (Cambridgeshire)	May 2015	-	May 2018	**1 out of 4**
Jo Griffin	Public (Cambridgeshire)	May 2017	-	May 2020	**2 out of 2**
Dr Charlotte Paddison	Public (Cambridgeshire)	May 2016	-	May 2019	**0 out of 4**
Maggie Barker	Public (Peterborough)	June 2018		June 2021	**3 out of 4**
Nazreen Bibi	Public (Peterborough)	June 2018		June 2021	**2 out of 4**
Chris York	Public (Peterborough)	July 2012	July 2015	July 2018	**0 out of 4**
David Over	Public (Peterborough)	May 2015	-	May 2018	**0 out of 4**
Helen Blythe	Public (Peterborough)	May 2016	-	May 2019	**0 out of 4**
Sarah Fox	Public (Peterborough)	June 2018		June 2021	**1 out of 4**
Margery Abbott (Note 3)	Patient/Service user(Interim)	June 2018		June 2019	**2 out of 2**
Mark Prince	Patient/Service user	June 2018		June 2021	**2 out of 2**
Ashley Curry	Patient/Service user	June 2018		June 2021	**2 out of 2**
Keith Grimwade	Patient/Carer: Carer	May 2014	May 2017	May 2020	**4 out of 4**
Mirka Anderson	Patient/ Carer: Carer	May 2017	-	Stepped down: November 2018	**1 out of 3**
Xander Sellers	Patient/ Carer: Service User	May 2017	-	Stepped down: November 2018	**0 out of 2**
Robert McCaighey (Note 4)	Patient/ Carer: Service User	May 2017		May 2018	**2 out of 2**
Sue Rampal (Note 5)	Staff (Interim)	June 2018		June 2019	**2 out of 2**
Matthew Barker	Staff	June 2018		June 2021	**2 out of 2**
Rebecca Manning	Staff	May 2017	-	Stepped down: October 2018	**2 out of 2**
Nora O'Shea	Staff	May 2017	-	May 2020	**1 out of 4**
Sara Simpson	Staff	May 2016	-	May 2019	**3 out of 4**

Note 1 - Elizabeth Mitchell was Lead Governor until 25 April 2018. The Trust's new Lead Governor is Keith Grimwade.
Note 2 - Clare Tevlin 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 her term of office
Note 3 - Margery Abbott 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 her term of office.
Note 4 - 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.
Note 5 - Sue Rampal 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 her term of office.

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

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**
Charlotte Black	Cambridgeshire County Council and Peterborough City Council	Stakeholder	September 2018	**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	**3 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
Tracy Dowling	Chief Executive	4 out of 4
Brian Benneyworth	Non-Executive Director	4 out of 4
Chess Denman	Executive Medical Director	1 out of 4
Geoff Turral	Non-Executive Director	4 out of 4
Jo Lucas	Non-Executive Director	3 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)	3 out of 4
Melanie Coombes	Executive Director of Nursing and Quality	4 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	2 out of 4
Scott Haldane	Executive Director of Finance	3 out of 4
Stephen Legood	Executive Director of People and Business Development	3 out of 4
Sarah Warner	Director of Service Transformation	2 out of 4
Julie Frake-Harris	Executive Director of Operations	3 out of 4

Angela Single was appointed as an Advisory NED in March 2019 and therefore did not have the opportunity to attend any Council of Governor meetings.

Governor Elections Update

UK Engage acted as Independent Returning Officer for the Trust's Governor election process in 2018. Results of this annual election were published in June 2018. In summary, the following Governors were elected or re-elected:

PUBLIC – CAMBRIDGESHIRE

Fiona Kerr
Newly elected following the 2018 elections

Stephen Mallen
Newly elected following the 2018 elections

Adrian Howson
Newly elected following the 2018 elections

Sarah Fox
Newly elected following the 2018 elections

PUBLIC - PETERBOROUGH

Maggie Barker
Newly elected following the 2018 elections

Rick Harris
Newly elected following the 2018 elections

* Adiolah Mberi
was appointed as interim Governor due to an elected Governor stepping down

*** Nazreen Bibi**
Newly elected following the 2018 elections

Rebecca Dunkerly
Newly elected following the 2018 elections

PUBLIC REST OF ENGLAND
Helen Brown
Newly Elected following the 2018 elections

SERVICE USERS LIVING WITHIN THE ELECTORAL AREAS OF CAMBRIDGESHIRE COUNTY COUNCIL, PETEROBOURGH CITY COUNCIL AND THE REST OF ENGLAND:

Mark Prince (Peterborough)
Newly elected (uncontested) following the 2018 elections

Ashley Curry
Newly elected following the 2018 elections

Catherine Darler–Ballard
Newly elected following the 2018 elections

Margery Abbott was appointed as interim Governor due to an elected Governor stepping down

*

*

STAFF
Matthew Barker
Newly elected following 2018 elections

A total of 13 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.
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 September

The Council of Governors has appointed Joanna Lucas as Senior Independent Director. Working with the Lead Governor, the Senior Independent Director appraised the Trust Chair's performance and reported to the April 2019 Council of Governors.

The Committee confirmed the appointment of Angela Single as an Advisory Non-Executive Director at its January 2019 meeting and approved extensions of the terms for Sarah Hamilton and Julian Baust.

Register of Interests

All Governors are required to declare any (potential) conflicts of interest at the time of their appointment or election. The register is maintained by the Trust Secretary and all Governors, in addition to providing annual declarations, are given the opportunity to declare any new interests at the beginning of every CoG meeting.

The CoG Register of Interests is maintained by the Trust Secretary. It 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

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

As at 31 March 2019 the membership numbers were as follows:

Public	8754
Service User/Carer	1127
Staff	4324

A total of **713** new members were recruited between 31 March 2018 and 31 March 2019.

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. 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 Foundation Trust Code of Governance, most recently revised in July 2014, is based on 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 that 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 nine Non-Executive Directors including the Trust Chair and two advisory NEDs, and six Executive Directors and two Directors. These Non-Executive Directors are considered by the Board to be independent. Two Directors and two Advisory Non-Executive Directors do not have voting rights. This ensures that there are more Non- Executive Directors with voting rights in total.

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

B.3.3 Scott Haldane, Director of Finance, is a Non-Executive Director for Edinburgh Leisure.

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 Directors' Report.
A.5.3	Contained within the Directors' Report.
B.1.1	Contained within the Directors' Report.
B.1.4	Contained within the Directors' Report.
B.2.10	Contained within the Directors' Report.
B.3.1	Contained within the Directors' Report. These commitments are also captured within the Directors' Register of Interest, and upon appointment to the Trust.
B.5.6	Contained within the Directors' Report.
B.6.1	Contained within the Directors' Report.
B.6.2	There was no external evaluation of the Board of Directors during 2018 – 2019.
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 Directors' Report.
D.1.3	Not applicable.
E.1.4	Contained within the Directors' Report.
E.1.5	Contained within the Directors' Report.
E.1.6	Contained within the Directors' 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.

Segmentation

The Trust has been segmented as a '2' in NHS Improvement's assessment process. This segmentation information is the Trust's position as at 31 March 2019. 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 rating 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	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	1	3	2	2	1	2	3	3
	Liquidity	1	1	1	1	1	2	3	3
Financial efficiency	I&E margin	1	3	2	2	1	3	4	4
Financial controls	Distance from financial plan	1	3	1	1	1	3	3	3
	Agency spend	1	1	1	1	3	3	4	4
Overall scoring		1	2	1	1	1	3	3	3

Information on Serious Incidents (SI) involving data loss or confidentiality breaches

SI LEVEL	FY 2018 – 2019	FY 2017 - 2018
Level one	9	26
Level two	3	5

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

All Information Governance incidents are reported using the internal incident reporting system. The Information Governance team reviews each incident against the *NHS Digital Guide for the Notification of Data Security and Protection Incidents.*

Incidents that reach the threshold for reporting are entered onto the *Data Security and Protection Toolkit* reporting tool.

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

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.

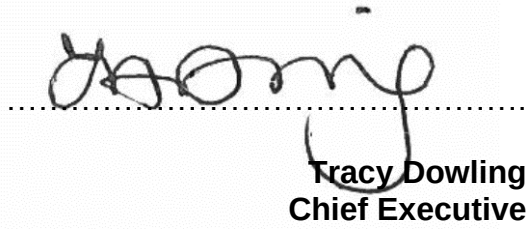
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions that require Cambridgeshire and Peterborough NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The 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,
- confirm that 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 Trust's performance, business model and strategy; 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

23 May 2019

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 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 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 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 2019 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 (including corporate services) has been designed to support comprehensive management of the directorate risks including those risks that impact on key overarching and strategic risks for the Trust. All directorates (and individual teams within each directorate) are expected to identify, understand and mitigate local risks, ensuring that these are reviewed and managed at various levels within the organisation, depending on the mitigated risk score.

The Trust produces a corporate risk profile, that is logged on an electronic system (Datix) and mapped to each directorate. 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 where key risk issues are discussed.

The Executive Directors hold each directorate leadership team to account for their management and mitigation of these risks and to understand the collective risk on the organisation. This forum is also an opportunity for key directorate-level issues that may pose a risk to the achievement of the Trust's strategic objectives to be added to the Operational Risk Register (ORR) and, where appropriate, the Board Assurance Framework (BAF).

Another key governance forum where information is shared between directorates and the Executive Directors is the monthly Trust Leadership Team (TLT). This meeting is attended by Clinical Directors, Associate Directors of Operations, Directorate Nurse Leads, Associate Directors of Corporate Functions 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 Trust Leadership Team 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' and in accordance with the Trust's Risk Management Framework. Risk is also regularly reviewed in the following formally constituted sub-committees 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 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 and mitigation 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 Board Assurance Framework ("BAF") and Operational Risk Register ("ORR") are updated monthly as 'live' documents to ensure they reflect up-to-date risks and mitigations. Operational risks are escalated monthly through directorate PRE meetings as described above, with appropriate actions discussed and agreed to reduce or manage operational risks.

Together, the Operational Risk Register (ORR) and Board Assurance Framework (BAF) 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.

At the end of each Trust corporate meeting the final agenda item is to consider whether any issues discussed at the meeting need to be included in the BAF or ORR, which has proved to be an effective way to ensure that the strategic and operational discussions happening at these meetings are reflected in the BAF/ORR.

The relevant sections of the BAF/ORR 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 Trust Leadership Team and the Board of all the risks on the Board Assurance Framework to ensure that these appropriately reflect the current risk status and that the BAF/ORR is a 'live' document.

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 Business and Performance Committee:

1. Considers and comments upon revisions to the Trust's Risk Management Strategy and supporting policies and procedures;

2. Receives the Risk Register to consider and provide views regarding financial and business risks prior to reporting to Trust Board; and

3. Considers and highlights to the Trust Board, any areas of business, performance or financial risk that may escalate and impact upon delivery of the annual plan and Trust objectives.

The Quality, Safety and Governance Committee:

1. Ensures the Trust Board is sighted on areas of good practice and emerging risks in relation to clinical governance and ratifies the policy assurance process;

2. Leads on compliance with the CQC fundamental standards for quality and safety and including preparation for any CQC assessments and actions to be taken following the inspection; and

3. Leads on the implementation of the Trust's Quality Strategy and ensures issues that impact on the quality of our services 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; and

2. Is comprised of at least three Non-Executive Directors, including a Chairperson, who is required to have significant recent financial experience

The Quality and Compliance Executive 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.

The Quality and Compliance Executive (QCE) has over-arching responsibility for monitoring quality and compliance matters in the Trust; particularly in relation to patient safety, clinical effectiveness, and patient experience. It also has delegated responsibility over ensuring Trust compliance with the CQC standards, as well as identifying and acting on cross-cutting themes across the three clinical directorates.

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 of Governers' meetings. Control measures are also in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with.

We have a range of mechanisms to provide the Trust Board with assurance in respect of compliance with the CQC registration requirements. This includes certain metrics within the Integrated Performance Report (IPR) and the more detailed Quality and Safety Report; both produced on a monthly basis. Other sources of assurance include internal patient, carer and staff surveys, as well as bespoke assessment tools such as our Quality Improvement and Evaluation Tool (QuIET) which monitors practice around care planning standards. We also use intelligence from safeguarding and Serous Incident (SI) investigations, complaints, compliments, and concerns raised from the Freedom to Speak Up Guardian process; as well as through clinical audit and service reviews, NICE scoping and gap analysis, accreditations, and other benchmarking information.

Within the clinical directorates, there is a programme of regular Quality Improvement Visits (QIV) that have been designed around the CQC Key Lines of Enquiry (KLoE). Emerging themes are triangulated against known data and other information to support the development of improvement actions.

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.

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 Data Security and Protection Toolkit (formerly known as the Information Governance Toolkit) submission. The Trust successfully recorded compliance with the NHS Digital Information Governance requirements.

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 sub-Committee structures. The Chief Executive updates the Board in her report which includes links to STP board papers. 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 Trust's own responsibilities as defined in statute.

The organisation's major risks, as identified within the Board Assurance Framework and Operational Risk Register as reported to the Board of Directors at the end of Quarter 4, are detailed below:

Description of risk mitigation

Description of Risk	Mitigation
Trust unable to provide sustainable Discharge to Assess Service due to unclear commissioning arrangements and lack of clear governance structure for care support and provision.	• Problems escalated to highest level within CCG. • Engagement with North and South Alliances to discuss solutions • Continue to provide restricted service in line with level of funding available.
Engagement in Joint Venture with Cambridgeshire Community Services for provision of children's services creates reputational and funding risks for services and increases health inequalities in the Peterborough area.	• Internal and external discussions ongoing to mitigate reputational risk. • Escalated financial concerns to Public Health Commissioners to address financial and inequalities risks.
Adult eating disorder services do not meet the population health need due to gaps in the commissioned service pathway and challenges recruiting an experienced workforce across all service areas.	• Raised commissioning gap issues with commissioners in C&P and in Norfolk. • Assigned a Matron to take overall responsibility for the services. • Developed clear referral criteria and communications for GPs regarding these so that the most at-risk patients do receive assessment and treatment. • Put temporary arrangements in place within community services for medical monitoring of high-risk patients where their GPs are refusing to monitor them. • Quality Improvement redesign work which is co-produced with patients and staff has been led by the Matron and clinical leaders in the services. • Developed many recruitment and retention initiatives to address workforce issues.

	• CEO engaged with national and regional work to raise the profile of challenges facing delivery of Eating Disorder services. • Engaged with regional Eating Disorders clinical network. • Presenting updates to the Cambridgeshire Health Committee at regular intervals.
Proposed changes to learning disability inpatient services by Commissioners creates financial risk for the Trust	• Developing a business case for an alternative use of any space that becomes available from the closure of any services.
Failure to deliver planned CIP recurrently may compromise the financial stability and aspirations of the Trust.	• Focus on performance through PRE meetings and System Change Committee
Failing to secure New Care Model (NCM) opportunities across Cambridgeshire and Peterborough and beyond within Specialist Commissioned CAMH Tier 4 services provide a significant financial risk to the Trust.	• The Trust is working with NHSE to renegotiate contracts and has requested to be a lead provider of NCMs.
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, particularly consultant psychiatry, DNs community wards and mental health wards and teams.	• 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.

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. Nine 'Stop the Line' incidents were reported in 2018-19. The Executive Committee reviews 'Stop the Line' as a standing item at each Trust Leadership Team meeting.

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.

Quarterly Freedom to Speak Up reports are submitted to the Trust Board, and Brian Benneyworth, is the designated Non-Executive Director lead. Freedom to Speak Up is also a standing item on the Trust Leadership Team agenda.

The public Board receives a regular Safer Staffing report for all bed-based services, highlighting exceptions and possible impact on patient care. This provides figures and analysis of the RNs and HCAs monthly average fill rates for day and night shifts, where these fall below or above threshold (i.e. below 80% and above 120%). Data is derived from the Trust's live on-line safer staffing reporting system, entered at ward level and collated centrally. This system was originally based on the Hurst Multiplier Tool. Information is triangulated with other data including: Datix reports/complaints regarding inpatient staffing; deep dives; Stop the lines; noting changes e.g. bed reconfigurations, skill mix; recruitment.

The Trust has committed to implementing the Safecare module on Healthroster to manage and report demand versus acuity for inpatient areas. This shows live data based on actual patient acuity per shift, clear visibility across the organisation of real-time staffing levels, identifying hot spots and potential risk, thereby enabling informed decision making. However, this has been delayed due to national issues regarding the licensing of the acuity tool. The Trust is looking at other ways to progress while the licensing is resolved.

The Trust submits Care Hours per Patient Day (CHPPD) data to NHSI every month. The monthly Safer Staffing Report also includes a narrative regarding any staffing hotspots and Directorate plans to mitigate the risks. The CHPPD data is designed to allow for a national picture of how nursing staff are deployed on inpatient units and for Trusts to be able to compare their staff deployment with similar Trusts. CHPPD also includes AHP staff, with the data for this aspect of the return currently being drawn from the staff in post list. The RN and HCA CHPPD data can be generated from the Healthroster system.

The performance team is in the process of reviewing the staffing numbers used to calculate the fill rates from the safer staffing online tool and will be verifying and validating any changes made with the directorate senior leadership teams.

For community services, safer staffing and staffing levels are monitored within directorates. These are discussed at Service Line Reporting meetings and at PREs. Mechanisms are in place to raise areas of concern via Stop the Line and incident reporting.

On a monthly basis the Trust reviews vacancies. Any areas that cause concern are analysed in detail to identify and develop specific plans to recruit or cover vacancies. The Trust's temporary staffing service will also support covering gaps via the bank and, if required, agency to ensure there are sufficient staffing numbers in place.

In relation to developing workforce safeguards, the process in place for safer staffing is in line with the principles stated and this will be improved with the implementation of Safecare within the rostering system. The Trust continues to develop the use of rostering to incorporate job planning for staff. This will commence with medical staff and the plan is to progress to other staff groups. The Trust has submitted an operational plan to NHSi which contains 12-month workforce planning figures. Further work is starting to develop a Trust and system-wide longer-term workforce plan.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust is required by the '*Managing Conflicts of Interest in the NHS*' guidance to publish Declarations of Interest of decision-making staff and is reviewing its procedures and definitions in order to comply with this duty.

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.

The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place that takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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 information is appropriately and effectively managed, properly controlled, is accessible and available for use. The Trust has an Information Governance Steering Group which reports in to the Business and Performance Committee.

A risk-assessment process is embedded to ensure that the severity of any information governance incident 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 2018-19. Two of these were subsequently withdrawn as it was established on investigation that there were no significant breaches. The ICO accepted both withdrawals. The ICO closed the other three incidents stating no further action was required due to the remedial and proactive measures put in place by the Trust.

In respect of other non-reportable 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 Data Security and Protection Toolkit. The Trust has a Senior Information Risk Owner (SIRO) (Executive Director of Finance), who reviews all confidentiality and data protection issues with the Information Governance Manager and Caldicott Guardian (Executive Medical Director).

The Trust submitted a return to the Data Security and Protection Toolkit that showed a published assessment of standards met. All 100 mandatory pieces of evidence were provided with 38 out of the 40 assertions completed.

The Trust's Internal Auditors conducted an audit of the Trust's implementation of the new General Data Protection Regulations (GDPR) across the Trust, which became law from 25 May 2018, when it superseded the UK Data Protection Act 1998 (DPA).

The auditors gave the Trust 'Substantial Assurance' on both the design and controls in place in the implementation of the GDPR across the organization.

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 that 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 structures.

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 2018-19.

The Trust has policies and procedures that 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 effectively discharge their duties and responsibilities. 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 regulation 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 June 2018. The Trust is receiving another inspection in May-June 2019.

The Trust has a Quality Dashboard that is mapped against the CQC Essential Fundamental 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, 13 unannounced Mental Health Act (MHA) visits were carried out by the CQC during 2018-19. 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 nine 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, that 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. 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, a copy of the 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 mechanisms 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.

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 a limited assurance review, conducted in accordance with the 2018-19 Detailed Requirements for External Assurance for 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 that 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 comprehensive programme 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 BDO and has had a range of internal audits undertaken in the year including audits relevant to risk management, CQC compliance, GDPR, procurement and key financial systems. All internal audit reports are reported to the Audit and Assurance Committee which also reviews 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:

> *"The role of internal audit is to provide an opinion to the Board, through the Audit and Assurance Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the Trust's objectives in the areas reviewed."*

The Annual Report from internal audit provides an overall opinion on the adequacy and effectiveness of the Trust's risk management, control and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period.

Head of internal audit opinion
For the 12 months ended 31 March 2019, the head of internal audit opinion for Cambridgeshire and Peterborough NHS Foundation Trust is as follows:

Overall, we are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.

The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year;

- This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and

- Any reliance that is being placed upon third party assurances.

In forming our view, we have taken into account that:

- In respect of the design of the controls, an opinion of moderate assurance was provided for seven out of the nine assurance audits, substantial assurance was provided in two audit areas

- In respect of the operational effectiveness of the controls, an opinion of moderate assurance was provided for five of the nine assurance audits, substantial assurance was provided in three areas, and in one area limited assurance

- The Trust has specifically requested audits into known areas of concern and new areas of risk -e.g. controls over the recruitment and management of agency staff.

- Management has responded positively to reports issued and action plans have been developed to address the recommendations raised

- We have confirmed that 97% of recommendations due for implementation by the end of 2018-19 had been completed.

Our Annual Report and head of internal audit opinion has been prepared based on the audit work undertaken during the year.

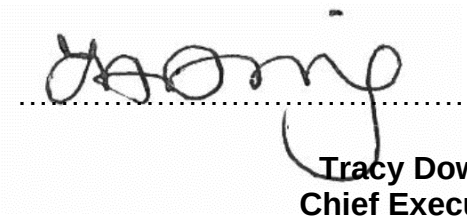
The internal audit assurance framework provides assurance on the design of controls and the operational effectiveness of controls. Each report contains recommendations rated as high, medium or low.

The Trust has agreed actions to strengthen the control framework in areas identified by audit to manage the identified risks in each of these areas. All high and medium rated recommendations will be followed up through progress reports to the Audit and Assurance Committee.

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.

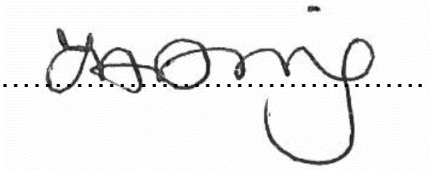


Tracy Dowling
Chief Executive

23 May 2019

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

23 May 2019

Voluntary Disclosures

Freedom to Speak Up

In response to the Freedom to Speak Up review by Sir Robert Francis in 2015; all NHS Trusts in England are required to have a Freedom to Speak Up Guardian. This key role contributes to the development of an open organisational culture by:

- Protecting patient safety and quality of care
- Improving the experience of everyone who works in health and care, and
- Promoting learning and improvement

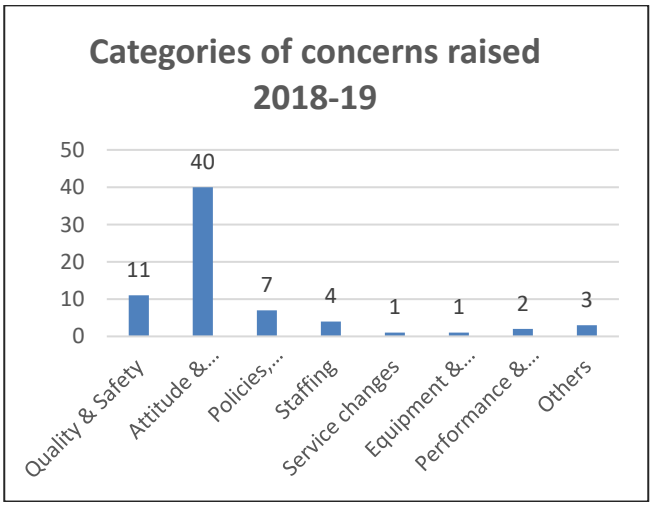
By ensuring that:

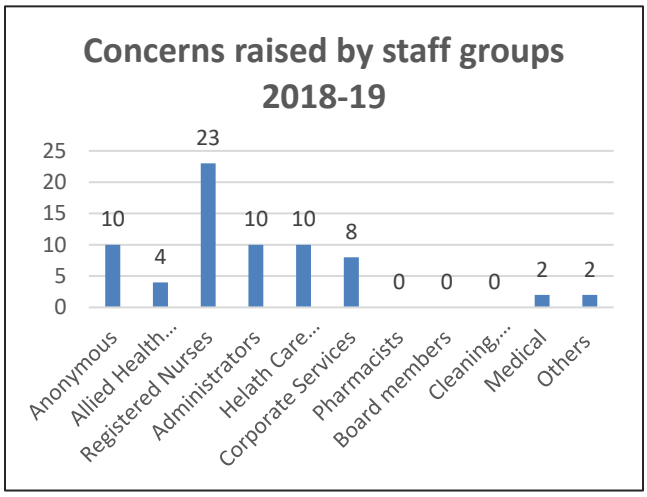
- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered

The Freedom to Speak Up Guardian works alongside the Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and supported to speak up.

The Trust quarterly staff barometer surveys consistently indicate a majority of staff know how to raise concerns. On average, 96% of Trust staff indicated they know how to raise concerns in 2018-19.

Categories of the concerns raised and the staff group who raised concerns in 2018-19 are shown in the two graphs below.





Examples of improvements in particular where these have been embedded in the Trust governance, training and HR processes in response to concerns received by the Freedom to Speak Up Guardian include:

- E-rostering practices reviewed and improvements implemented in a service team.
- Clarity of role requirements following temporary role changes for staff.
- Trust staff exit interviews process and procedures have been reviewed and improvements implemented following feedback from staff in relation to exit interviews and a review of the Trust exit interview data.
- Adherence to recruitment practices and processes was reinforced.
- Trust infection control policy in relation to having pets in the work environments consistently applied.
- 'Be-Nice' campaign launched to tackle incidents of bullying and undermining behaviour in the workplace.
- Conflict resolution training developed and implemented for Trust staff in dealing with situations of bullying and undermining behaviour.
- Caseload for a specialist service area was reviewed and collaborative plans put in place to maintain support for the team to manage its on-going caseload.

Freedom of Information

The Trust operates a transparent and open system of access to information about its services, whilst recognising and adhering to the best practice on protecting the confidentiality of certain types of information.

From 1 April 2018 to 31 March 2019 the Trust received 475 Freedom of Information requests. This is an increase of 19% over 2017/18. The majority of requests contain multiple questions that require input from across the Trust's Directorates.

Across the entire year, compliance with the 20-day working response target was 55%.

We made significant changes to the way in which we process FOI requests in quarters three and four of this financial year and identified a dedicated resource to process these requests; this has improved compliance, which in these quarters rose to 85%. We expect compliance to further improve in 2019/20.

Although requestors are not obliged to disclose the capacity in which they are submitting their request, we estimate the majority of requests were from Individuals (45.6%), though this may conceal other categories as requesters from commercial and media organisations do not always identify themselves as such. This is followed by Private Companies (25.3%) and Media (11.2%). The topics most frequently asked about were Clinical Services (17.9%), Budget/Expenditure/Finance (11.8%) and Human Resources (9%).

SECTION 3: Quality Report

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Quality Report | 2018-19

Pride in our care

Contents

Every year, providers of NHS healthcare are required to publish a quality account by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 (as amended in 2011, 2012 and 2017).

NHS Improvement (NHSI, previously Monitor) also requires all NHS Foundation Trusts to produce quality reports as part of their annual reports. The quality report incorporates all the requirements of the quality accounts regulations and the additional reporting requirements mandated by NHSI.

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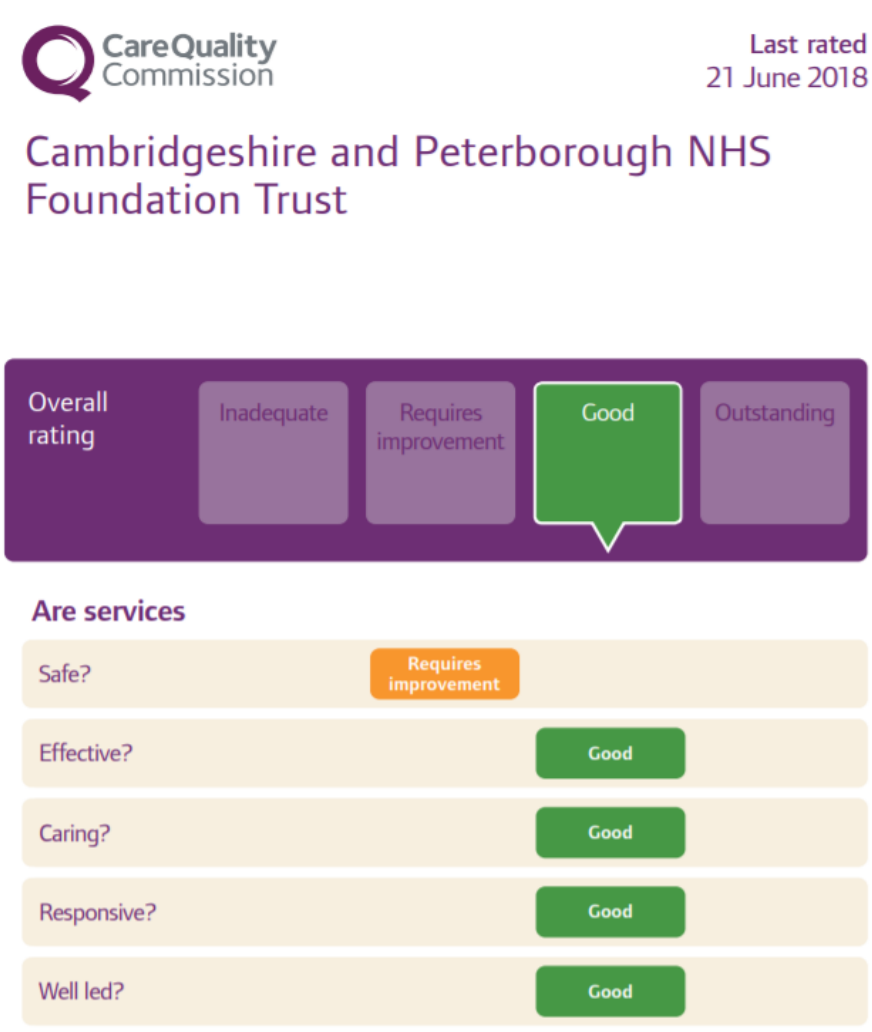
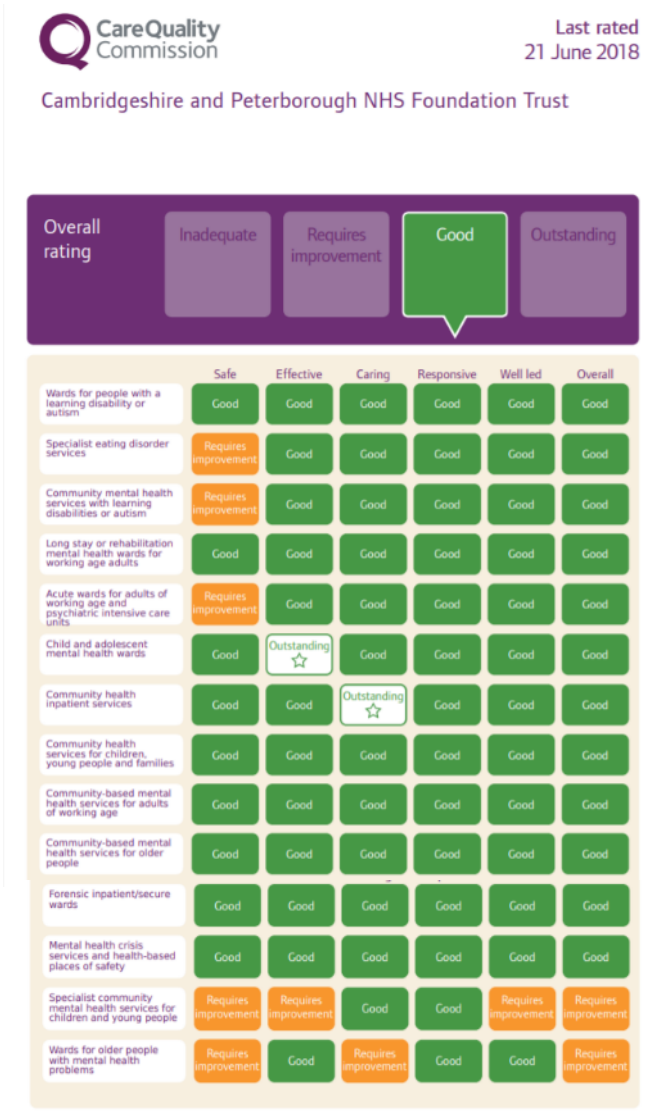
Our CQC Rating

We were rated ‘Good’ following the inspection by the Care Quality Commission (CQC) in March 2018 report published on 21 June 2018.





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 approximately 900,000 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 Collaborations (CLAHRC) East of England

Three clinical directorates

177 clinical teams

77 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 universal
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 £220 million in 2018-19

Our partners include, among others:

- Peterborough City Council
- Cambridgeshire County Council
- Learning Disability Partnerships
- Cambridgeshire Community Services NHS Trust
- Cambridge University Hospitals NHS Foundation Trust
- North West Anglia Hospitals NHS Trust
- East of England Ambulance Trust
- NHS England Specialist Commissioning Group
- Cambridgeshire and Peterborough Clinical Commissioning Group

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)
- 5 Locality teams
- 1 Early Intervention in Psychosis (EIP) team
- 2 Eating Disorder teams
- 4 Psychological Wellbeing teams (PWS IAPT)
- 1 ADHD (Attention Deficit Hyperactivity Disorder) team
- 1 Personality Disorder team
- 1 Primary Care Service for Mental Health team
- 1 Intensive Support Team (IST)
- 1 CCPNR (Cambridge Centre for Paediatric Neuropsychological Rehabilitation) team
- 1 Aspergers clinic (CLASS)
- 3 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 Liaison and Diversion team
- 1 Perinatal Mental Health Team
- 1 Supported Employment Day Service for people with Learning Disability
- 3 Victim Pathfinders service
- 1 Integrated Mental Health Team (IMHT, Hinchingbrooke Police Station)
- 1 Short term reablement team

49 TEAMS / 32 SERVICES

Children, Young People and Families (CYPF) Directorate

- 1 Mental health ward
- 1 Eating Disorder ward
- 1 Child and Family mental health ward

MH Community services

- 3 Child and Adolescent Mental Health (CAMH) core teams
- 3 CAMH Neuro teams (ADHD/LD ASD – Autistic Spectrum Disorder)
- 1 Forensic CAMH service
- 1 CAMH Eating Disorder team
- 1 CAMH Intensive Support team
- 1 Child and Adolescent Substance Use team
- 1 MST (multi-systemic therapy) team

Universal services

- 1 Community Paediatric team
- 1 Paediatric Physiotherapy & Occupational Therapy team
- 1 Paediatric Psychology team
- 1 Paediatric Speech and Language Therapy team
- 1 Community Nursing team
- 1 Family Nurse Partnership team
- 10 Health Visiting teams
- 2 School Nursing teams

35 TEAMS / 18 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
- 4 Joint Emergency Teams (urgent response service)
- 14 Neighbourhood Teams (Integrated mental and physical health services)
- 4 Older People Mental Health teams (integrated into the Neighbourhood Teams above)
- 4 Out of Hours District Nursing teams
- 4 Neuro Rehabilitation teams
- 4 Nutrition and Dietetics teams
- 6 Podiatry teams (including Bone Surgery pathway)
- 4 Speech and Language Therapy teams
- 2 Discharge Planning / Intermediate Care Tier
- 2 CRHT teams (incorporating Dementia IST)
- 4 Memory Clinics
- 4 Stroke Early Supported Discharge teams

Specialist nursing services:

- 4 Respiratory / Tuberculosis teams
- 2 Parkinson's teams
- 1 Epilepsy team
- 1 Multiple Sclerosis team
- 1 Chronic Fatigue Syndrome team
- 3 Heart Failure / Cardiac Rehabilitation teams
- 3 Continence teams
- 4 Tissue Viability teams
- 4 Diabetes teams

93 TEAMS / 27 SERVICES

2018-19 activity

Referrals	2017-18	2018-19	Change	
			n	%
Adults & Specialist services	54,236	49,601	-4,635	**-8.55%**
Primary Care Mental Health Service	8,345*	14,960	6,615	**79.27%**
Psychological Wellbeing Service	14,063	16,759	,2696	19.17%
Total ASMH	**76,644**	**81,320**	**4,676**	**6.10%**
Children's mental health services	7,636	7,178	-458	-6.00%
Children's community services	15,775	16,519	744	4.72%
Total CYPF	**23,411**	**23,697**	**286**	**1.22%**
Older people's mental health services	7,622	11,590	3,968	52.06%
Older people's community health services	149,742	166,727	16,985	11.34%
Total OPAC	**157,364**	**178,317**	**20,953**	**13.31%**
Total CPFT	**257,419**	**283,334**	**25,915**	**10.07%**

* *Commenced in May 2017 and fully established by the end December 2017. This service places specialist mental health staff in GP practices to promote early assessment, treatment and/or onward referral of patients with mental illnesses of moderate to high severity. This has resulted in a reduction in patients being referred to secondary care services evidenced by reductions in referral activity to the adult and specialist services.*

Contacts – face to face & telephone	2017-18	2018-19	Change	
			n	%
Adults & Specialist services	122,591	122,374	-217	-0.18%
Primary Care Mental Health Service	4,712*	16,346	11,634	246.90%
Psychological Wellbeing Service	69,792	81,241	11,449	16.40%
Total ASMH	**197,095**	**219,961**	**22,866**	**11.60%**
Children's mental health services	25,825	25,645	-180	**-0.70%**
Children's community services	72,441	87,368	14,927	**20.61%**
Total CYPF	**98,266**	**113,013**	**14,747**	**15.01%**
Older people's mental health services	43,093	52,272	9,179	21.30%
Older people's community health services	735,967	780,299	44,332	6.02%
Total OPAC	**779,060**	**832,571**	**53,511**	**6.87%**
Total CPFT	**1,074,421**	**1,165,545**	**91,124**	**8.48%**

Occupied bed days excluding leave	2017-18	2018-19	Change	
			n	%
ASMH	**43,732**	**43,742**	**10**	**0.02%**
Darwin & Phoenix Centre	6,749	4,782**	-1,967**	-29.15%**
The Croft (young people only)	913	1,126	213	23.33%
Total CYPF	**7,662**	**5,908**	**-1,754**	**-22.89%**
Mental health wards	15,015	16,080	1,065	7.09%
Physical health wards	33,985	34,634	649	1.91%
Total OPAC	**49,000**	**50,714**	**1,714**	**3.50%**
Total CPFT	**99,481**	**99,238**	**-243**	**-0.24%**

** *The Phoenix Centre, a specialist centre for young people aged 13-18 with complex eating disorders, was closed for 5 months in May-September 2018 due to challenges with staffing and to allow time for the development of a robust and sustainable clinical service model and a full infrastructure development.*

283,334 referrals received

1,165,545 face to face and telephone contacts

10.07% (n=25,915) more referrals and 8.48% (n=91,124) more face to face and telephone contacts in 2018-19

Our statement of purpose

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.

Our values

The PRIDE awards celebrate the great work of teams and individuals across the Trust who go above and beyond to deliver one of the PRIDE values of professionalism, respect, innovation, dignity or empowerment.

A special ceremony hosted by Chief Executive Tracy Dowling presented awards to -

more than 50 staff in July 2018,

… more than 60 staff in November 2018, and

…more than 60 staff in March 2019.

.

Highlights in the year…

Game developed by CPFT scoops five BAFTAs

Staff and students at CPFT Recovery College East (RCE) and the honorary consultant and academic lead for the ASMH directorate spent three years acting as special advisers to game developers, Cambridge-based Ninja Theory, to develop a ground-breaking computer game which gives insight into experiences of psychosis.

The central character in ***Hellblade: Senua's Sacrifice*** is a Celtic warrior who has mental health challenges which has been brought on by trauma.

The game went on to become a worldwide success, earning nine BAFTA nominations and winning five in the BAFTA Game Awards event that took place in London on 12 April 2018 - *Best British Game*, *Artistic Achievement*, *Audio Achievement*, *Best Performer* and *Game Beyond Entertainment* awards.

New Heart Failure service is launched

CPFT launched a new Heart Failure service in Huntingdon in April 2018, in addition to existing service East Cambridgeshire and expanding its service in Peterborough following more than £450,000 additional funding from the Sustainability and Transformation partnership (STP).

The service ensures that those with chronic heart failure receive dedicated help and support to manage their condition and aid their rehabilitation.

New specialist perinatal service opened

Good mental health care for mothers mean better care for their children, which will have lifelong benefits. CPFT was able to secure a £3 million funding from NHS England to provide specialist mental health services for new and expectant mothers from the autumn of 2018.

CPFT pledges to become smoke free

CPFT signed up to the NHS Smoke Free Pledge in June 2018, committing to helping patients and staff to quit smoking.

New Equality & Diversity campaign

The Trust launched the equality, diversion and inclusion campaign in April 2018 to raise awareness of the equality, diversity and inclusion work within CPFT. This takes its principles from research that shows having a more diverse workforce increases employee satisfaction, fosters innovation and creativity, and improves decision making.

Happy 10th birthday CPFT

On 1 June 2018, CPFT celebrated its 10th anniversary as a Foundation Trust. Foundation Trusts are different from standard NHS Trusts in three important ways: They are free from central government control and therefore

- have freedom to decide locally how to meet their obligations
- are accountable to local people, who can become members and governors
- are authorised and monitored by an independent regulator for NHS Foundation Trusts

Award for Peterborough's PWS

The Peterborough Psychological Wellbeing Service (PWS) team won the *Integration Award* at the British Heart Foundation Alliance Awards 2018 held in June, for their work with the Cardiac Rehabilitation Service at Peterborough City Hospital to improve care for people recovering from a heart attack or heart surgery.

Team 'jets' off to Utrecht

CPFT's Joint Emergency Team (JET) was invited to showcase the excellent work being done by the service at the *18th International Conference for Integrated Care*.

JET is an urgent 2 or 4-hour response service that supports people over the age of 65 or those with long-term conditions in their home environment when they become unwell and need urgent care but do not need to go into hospital.

New ESD service

CPFT's new Stroke Early Supported Discharge (ESD) service is part of a package of measures to help stroke patients, following a £1.8 million investment from the STP.

The service helps patients who are admitted to hospital following a mild stroke to recover more quickly across Cambridgeshire and Peterborough, working closely with the Neuro Rehabilitation team, which supports people with complex neurological problems who need more than six weeks rehabilitation.

CQC rates CPFT as 'Good'

CPFT retained its rating of 'Good' following the inspection in March-April 2018 based on the new inspection framework. The report, published on 21 June 2018, highlighted many examples of outstanding practice. CEO Tracy Dowling and Director of Nursing and Quality Melanie Coombes praised the dedication of staff in maintaining the rating first achieved in 2015.

CPFT goes top of the table in research

CPFT was named top performing NHS Trust for mental health research in the East of England and one of the five Trusts in England in the Research Activity League table, published by the National Institute for Health Research (NIHR) in July 2018.

Forensic CAMH service roll out

The new East of England Community Forensic Child and Adolescent Mental Health Service (FCAMHS) - which is being delivered by CPFT - began a phased roll-out following the launch on 29 August.

FCAMHS is a regional child and adolescent mental health service which takes referrals for high risk young people with complex needs. FCAMHS aims to provide a full clinical service across the East of England by April 2019.

Phoenix Centre re-opens

The Phoenix Centre is a specialist centre for young people aged 13-18 with complex eating disorders

The service was temporary closed in May to September 2018 to allow time for the development of a robust and sustainable clinical service model and a full redesign and infrastructure development of its premises, undertaken with the full involvement of patients and their families. It officially re-opened on 3 October 2018.

CPFT's Windsor Research Unit wins award for Putting Patients First

The Windsor Research Unit won the *Celebration Award for Putting Patients First* at the Clinical Research Network (CRN) Eastern's Celebration Day in October 2018 for their commitment to improving the patient experience.

CPFT triumph at awards by Royal approval

CPFT's Recovery College East (RCE), along with the honorary consultant and academic lead for the ASMH directorate, won the *Psychiatric Communicator of the Year Award* at the Royal College of Psychiatrist's Annual Awards for their work to develop the world wide hit computer game ***Hellbalde: Senua's Sacrifice*** in November 2018.

The month before, game developer Ninja Theory launched ***Senua's Scholarship Scheme*** in October 2018 in partnership with the RCE – the student awarded the scholarship will be supported to develop their training skills and work towards a professional qualification.

6 years of Windsor research with care

CPFT's Windsor Research Unit turned six years old on 7 November. Previously, Fulbourn became an internationally renowned leader of social therapy and was one of the first mental health hospitals to use Imipramine, one of the first antidepressant medications. Today, the Windsor team trials new drugs and therapies. During the year, the team has helped over 1,500 people take part in dementia, mental health and community studies to improve mental and physical health.

Health visitors praised by UNICEF – maintains Level 3 accreditation

CPFT's health visitors were praised following a visit by UNICEF assessors. During the visit the assessors interviewed clinical staff and parents, went to several children's centre and reviewed Trust policies, standards and guidelines. The service was recognised for "*delivering a fantastic high-quality service…standing out significantly from other Trusts inspected*".

The team retained its prestigious Level 3 accreditation, which is the highest accreditation available and shows what a great service the team is providing to parents and their babies.

Adult locality team testing new therapy

CPFT was selected as one of the research sites for testing a new treatment - integrative cognitive behavioural therapy (CBT) - developed to help patients with chronic, persistent, and highly recurrent depression. CPFT service teams are linking research with care practice by taking part in this study, ensuring patients can access a new therapy.

FRS team awarded national honors by GPs

CPFT's First Response Service (FRS) won the *Mental Health Initiative Award* at the General Practice Awards 2018 at ceremony in London.

Launched in 2016, FRS provides 24-hour access, seven days a week, 365 days a year, to mental health care, advice and support. As of December 2018, staff have taken nearly 40,000 calls; and since the service was launched attendances at local emergency departments have fallen by more than 20%.

Nursing Associates graduate

The first group of staff to become Nursing Associates graduated in February 2019. 11 staff members who were all working as healthcare assistants applied for the programme, undertaking training led by CPFT while also studying at Anglia Ruskin university over the last two years.

At the ceremony, the graduates received a special badge designed by nursing associate lead, which included the Royal College of Nursing motto **Tradimus Lampada** which translates as: **We carry the torch**.

PWS standing strong after 10 years

CPFT's Psychological Wellbeing Service (PWS) marked its 10th anniversary in December 2018.

During the year, PWS expanded its service provision to include Long Term Conditions. It has consistently exceeded national 'referral to treatment' targets, with satisfaction rates exceeding 99% in the last three years. See page 88 for more details.

Trust team feature in Long Term Plan

CPFT's Primary Care Mental Health Service featured as a special case study in the NHS Long-Term Plan.

NHS England approached the team after seeing the service's positive evaluation report published just before Christmas. The service was asked to provide some background about how the service works, along with patient and GP feedback for the case study, which is now live on the NHS Long-Term website.

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 the 2018-19 Quality Report of Cambridgeshire and Peterborough NHS Foundation Trust.

In the past year, we have continued our relentless drive to improve the quality of our services and the care we provide to the people who use our services, in line with the objectives of our new three-year Trust Strategy. During 2018-19,

- we provided care, treatment and support to more patients than ever before with a 10% increase in referrals received and over 8% increase in face to face and telephone contacts overall.
- our innovative *Primary Care Mental Health Service,* based in GP surgeries, received 15,000 referrals in its first full year of operations with over 16,300 contacts. An independent evaluation of the service hailed it as 'a value-adding addition to the mental health support landscape in Cambridgeshire and Peterborough', and has been featured in the NHS Long Term Plan. The service has led to a reduction in the number patients referred to our secondary adults and specialist mental health services in the year.
- our *First Response Service* continues to receive numerous national recognition for innovative care and outstanding practice, and is now being used as a model for national implementation. The service was expanded during the year to include children and young people.
- our *Early Intervention in Psychosis* (EIP) service and *Psychological Wellbeing Service* (PWS) continue to exceed national referral to treatment targets, ensuring that people receive high quality evidence-based treatment in a timely manner.
- we developed more new and innovative services to meet the needs of the people who use our services. This includes the *Perinatal Mental Health* service, *Stroke Early Supported Discharge* service, *Child and Adolescent Mental Health* (*CAMH) Complex Case Management* service and the *Forensic CAMH* service.

In addition, we continue to produce world-class studies to national and international acclaim. Research undertaken by our staff and/or within our services are making a real difference in the treatment of clinical disorders. Examples are presented in page 48-52.

We have made positive steps in embedding an improvement culture in the Trust, consolidating our approach to Quality Improvement (QI) during the year. We now have 20 staff who have completed the QSIR (Quality, Service Improvement and Redesign) practitioner training course which was developed by NHS improvement. Furthermore, we have embraced the principles of co-production which will underpin and drive our improvement work in the coming years.

The Trust was re-inspected by the Care Quality Commission in March/April 2018, retaining its 'Good' rating. The report, published in June 2018, highlighted many examples of outstanding practice which are detailed in page 54.

All of this, and more, are not possible without the continued hard work, dedication, commitment and resilience of our staff who are doing a tremendous job in delivering high-quality care in an extremely challenging and constantly changing landscape, and for that they have my utmost respect, admiration and heartfelt gratitude.

Our priorities for improvement in 2018-19

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

- We fully achieved three of the six priorities for Patient Safety, most notably a 5% reduction in the number of falls that lead to moderate or severe harm in our older people's services overall with a 29% reduction in the community services.
- We fully achieved three of the four priorities for Clinical Effectiveness, strengthening and embedding our process for NICE implementation across the Trust. Our ASMH and OPAC directorates also achieved their priorities relating to embedding a framework for learning and increasing the number of memory assessments undertaken.
- In terms of improving the experience of care,
  - from the perspective of our patients, we fully achieved four of our six priorities. In particular, we saw marked improvement in our score on the National Community Mental Health Patient Survey 2018 relating to '*having a formal meeting in the last 12 months to discuss care'* and, while the question was not directly comparable, our score on '*being supported to take part in activities*' still showed an improvement.
  - from our carers' perspective, we achieved four of our six priorities, delivering Carer Awareness training and seeing significant improvements in the number of identified informal carers with completed carer records across both our adults and older people's services, and the adults services achieving the Trust target in the year.
  - from our staff perspective, we achieved seven of our 11 priorities, seeing increases in our National Staff Survey scores around '*quality of appraisal*', '*staff satisfaction with resourcing and support*', and '*staff satisfaction with the quality of work they are able to deliver*'. In addition, our children's services saw marked improvements in the '*number of staff working additional unpaid hours*' and '*satisfaction with the quality of work and care they are able to deliver*'.

Whilst there are improvements in our National Staff Survey scores, our results are broadly similar to last year and we remain 'average' in terms of our overall scores compared with other NHS hospitals. This is not where we want to be, and I am determined to improve the experience of our staff in all areas to truly become an excellent place to work. In view of this, I have been going around the Trust to talk to our staff in order to understand the issues and challenges they are facing and to listen to their feedback and suggestions so that we can work together to improve their experience of working in CPFT. This goal is fully embedded within our new Trust Strategy and our priorities for 2019-20.

I am pleased to report that we achieved the national CQUIN on improving the uptake of flu vaccinations for frontline clinical staff for the first time this year, achieving 77% against the target of 75%, which is a tremendous achievement. Please see page 53 for full details on our expected CQUIN achievement for 2018-19.

Our priorities for improvement in 2019-20

For 2019-20, we will continue to align our quality priorities to the strategic objectives of our Quality Strategy and our goal to achieve an outstanding rating from the Care Quality Commission (CQC), mapping it against the CQC Key Lines of Enquiry (KLoE). These are grouped under four key headings which are our Quality Goals -

- *reduce avoidable harm,*
- *improve health outcomes*
- *improve the experience of care for our patients, carers and staff,* and
- *develop and support our staff*

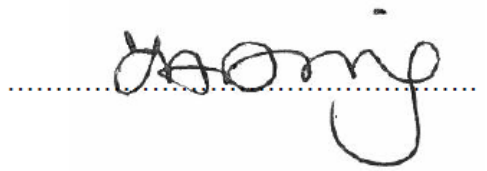
Some of the priorities for 2019-20 have its foundations in the previous year's priorities, including those that we have not achieved in the year, as well as those areas where we want to further build on our successes. This includes risk assessments in our children's community services, patient falls in our older people's services, as well as NICE implementation, outcome measures, carer records and improving the experience of our staff across our services. New areas of focus include self-harm and physical assaults, care planning, training and supervision.

Our clinical staff and services have been fully engaged in the development of these priorities, having been discussed and agreed in their respective directorate Quality and Safety meetings, and are informed by the views of our patients, carers and other key partners. These are detailed in page 38.

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
23 May 2019

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 strategies for quality and quality improvement and statements of assurance from the Board on key aspects of our service.

We also report on our performance in 2018-19 against the quality priorities set in the beginning of the year, and our CQUIN targets. Finally, we present our quality priorities for 2019-20 and outline how we are going to monitor our progress against these during the year.

2.1.1 Our Strategy

Our over-arching Trust Strategy was refined and updated for 2018 – 2021. We took an inclusive approach to the development of the new strategy, holding a series of Wider Leadership Workshops and engaged with a broader audience within the Trust and across the health and social care system to help develop and inform our approach

The three-year strategy was approved by the Board of Directors in May 2018.

Purpose

We strive to improve the health and wellbeing of the people we care for, and our staff and members, in order to support and enable them to lead a fulfilling life that they want to lead.

Goals

1. ***Deliver best care***
2. ***A leading innovator in healthcare and research – nationally & internationally***
3. ***Demonstrate best value***
4. ***Improve the experience of working in CPFT***

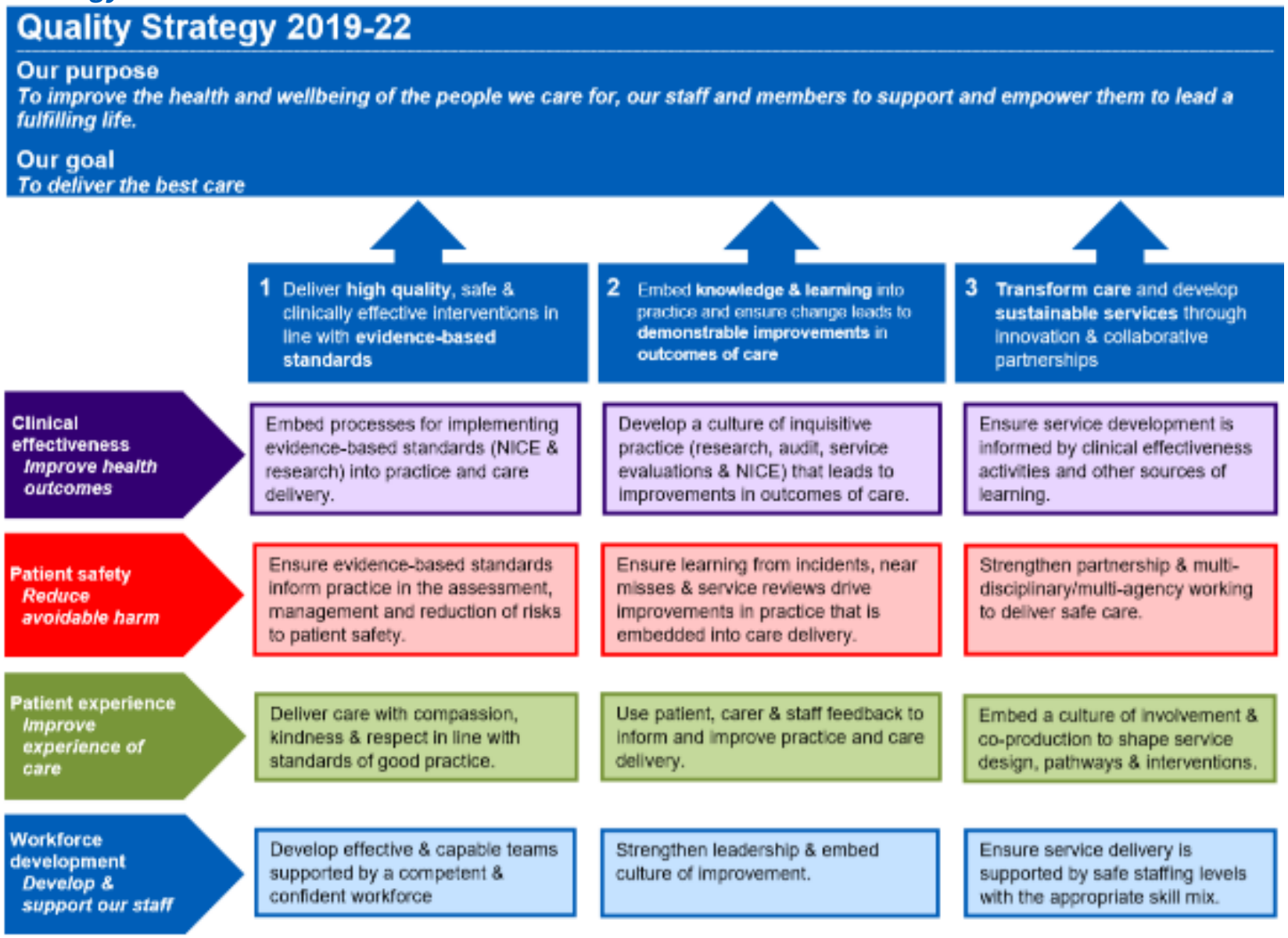
Our patients and their carers are at the heart of our strategy. This is supported by a number of 'enabling strategies' and will be delivered through a culture of improvement.

2.1.2 Our Quality Strategy

Our Quality Strategy was updated in December 2018 and was approved by the Board of Directors in March 2019.

It reflects the progress we have made in the last three years and the strategic objectives and priorities of the new Trust Strategy. It focuses on embedding a culture of high-quality care through the effective utilisation of learning and co-production to drive sustainable improvements in outcomes of care.

It also underpins our goal to achieve an outstanding rating from the Care Quality Commission (CQC).



2.1.3 Quality Improvement (QI) in CPFT

We have made positive steps in embedding a culture of improvement across the Trust in the past year, bringing clarity to our approach and framework.

ACT Academy

Quality, Service improvement and Redesign (QSIR)

We have chosen the QSIR programme, developed by NHS Improvement (NHSI), to support our goal in developing quality and efficiency capability across the Trust.

To achieve our QI goals, we need to learn from outstanding organisations and listen to the views of our patients and carers, make best use of research-based evidence and ensure that we have a highly skilled, dedicated and empowered workforce.

Our QI work will focus on three priority areas in 2019-20:

- Reduce the level of avoidable harm
- Increase patient contact time
- Projects co-designed with patients and carers

As of March 2019 –

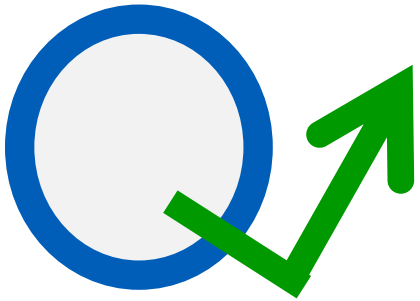
QSIR Practitioner

20 staff have completed their QSIR practitioner training and 6 more are undergoing the training

QSIR COLLEGE

We will develop our staff to become associate members of the QSIR Teaching Faculty to deliver QSIR practitioner training within the Trust

Our approach to Quality Improvement will be underpinned by the principles of co-production, working in close partnership with our patients, their families and carers, and our staff.



Improving quality

As part of our inclusive approach to quality improvement, we have used a range of tools and methodologies to improve the quality of our services and outcomes of care in 2018/19 – clinical audit, service evaluations, research and Quality Improvement projects. These are examples of improvements made during the year.

People with chronic wounds receive a high (and improving) quality evidence-based assessment to inform & improve care delivery.

Assessment of diabetic footcare needs has been enhanced with the use of ankle brachial pressure index. Staff training and equipment now in place.

Home safety packs have been introduced to reduce unintentional injuries for children at home.

Improved end of life care planning for young people in the community nursing service is now in place, supported by training and correct documentation.

Staff rated outcome measures are showing that patients with rehabilitation needs are benefiting from our bed-based intermediate care service.

Patients with Parkinson's have flexible access to specialist nursing care (favourable compared

Listening to the voice of people experiencing mental health seclusion – staff are optimizing patient comfort when ordering furniture for the seclusion room.

Enhanced monitoring of sexual side effects for patients prescribed medications for ADHD (Attention Deficit Hyperactivity Disorder).

Improved care for young people transitioning to adult mental health services – for example, having the right people at transition planning, knowing and discussing together prospective transitions cases. As of the last audit, 19 of the 21 meetings had all the right people attending and the right timeframe.

98% of patients with wound care needs now have a full evidence-based assessment.

2.1.4 Quality Assurance

Our Trust Board holds ultimate accountability for the quality of the services that we provide. Our governance framework provides assurance over the quality and timeliness of data and other information on quality and performance throughout the year.

The Quality, Safety and Governance Committee, chaired by a non-executive director, has delegated authority over clinical quality and risk. The membership includes our Chief Executive Officer, executive and non-executive directors, and Governor representation

Executive groups are responsible for reviewing monthly performance reports and holding services to account. These include the Performance and Risk Executive, Quality and Compliance Executive and the Workforce Executive. These are supported by working groups responsible for key areas in the Trust.

Within the clinical directorates, activity and performance are monitored through service line reporting to the Quality and Safety Group and Directorate Management Team meetings.

Good quality and timely information underpin the delivery of high quality care and is an essential element in improving standards of care.

We have a comprehensive range of activity and performance indicators captured from our business intelligence and clinical information systems that are reported electronically and are accessible by all staff from the Trust intranet, called **Mi Reports**. At Trust and directorate levels, an Integrated Performance Report (IPR) is produced monthly consisting of key performance indicators, as well as the Quality and Safety Report that contains more detailed qualitative data and information. These enable us to monitor the quality of our services and develop improvement actions, as and when required, in a timely manner.

2.1.5 Looking Back – our priorities for improvement for 2018-19

Our quality priorities were developed jointly with our staff and clinical services, and are informed by the views of our patients, carers, Governors, partners and other key stakeholders, focusing on those areas that we believe will make the most impact on outcomes and experience of care for both our patients, their carers, and our staff.

The priorities support the achievement of our over-arching quality goals, aligned with the three dimensions of quality, and reflect the objectives of the *Five Year Forward View*.

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***

A summary of our performance on our quality priorities for 2018/19 is outlined below.

Improvement priority	Performance
Patient Safety: Quality Goal 1 – *Reduce avoidable harm*	
• **ASMH** 1. Increase number of staff trained in DICES to embed risk formulation across the directorate 2. Include the following in staff appraisal objectives ▪ 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) • **CYPF** 1. 95% of children and young people on CAMH waiting list will be risk assessed in accordance with agreed management guidance • **OPAC** 1. Reduce number of patient falls that lead to moderate or severe harm 2. Increase number of staff who complete the online falls training 3. Reduce number of missed/omitted insulin injections	✓ Achieved ✓ Achieved ✘ Not achieved ✓ Achieved ≈ Partly achieved ✘ Not achieved
Clinical Effectiveness: Quality Goal 2 – *Improve health outcomes*	
• **Trust wide** 1. Strengthen the framework for supporting our clinical services to translate and embed evidence, based on NICE guidelines and quality standards, into practice 2. 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 • **ASMH** 1. Strengthen the framework for translating lessons learned into practice and sharing of good practice within the service • **OPAC** 1. Increase the number of memory assessment undertaken within 6 weeks in line with the standards recommended by the Memory Service National Accreditation Service (MSNAP)	✓ Achieved ≈ Partly achieved ✓ Achieved ✓ Achieved
Patient, Carer & Staff Experience: Quality Goal 3 – *Improve experience of care*	
Our patient's perspective • **Mental health inpatients** 1. Improve scores on weekend and evening activities in Meridian patient experience survey • **Mental health community** – improve scores on National Community Mental Health Patient Survey on 1. had a formal meeting in the last 12 months to discuss care 2. supported to take part in local activities • **Physical health older people services** 1. Develop a simple referral mechanism within the directorate and strengthen cross-specialty case discussions 2. Increase the number of referrals between specialties within the directorate 3. Increase the number of capacity assessments recorded on SystmOne	≈ Static ✓ Achieved ✓ Achieved ✓ Achieved ✓ Achieved ✘ Not achieved
Our carer's perspective • **Trust wide** 1. Achieve 60% target of service users having an identified carer in our patient records 2. Roll out the revised Carer Awareness training to all relevant staff 3. Develop a consent and confidentiality course to increase awareness and improve practice in this area • **CYPF** 1. 95% of parents and young people seen within children services will have a discussion related to being a carer • **OPAC** 1. Increase the number of identified informal carers in RiO and SystmOne 2. Increase in the number of records with details of informal carers recorded in RiO and SystmOne	≈ Partly achieved ✓ Achieved ✓ Achieved ✘ Not achieved ✓ Achieved ✓ Achieved

Our staff's perspective	
• **Trust wide**	
1. Improve our scores in the National Staff Survey in the following:	
a. Quality of appraisals	✓ Achieved
b. Staff satisfaction with resourcing and support	✓ Achieved
c. Staff satisfaction with quality of work and care they are able to deliver	✓ Achieved
2. Support staff to improve their health and wellbeing through increased opportunities to access health and wellbeing initiatives, measured by	
a. reductions in sickness absence	✘ Not achieved
b. reduction in the NHS Staff Survey score on '*feeling unwell due to work related stress in the last 12 months*'	✘ Not achieved
c. increase in NHS Staff Survey score around '*staff motivation at work*'	≈ Static
• **ASMH**	
1. Improve the experience of staff in relation to the quality and frequency of supervision	✓ Achieved
• **CYPF**	
1. Improve staff survey scores in these areas	
a. staff working extra hours	✓ Achieved
b. staff reporting good communication between senior management and staff	✘ Not achieved
c. staff satisfaction with quality of work and care they are able to deliver	✓ Achieved
2. Increase the proportion of physical assault incidents involving patient to staff that lead to no/low harm	✓ Achieved

More detailed information on our performance against our quality priorities 2018/19 is presented below.

Patient Safety

Quality Goal 1: *Reduce avoidable harm*

Adults and Specialist Mental Health Directorate (ASMH)

1. Increase number of staff trained in DICES to embed risk formulation

✓ **Achieved**

DICES is a risk assessment and management in mental health training delivered by the Association for Psychological Therapies (APT). It stands for:

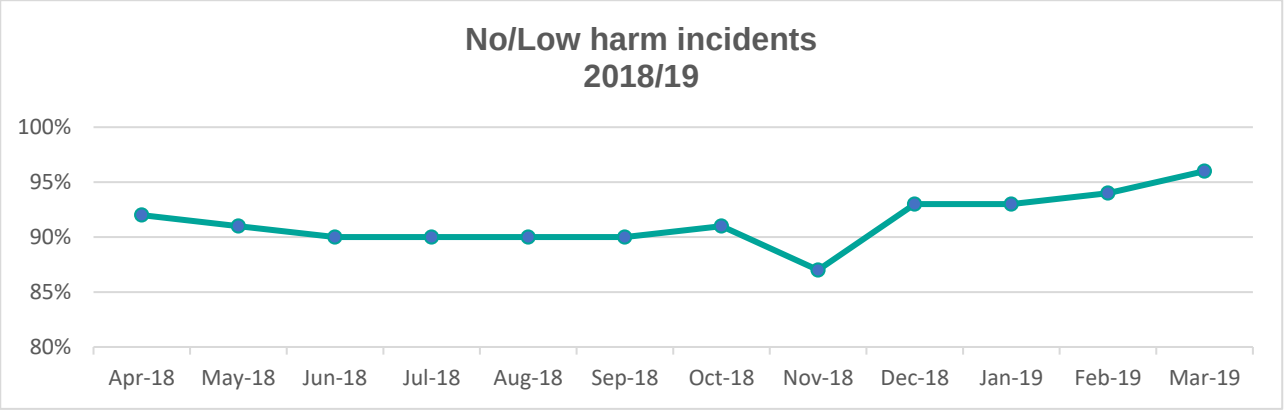
- **D**escribe the risk
- **I**dentify all the possible options
- **C**hoose your preferred option
- **E**xplain your choice
- **S**hare the decision with others

37% of our total reported incidents are from the ASMH services, and a quarter of these involve self-harm and physical assaults. The directorate chose DICES as their approach to risk assessment and management to reduce avoidable harm in their services

At the start of the year, 10 members of staff completed a 'Train the trainer' programme. As of March 2019, 118 additional staff members were trained in DICES.

This is a significant achievement for the service.

Whilst there may be other factors involved, the increased level of risk assessment and management skills appears to have made a positive impact on the level of harm of reported incidents in the service. The chart below shows an increasing trend in the proportion of incidents that lead to no or low harm in the second half of the year.



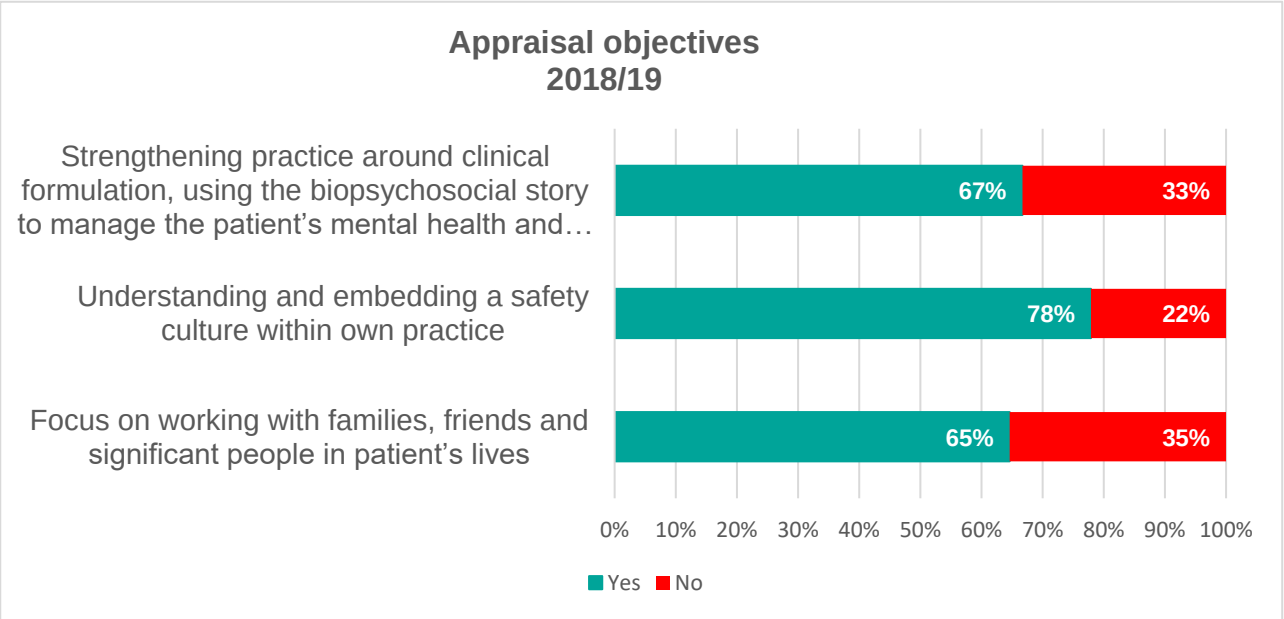
The dip in November is due to one incident in our adults Psychiatric Intensive Care Unit (PICU)

2. Include objectives that support a safety culture in staff appraisal

✓ **Achieved**

As part of the directorate's aim to embed a safety culture within their services, they also committed to including three objectives in staff appraisals in the year.

A survey was conducted across their services in March 2019 to gather feedback from staff on whether this was done. As of 31 March 2019, there were 116 responses – 80% from community services and 20% from inpatient services. The chart below shows the results of the survey.



The directorate will build on these results and continue to work with their staff to strengthen the safety culture within their services.

Children, Young People and Families Directorate (CYPF)

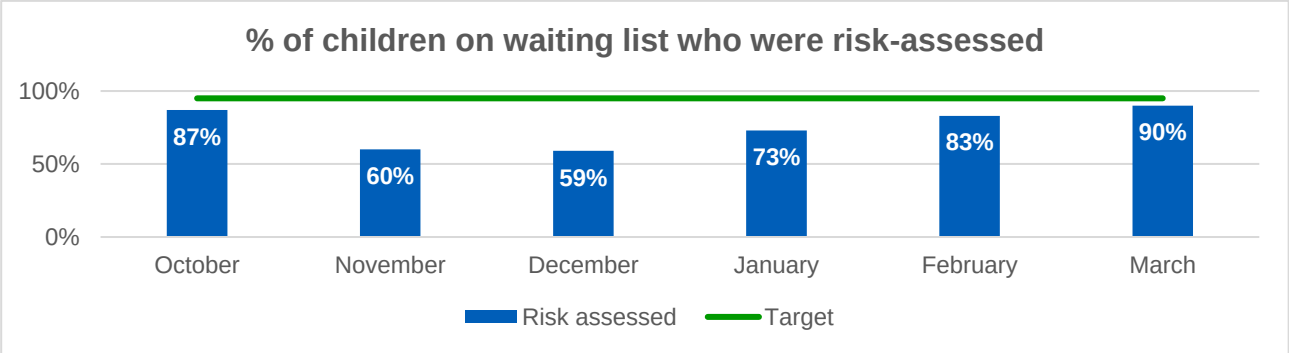
1. 95% of children and young people on CAMH waiting list will be risk assessed

✘ **Not achieved**

The CQC inspection in March 2018 highlighted the need to improve monitoring the risks of young people waiting to receive treatment in our community mental health services for children and young people. This directorate set a target of 95% of children and young people on Child and Adolescent Mental Health (CAMH) waiting list to be risk assessed in accordance with agreed procedures.

Actions taken by the directorate include:

- Reviewing existing processes for reviewing levels of risk of patients on the waiting lists.
- Establishing a revised process for reviewing levels of risk for all children and young people on the waiting lists, in place in October 2018.
- Inviting NHS Improvement (NHSI) to review the revised waiting list management process in January 2019 to inform further improvement work.
- Undertaking an audit in April 2019 to check compliance.



Performance has been steadily improving with a compliance rate of 90% in March 2019.

This remains a priority for the directorate and has been carried forward to 2019-20.

Older People and Adults Community Directorate (OPAC)

Falls, pressure ulcers and medicines administration were the top three incidents reported within the OPAC services. In 2017/18, the directorate achieved their target of reducing Grade 3 or 4 pressure ulcers acquired in CPFT, while falls and insulin-related incidents continued to increase. For 2018/19, the directorate wanted to focus their attention on these two areas. Performance on these priorities are presented below.

1. Reduce number of patient falls that lead to moderate or severe harm

✓ **Achieved**

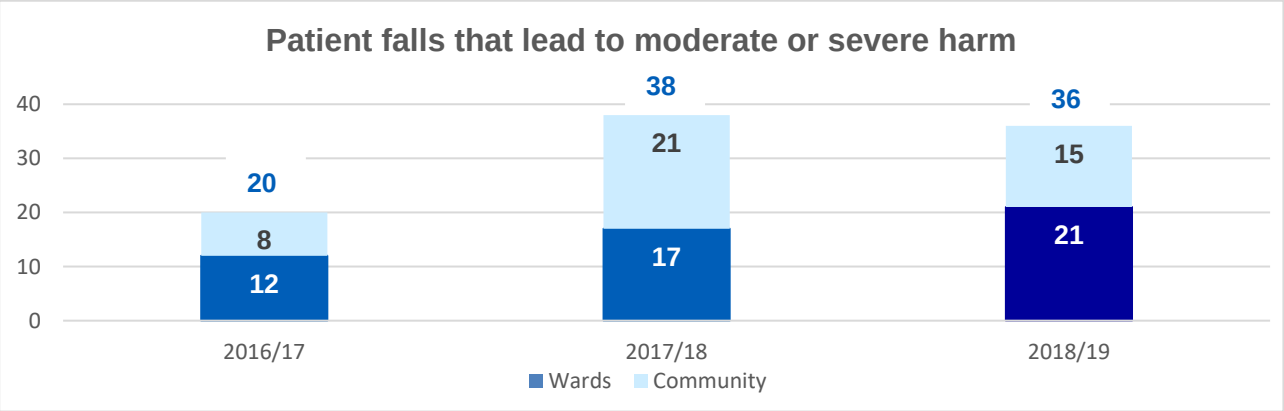
The directorate set a target of reducing the number of falls that lead to moderate or severe harm in 2018-19, which was carried forward from 2017-18.

In 2017-18, slips, trips and falls accounted for 12% of total incidents in the OPAC directorate, of which 5% result in moderate to severe harm. These rates have remained the same in 2018/19.

There was a 5% reduction in the number of patient falls that led to moderate or severe harm overall in 2018-19.

Inpatients

The 24% (n=4) increase in the number of falls in the wards is in the context of a 7% increase in occupied bed days in our mental health wards, equivalent to 1,065 more bed days; and a 2% increase in our physical health wards, equivalent to 649 more bed days in the year.



Community

The 29% (n-6) reduction in the number of falls in the older people's community services is in the context of a 52% increase in referrals to its mental health services, equivalent to 3,968, and an 11% increase in its physical health services, equivalent to 16,985, more referrals in the year.

Key actions taken in 2018-19 include:

- ✓ The Sustainability and Transformation Partnership (STP) Community Falls Pathway has been rolled out to all Neighbourhood Therapy Teams as well as partner organisations (Solutions4Health and Everyone Health). Staff in these services complete a falls screening question with patients over 65 and provide a multi-factorial falls risk assessment and appropriate interventions for those who have fallen.
- ✓ Falls link workers have been identified in all OPAC wards, and some from the ASMH wards. Regular Falls Link Worker sessions have started with the aim to increase falls awareness, provide additional training to the link workers and raise the profile of falls in the wards.
- ✓ Strength and Balance exercise prescription training is being provided to ward staff to implement effective falls prevention intervention on the wards.
- ✓ Falls Prevention Strategy Group meetings are continuing with increased attendance and engagement from ward managers.

In addition, a review of current Falls Prevention processes in the wards will commence in April 2019 to establish good practice and areas for improvement.

The service will continue to focus on reducing the number of falls in 2019/20.

2. Increase number of staff who complete the online falls training

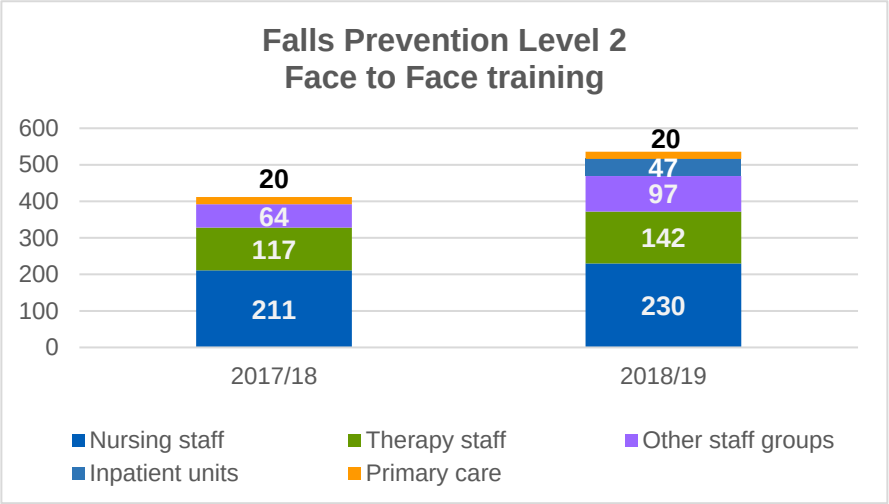
≈ **Partly achieved**

There was a delay in the development of the Falls e-learning package in the year.

To address this gap, the Falls Lead continued to deliver face to face training to all Neighbourhood Teams and inpatient staff during the year.

There was a 30% increase in Face to Face training delivered in the year.

The increase in training numbers appears to have made a positive impact on practice and outcomes of care as evidenced by improvements in the number of falls that led to moderate or severe harm in the year.



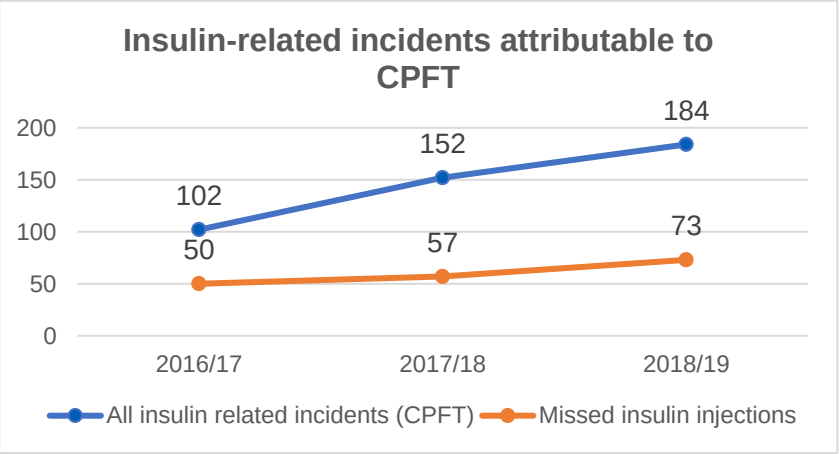
3. Reduce number of missed insulin-related incidents

✖ **Not achieved**

The directorate wanted to focus their efforts in reducing the number of missed insulin injections, which is the top category of all insulin-related incidents.

40% of all insulin-related incidents attributable to CPFT in 2018-19 related to missed/omitted insulin injections compared to 49% in 2016-17.

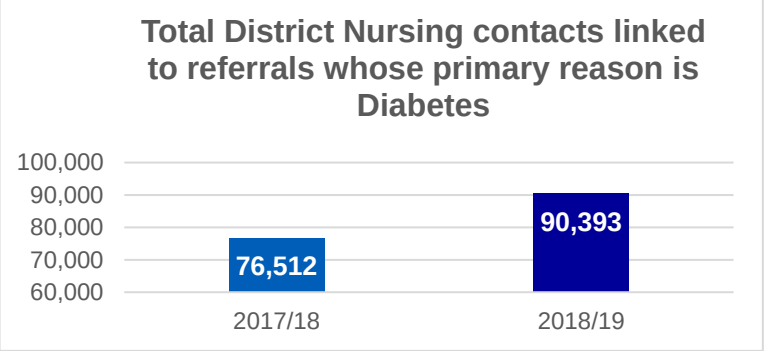
This shows a widening gap between the number of missed/omitted insulin injections against total insulin-related incidents in the last two years.



The directorate has continued to work hard to improve the reporting culture within its services and views the increase in the number of incidents reported as a positive outcome.

The majority of missed or omitted insulin injections were a result of scheduling and staffing issues.

During the year, there was an 18% increase in District Nursing contacts where the primary reason for referral was linked to 'Diabetes'.

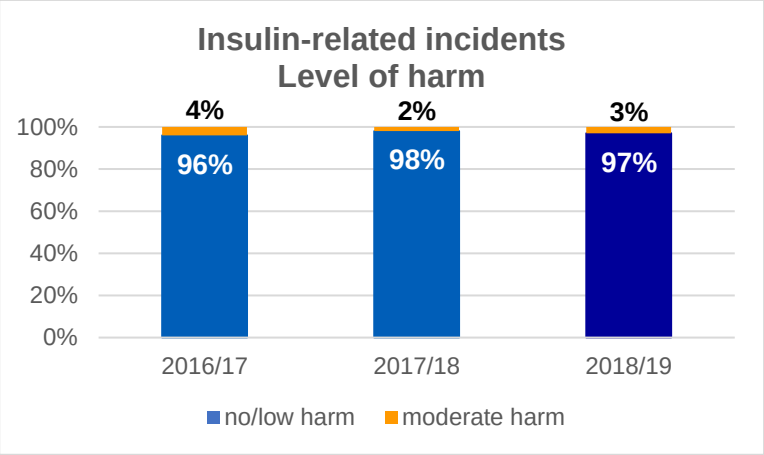


Whilst there were 13,881 more contacts for referrals linked to Diabetes in the year, there were only 32 more incidents related to insulin, of which 16 were missed or omitted injections.

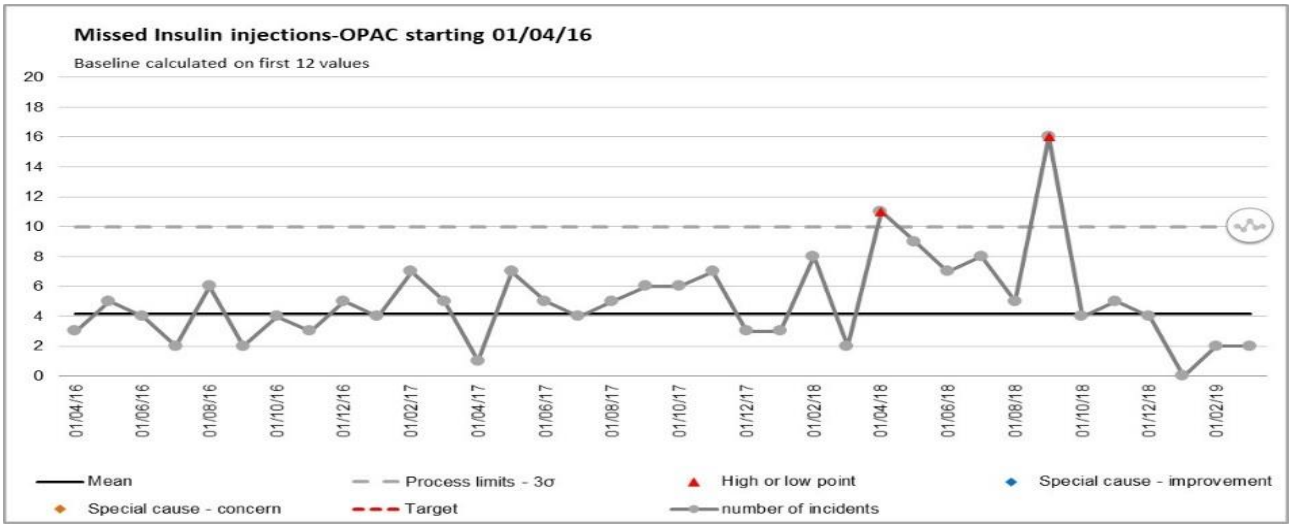
The proportion of all insulin-related incidents that led to no or low harm was 97% in 2018-19, a decrease of only 1%, having remained static at 98% for the first 11 months of the year.

This was due to one moderate harm incident that occurred in March 2019.

This is indicative of good quality care.



A detailed analysis of missed/omitted incidents over the last 3 years is shown below.



The sharp increases in April and September 2018 primarily occurred in three Neighbourhood Teams.

Except for the spike in September, there has been a reducing trend in missed/omitted insulin injections from April 2018, with only four incidents reported in the last quarter of 2018-19.

A full review of the circumstances around the incidents were undertaken to identify areas for improvement.

Key actions taken include:

- ✓ Development and implementation of a Standard Operating Procedure (SOP) around scheduling to ensure standardisation of practice for monitoring insulin injections.
- ✓ Introduction of a new Registered Nurse Medicines Administration Record RN (MAR) chart which has a cross-reference section to flag when a patient is on more than one insulin injection.

Clinical Effectiveness

Quality Goal 2: *Improve health outcomes*

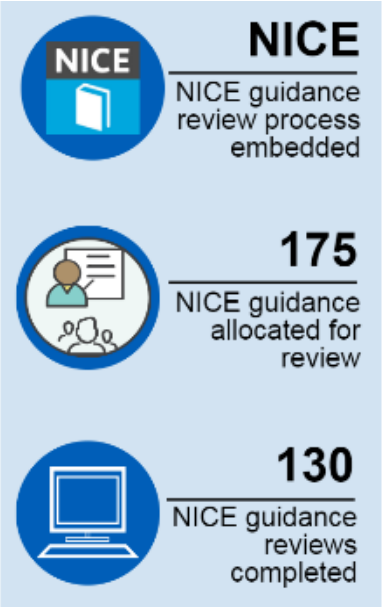
Trust wide

1. Strengthen the framework for embedding NICE guidelines into practice

✓ **Achieved**

We have made significant improvements in implementing NICE guidelines in the year, strengthening engagement within the clinical services and fostering ownership of actions to improve practice and care delivery.

Key highlights:



A process for evaluating published NICE guidelines is now firmly embedded within the directorates. Learning is shared through presentations at monthly directorate Quality and Safety meetings and infographics.

Infographics to share outcomes of baseline evaluations

NICE Works infographics to share guidelines and best practice

Figures above represent total activity over the two-year period, from 2017-18 to 2018-19.

In the second half of the year, we focused on getting a better understanding of the reasons behind non or partial concordance with NICE guidelines. Improvement actions are developed where gaps are due to practice issues, while commissioning or funding gaps and system-wide issues will inform the contracting process and partnership working.

2. Improve processes to support more meaningful use of outcome measures

≈ **Partly achieved**

Progress has been slower than planned in this area, influenced partly by the Trust's commitment to embrace the principles of co-production in improvement activities.

Electronic recording and reporting of a limited number of validated outcome measures are in place and currently being piloted in selected teams within the adults community services. This will help us to ensure that the data is meaningful and used appropriately in developing and reviewing plans of care. Learning from the pilot will inform how we introduce this data more widely across the Trust.

It is important that our patients are involved and that we learn from their experience and feedback, particularly in identifying outcomes to measure the effectiveness of our interventions and services.

This remains a priority of the Trust and is embedded within the Trust Strategy.

Adults and Specialist Mental Health Directorate (ASMH) priorities

1. Strengthen framework for translating lessons learned and sharing good practice

✓ **Achieved**

The directorate has continued to hold quarterly Learning Lessons events throughout the year, focusing on reviewing themes from serious incidents and complaints and actions.

Common themes

- Providing staff with access to all electronic patient records (EPR) in the Trust.
- Improving communication and access to services in other directorates, ensuring more collaborative working and joined up care
- Strengthening assessments to ensure the impact on children are considered and appropriate referral to the children's safeguarding service is made
- Strengthening risk assessments and formulations
- Improving practice around assessing and reviewing the capacity of patients, and involving families, carers and other relevant persons in planning care.

Positive actions and changes made:

- ✓ Strengthening collaborative working and communication between the Crisis Resolution and Home Treatment team (CRHT), locality community teams and the First Response Service (FRS).
- ✓ Bringing clarity to the child and adolescent mental health (CAMH) transition process
- ✓ Scaling up '*Rapid re-access*' across the locality teams, successfully implemented in Cambridge whereby patients contact the team directly.
- ✓ Holding two carer events, one co-presented with MIND on sharing information and confidentiality

Specific actions on violence & aggression (V&A)

- ✓ Thematic review of incidents across all inpatient services to identify areas for improvement
- ✓ Monthly V&A reduction meetings established, led by consultant psychiatrists and supported by the directorate Head of Nursing (DHoN)/deputy DHoN
- ✓ Training of bank staff in physical intervention

and currently developing -

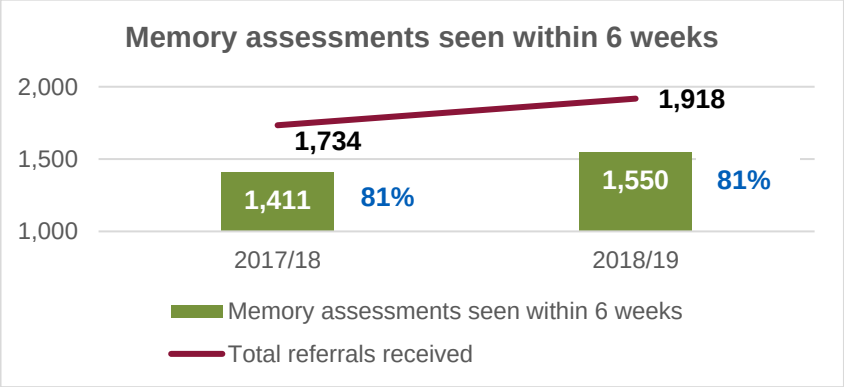
- one standard Trust wide capacity assessment form
- a trigger system in RiO (mental health EPR system) when a patient presents to different services multiple times to alert teams that action is needed to stop patients from bouncing between services

Older People and Adults Community Directorate (OPAC)

1. Increase memory assessments undertaken within 6 weeks in line with standards recommended by the Memory Service National Accreditation Service (MSNAP)

✓ **Achieved**

The first of the four objectives of the Dementia Strategy is to achieve "good quality early diagnosis and interventions for all". The MSNAP criteria supports the implementation of NICE guidelines and NICE Quality Standards for Dementia.



The number of memory assessments undertaken within 6 weeks of referral increased by 10% in 2018-19. This represents 81% of total referrals received in both years and is an achievement within the context of increased challenges in staffing during the year.

Patient, Carer and Staff Experience

Quality Goal 3: *Improve experience of care*

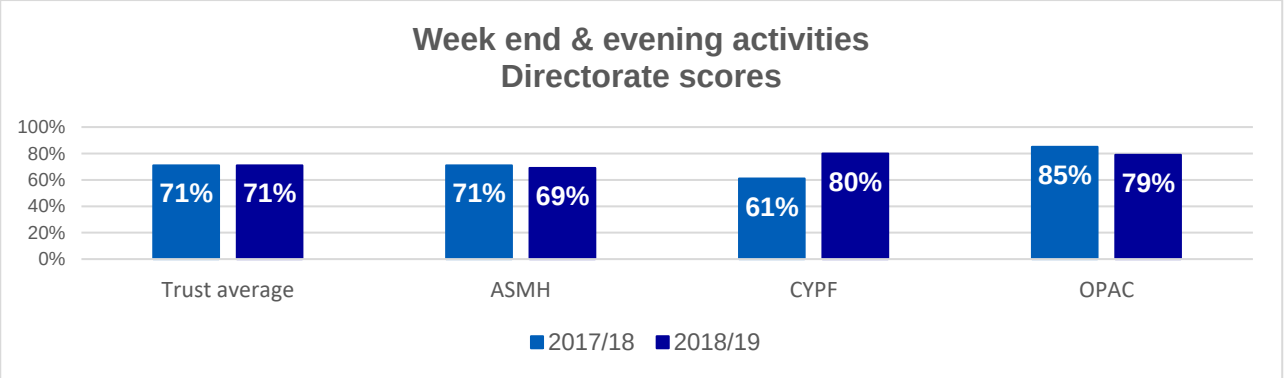
Patient's perspective

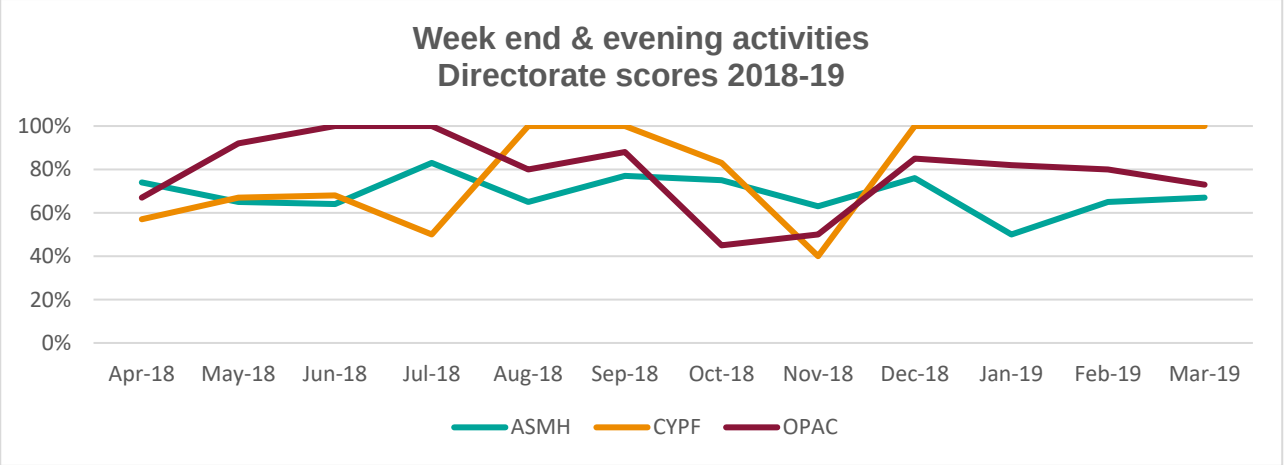
Mental health inpatient services

1. **Improve scores on weekend and evening activities in Meridian patient experience survey**

≈ **Static**

Trust wide average scores has remained static at 71% for both 2017-18 and 2018-19, while directorate scores show a significant increase in CYPF and slight reductions in ASMH and OPAC services.





The monthly directorate scores above show a dip across all directorates in October and November, and another dip in January in ASMH. Reasons for these include:

- ASMH - vacancies in Activities Coordinator posts and higher levels of temporary staff used at weekends and out of hours
- OPAC – there is no provision for Activity Coordinators at weekends, and an increase in acuity and challenging behaviour across the wards leads to an increase in observations to prioritise patient safety over running of activities
- CYPF – there is no clear reason apart from the increased acuity of patients during these periods.

On the other hand, the significant increase in CYPF scores overall was largely due to the appointment of Activities Coordinators in the service, reviewing activities on offer with the young people and ensuring the activities programme are varied.

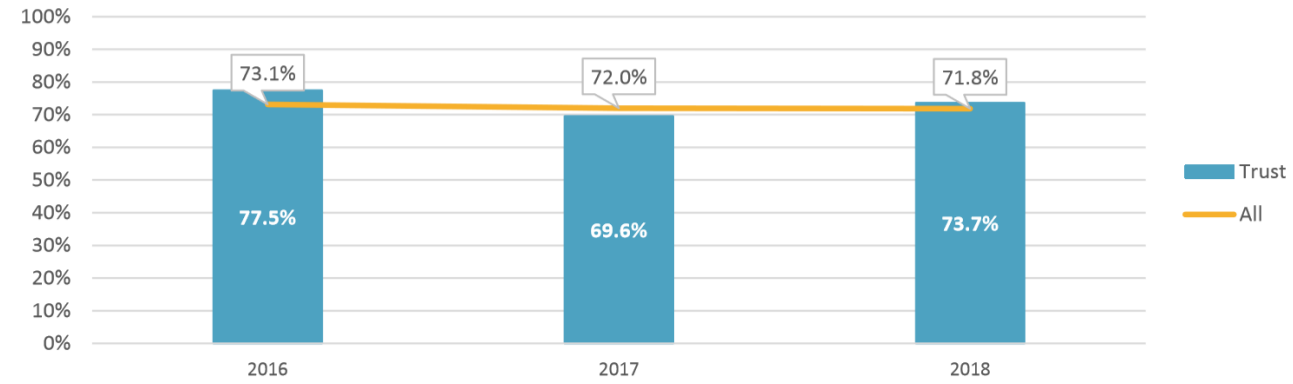
Mental health community services

For 2018-19, we focused on the areas where our scores had significantly reduced in the 2017-18 National Community Mental Health Patient Survey, to improve scores on

1. Had a formal meeting in the last 12 months to discuss care

✓ **Achieved**

13. 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?



The key action from the 2017 survey involved '*strengthening the common understanding and perception of what a review is to ensure that the patient recognises that a review has taken place*'.

We are pleased with the 4% improvement which puts us higher than the national average and reflects the work of our community mental health services.

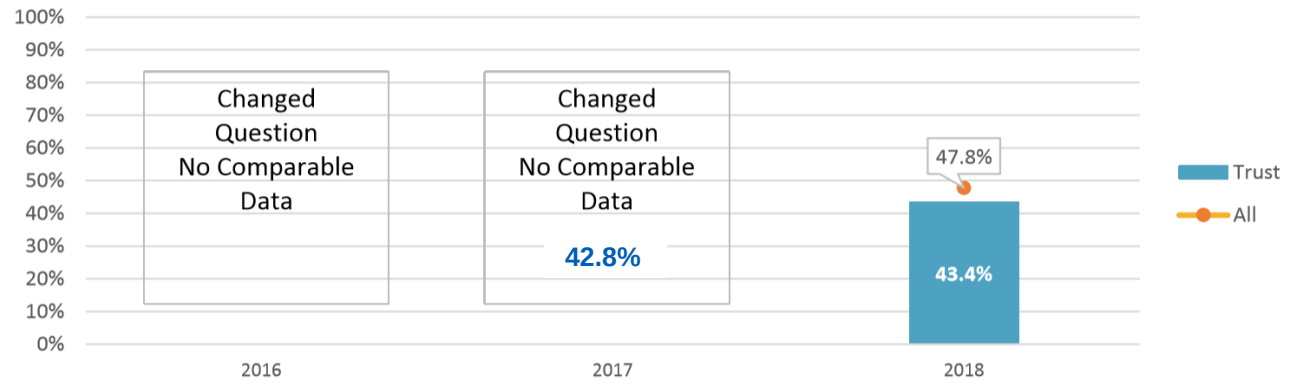
2. Supported to take part in local activities

✓ **Achieved**

We scored 42.8% in the 2017 survey, with the national average at 44%, on '*Has someone from NHS mental health services supported you in taking part in an activity locally?*'

In 2018, the question was changed and, while there is no directly comparable data, the score on the reworded question still shows an improvement at 43.4% as shown in the chart below.

34. In the last 12 months, has someone from NHS mental health services supported you in joining a group or taking part in an activity?



Older People's physical health services

1. Develop a simple referral mechanism within the directorate and strengthen cross-specialty case discussions

✓ **Achieved**

Sustainability and Transformation Partnerships (STP) STP investment and projects within the older people's services have led to improved integration and collaboration between teams during the year, such as Diabetes, Podiatry, Heart Failure, Respiratory, Discharge to Assess and JET. This is evidenced by the increase in the number of internal and external referrals between specialties during the year – see below.

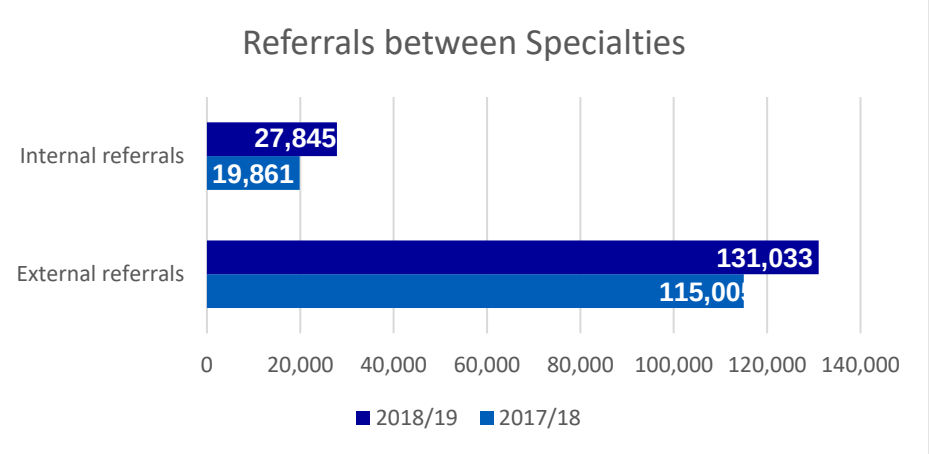
Improvements in referral mechanisms have resulted in more efficient transfer of information and speedier processing of internal referrals, closer working between teams and a more holistic approach to the referral, assessment and care planning processes.

2. Increase the number of referrals between specialties within the directorate

✓ **Achieved**

Improvements in integration and collaboration within these services have resulted in an increase in referrals between specialities across the directorate.

There has been a 40% increase in internal referrals between specialities and a 14% increase in external referrals, with an overall average increase of 18% in 2018-19.

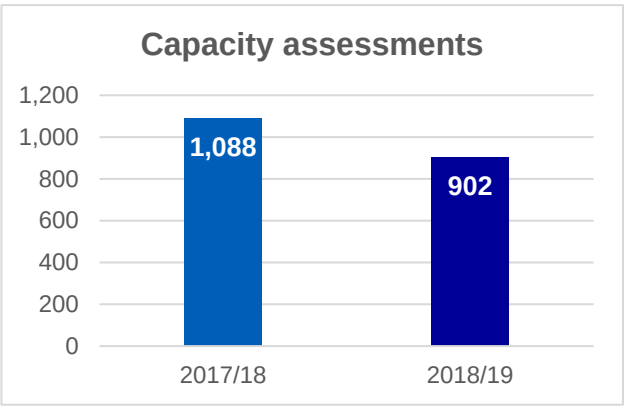


Work continues to improve integration and internal referrals to support patients to remain in their own home, whilst ensuring that they continue to receive appropriate care from the right service in a timely manner.

3. Increase the number of capacity assessments recorded on SystmOne

✘ **Not achieved**

In Q3 and Q4 of 2017-18 and Q1 of 2018-19, an STP-funded case management project was in place which involved setting up a service with dedicated case coordinator roles within the Neighbourhood Teams who provided links between CPFT clinicians, primary and other secondary care colleagues and performed full holistic assessments. Data analysis showed that more capacity assessments were recorded in the system during this period.



This ceased when the funding for the project was removed in Q2 of 2018-19.

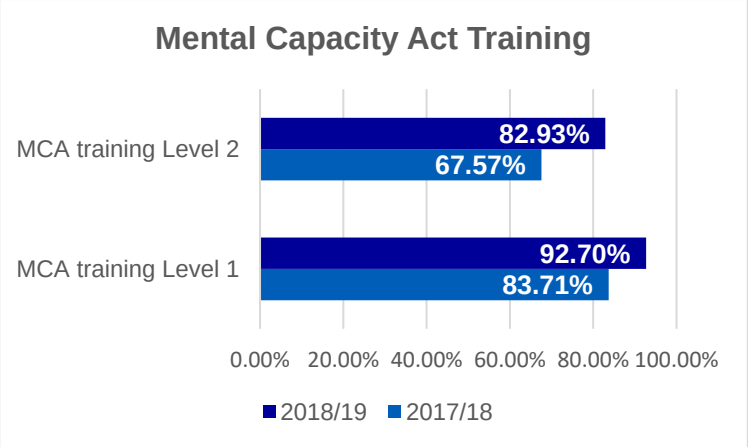
We completed an evaluation of the NICE Guideline (NG108): Decision-making and mental capacity, published in October 2018.

One of the key findings within the Neighbourhood Teams was that, while capacity assessments were indicated as being undertaken (i.e. box ticked), these were not always supported by progress notes in the patient records.

A key action following this review involved providing dedicated training to the community services within the older people services in the months following the NICE review.

There was a 9% increase in compliance rates for the Mental Capacity Act Level 1 training and a 15% increase in Level 2 during the year.

Other actions included agreeing a consent question to be added to SystmOne, the electronic patient record system used in the older people's community physical health services and monitoring this.



A re-audit is planned towards the end of 2019 to evaluate the success of the actions taken.

Carer's perspective

Trust wide

1. Achieve 60% target of patients having an identified carer in our patient records

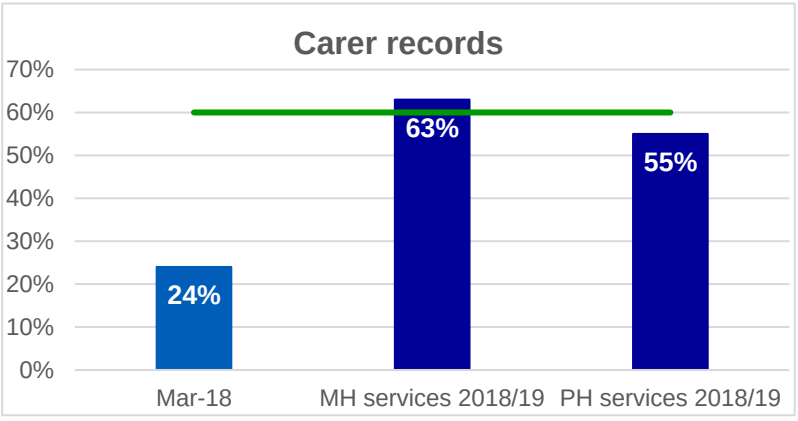
≈ **Partly achieved**

We have done a tremendous amount of work with carers during the year and have been awarded three stars for the implementation of Triangle of Care in recognition of our commitment to improve partnership working with unpaid carers. See **3.3.7** for details.

In 2018-19 the Carer Programme Board focused on ensuring a consistent approach to the identification and recording of informal carers across the Trust.

Recording of carers have increased significantly from a starting point of 23.83% at the beginning of the year.

Our mental health services achieved 63% while our physical health services achieved 55.5% at the end of the year against the target of 60%.



The increase is, in part, due to the change in recording, agreed by the Governors and the Carers Programme Board and implemented in August 2018. In addition, there has been a concerted effort to improve recording across the services.

Previously, the denominator included all service users on the case load including those who were on the waiting list which was not an accurate reflection of performance. The revised denominator only includes those patients who had had two face to face appointments and an open referral. The rationale for choosing the second appointment was that this provided clinical staff with a level of flexibility of deciding when it would be most appropriate to discuss carers with patients. It is worth noting that the difference between the first appointment and the second appointment was minimal. The numerator was also changed to include those with identified carers recorded.

The aim for 2019-20 is to achieve 80% recording of carer records and a focus on young carers.

2. Roll out the revised Carer Awareness training to all relevant staff

✓ **Achieved**

As of March 2019, compliance rates for the e-learning Carer Awareness Training show 85.37% compliance against our target of 90%.

Additionally, The Carer Trust also provide face to face training for teams if this is requested.

3. Develop a consent and confidentiality course to increase awareness and improve practice in this area

✓ **Achieved**

The workshop was developed during the year and provides an informal environment to explore the three perspectives of everyday issues of consent and confidentiality examples based on real life experiences from the perspective of the patient, carers and staff. This is provided to any team who requests it.

The workshop was first delivered in March as part of the training programme for the South Cambridge Locality teams within the ASMH community services. Further workshops are planned in 2019, with the aim to deliver it across the county.

We aim to continue to develop carer training in 2019-20.

Children, Young People and Families Directorate (CYPF)

1. 95% of parents and young people seen will have a discussion related to being a carer

✘ **Not achieved**

The directorate has focused on improving awareness of carer needs within the services during the year and has, in fact, reported the highest compliance rate on Carer Awareness training across the three directorates in 2018-19.

As of 31 March 2019, 91.81% of relevant staff in the Children's services had completed the Carer Awareness training.

However, the directorate is not able to provide accurate performance data on carers at this point. Further work is required to create systems which are able to clearly articulate, record and report on engagement with parent carers and to identify potential young carers.

Some work is also needed to promote a better understanding of terminologies used in the context of the children's services as most parents do not see themselves as 'carers'.

This remains a priority for the service.

Older People and Adults Community Directorate (OPAC)

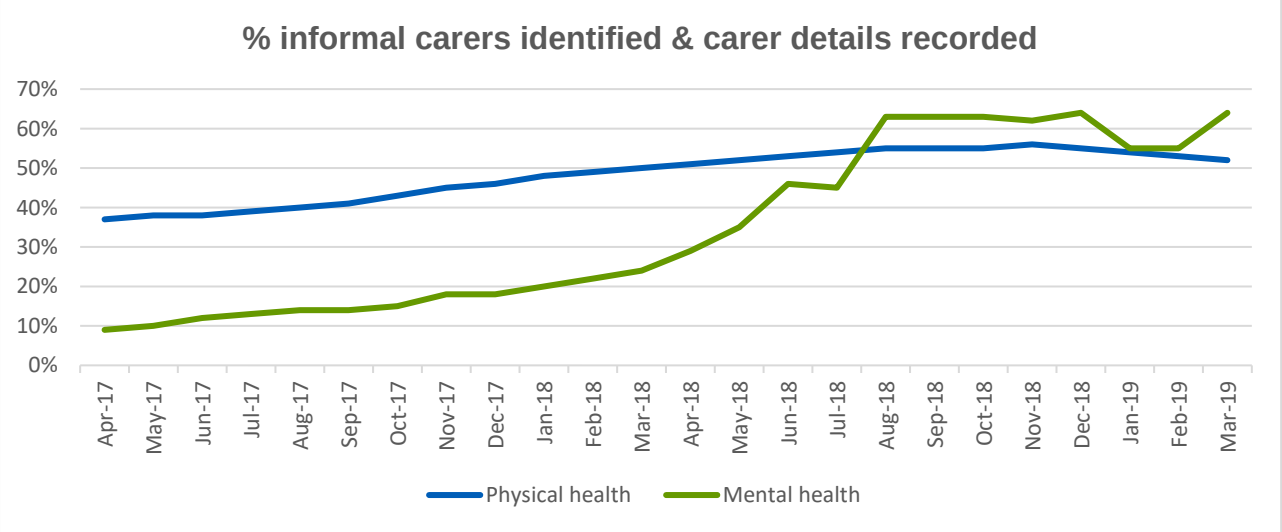
1. **Increase the number of identified informal carers in RiO and SystmOne**

✓ **Achieved**

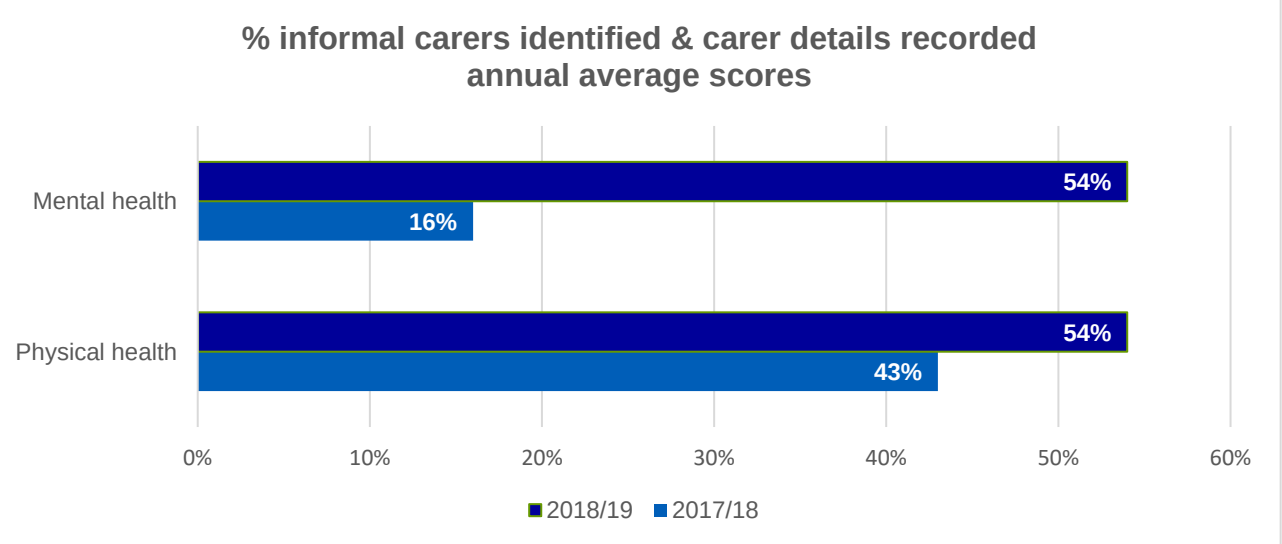
2. **Increase the number of records with details of informal carers recorded in RiO and SystmOne**

✓ **Achieved**

During the year, we strengthened the reporting and recording of carer details, combining both identification of carers and recording of carer details into one metric to support improvements in practice (see narrative under Trust wide above). The charts below show improvements reported across both physical and mental health services within the OPAC directorate.



On average, the percentage of the caseload with informal carers identified and having carer details recorded increased by 11% in the physical health services, and 38% in the mental health services.



This is a significant achievement and is testament to the hard work of the service and all staff in ensuring that carers are identified and recorded to ensure that they receive the support that they need.

Staff perspective

Trust wide

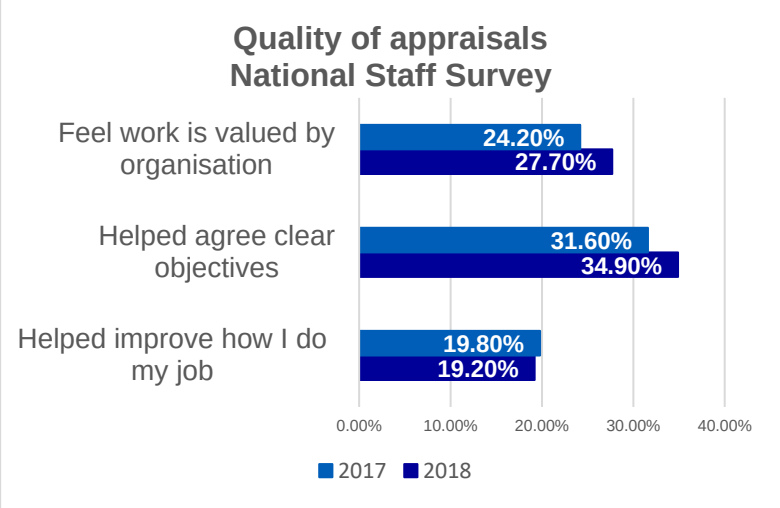
1. Improve scores in the National Staff Survey on the following

a. Quality of appraisals

✓ **Achieved**

There was an improvement in the organisation weighted key findings data at 3.5 in 2017 to 3.10 in 2018.

There are marked improvements in staff feeling that their work is valued by the organisation and that their appraisal helped them to agree clear objectives.

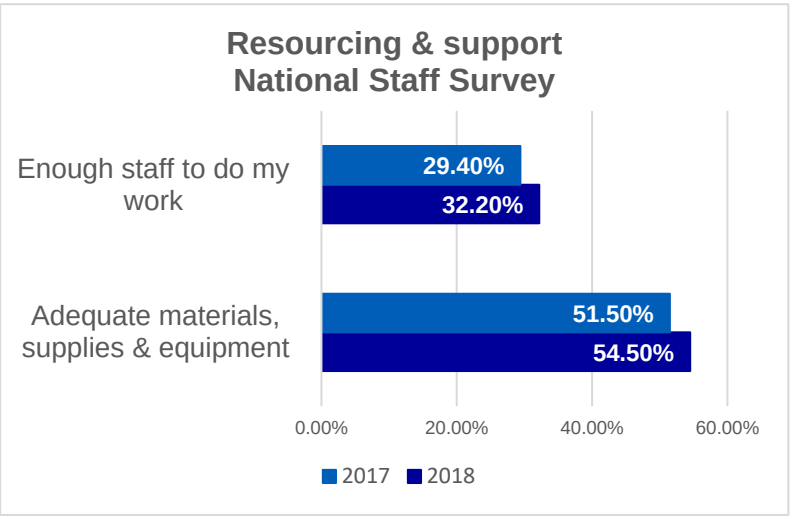


b. Staff satisfaction with resourcing and support

✓ **Achieved**

Weighted organisation key findings data show a slight improvement from 3.28 in 2017 to 3.33 in 2018.

There are marked improvements in staff feeling that there are enough staff to do their work and having adequate materials, supplies and equipment.



c. Staff satisfaction with quality of work and care they are able to deliver

✓ **Achieved**

Weighted organisation key findings data show a slight improvement from 3.80 in 2017 to 3.81 in 2018.

2. Support staff to improve their health and wellbeing through increased opportunities to access health and wellbeing initiatives, measured by the following indicators:

a. Reduction in sickness absence

✘ **Not achieved**

Sickness rate in 2017/18 was 4.1% and rose to 4.6% in 2018/19.

b. Reduction in the NHS Staff Survey score on '*feeling unwell due to work related stress in the last 12 months*'

✘ **Not achieved**

This has increased from 43% in 2017 to 45.7% in 2018.

c. Increase in NHS Staff Survey score around '*staff motivation at work*'

≈ Static

Weighted organisation key findings data has remained static at 3.92 in 2017 and 2018.

We recognise that we have more work to do to improve health and wellbeing of our staff.

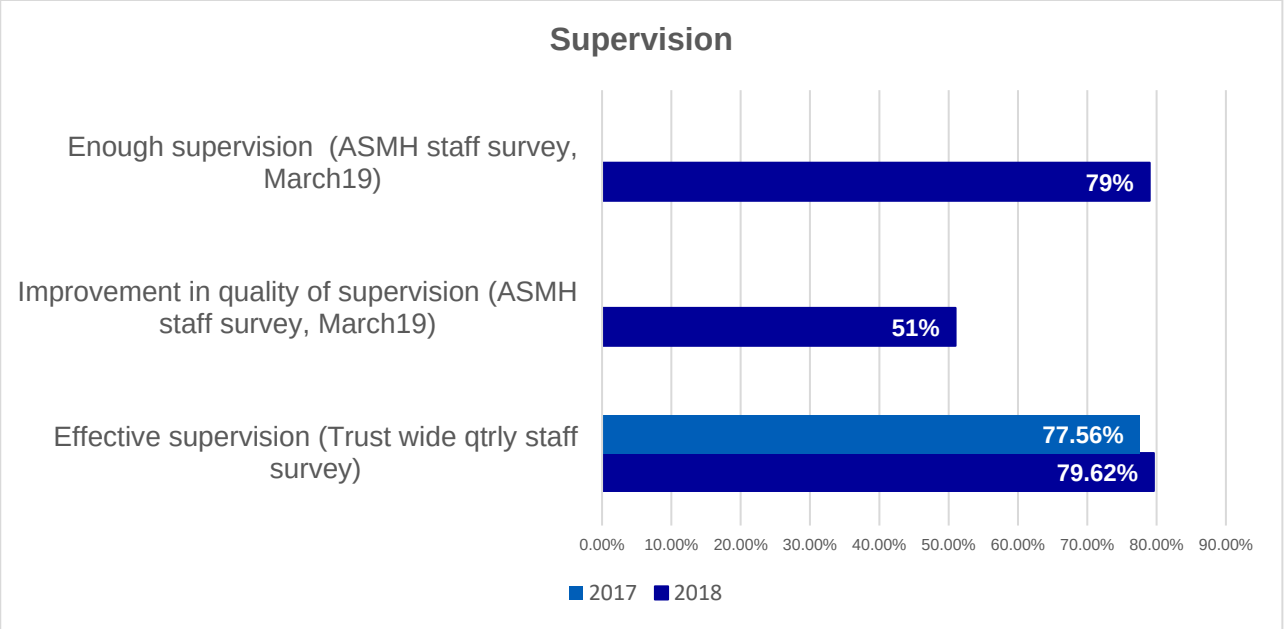
We know that staff who feel valued and supported are more likely to provide high quality care. We will work with our staff to jointly agree what we need to do to make improvements that matter and will make a difference to their health and wellbeing.

Adults and Specialist Mental Health Directorate (ASMH)

1. Improve experience of staff in the quality and frequency of supervision

✓ **Achieved**

The Trust's quarterly Safety Barometer staff survey shows an improvement in the scores for effectiveness of supervision within the directorate.



From the staff survey conducted by the directorate in March 2019, 79% felt that they received enough supervision to meet their support and development needs, while 51% felt there was an improvement in the quality of their supervision with another 20% saying they were unsure.

The directorate will continue to build on these results to improve the quality of supervision in 2019/20.

Children, Young People and Families Directorate (CYPF)

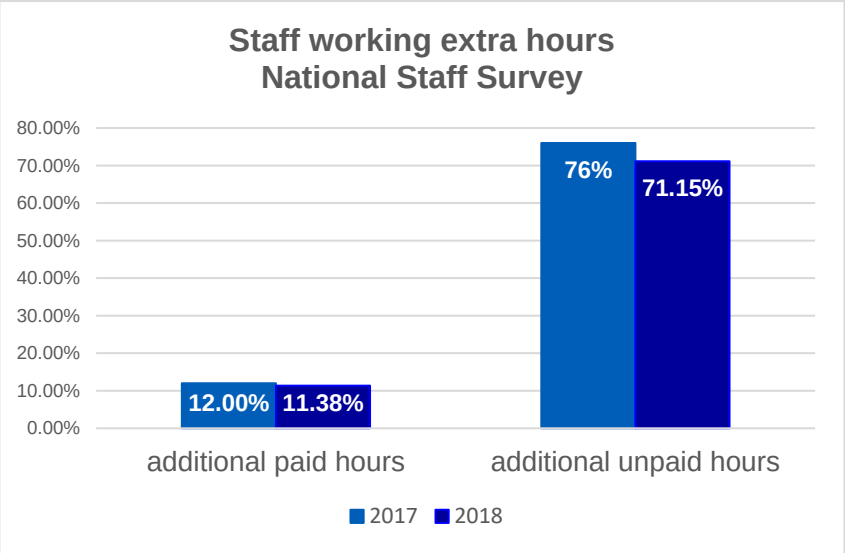
1. Improve National Staff Survey scores on the following areas:

a. Staff working extra hours

✓ **Achieved**

The directorate scores show improvements in this area, and in particular a marked decrease in the number of staff who reported working additional unpaid hours.

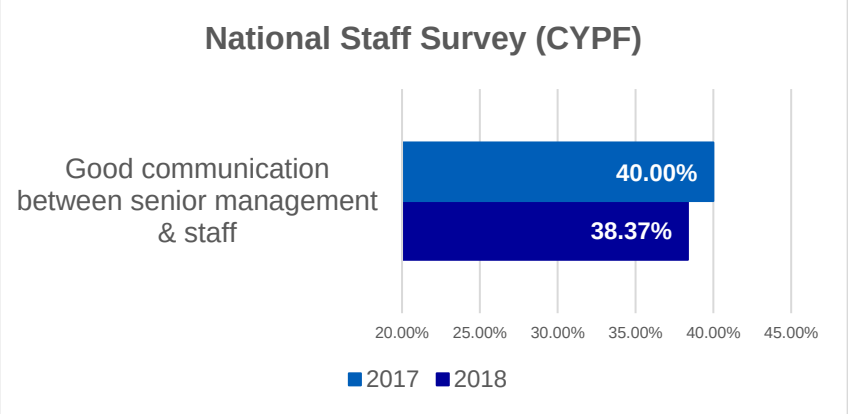
This is a significant achievement and reflects the work the directorate has done in improving staff experience during the year.



- **Staff reporting good communication between senior management and staff**

✗ **Not achieved**

The directorate believes in the importance of good communication between senior management and staff and will explore the reasons behind the slight decrease in the scores and work with staff to improve communication within the directorate overall.

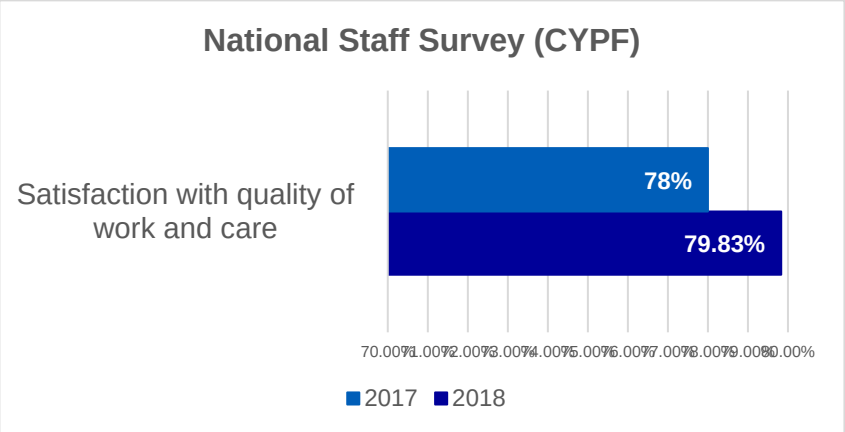


- **Staff satisfaction with quality of work and care they are able to deliver**

✓ **Achieved**

The directorate is very pleased with this almost 2% increase in the proportion of staff feeling satisfied with the quality of work and care they are able to deliver.

It will continue to build on this success in the coming year.



2. **Increase the proportion of physical assault incidents involving patient to staff that lead to no/low harm**

✓ **Achieved**

Physical assaults - patient to staff	2017-18	2018-19
No or low harm	77	77
Moderate harm	2	1
Total incidents	79	78
Proportion that led to no or low harm	**97%**	**99%**

The proportion of patient to staff physical assaults that led to no or low harm increased to 99% in 2018-19. This is an achievement for the service taking account of the increased acuity of the patients seen by the service during the year.

The directorate will build on these results and aim to maintain or improve on this performance for 2019-20.

2.1.6 Looking Forward – our priorities for improvement for 2019-20

The priorities for improvement for 2019/20 were developed by our staff, and are informed by the views of our patients, carers, governors, partners and other key stakeholders.

It has also been aligned to the strategic objectives of our Quality Strategy and our goal to achieve an outstanding rating from the Care Quality Commission (CQC). It also reflects the objectives of the *Five Year Forward View* and the *NHS Long Term Plan*.

Our Quality Goals

Patient Safety Quality Goal 1: ***Reduce avoidable harm***	**Safe**
Clinical Effectiveness Quality Goal 2: ***Improve health outcomes***	**Effective**
Patient, Carer and Staff Experience Quality Goal 3: ***Improve experience of care***	**Caring** **Responsive**
Workforce Development Quality Goal 4: ***Develop & support staff***	**Well Led**

Some of the priorities for 2019/20 have its foundations in the previous year's priorities, including those that we have not achieved in the year, as well as those areas where we want to further build on our successes this year.

Our clinical staff and services have been fully engaged in the development of these priorities, having been discussed and agreed in their respective Quality and Safety meetings, and are informed by the views of our patients, carers and other key partners.

This will be monitored through the Trust's governance processes, primarily by the Performance Review Executive (PRE) and Quality and Compliance Executive (QCE), with oversight from the Quality, Safety and Governance Committee (QSGC).

Patient Safety

Quality Goal 1: *Reduce avoidable harm*

Adults and Specialist Mental Health Directorate (ASMH)

What do we aim to achieve?	How are we going to measure it?
1. Reduce the number of incidents relating to self-harm and physical assaults in our acute wards.	Incidents data reporting
2. Increase the proportion of incidents that lead to no or low harm in our acute wards.	Incidents data reporting
3. Embed risk formulation and crisis planning across the directorate.	Audit of care records at Q1 and Q4

Baseline data

Year	All services						Acute wards only					
	Self-harm		Pt – Pt assaults		Pt – staff assaults		Self-harm		Pt – Pt assaults		Pt – staff assaults	
	# of incidents	% low harm	# of incidents	% no/low harm	# of incidents	% no/low harm	# of incidents	% low harm	# of incidents	% no/low harm	# of incidents	% no/low harm
17/18	826	90%	232	96%	497	96%	370	96%	149	96%	261	94%
18/19	606	88%	175	95%	559	95%	204	95%	94	100%	277	98%
Diff.	(220)	(2%)	(57)	(1%)	62	(1%)	(166)	(1%)	(55)	4%	16	4%

Children, Young People and Families Directorate (CYPF)

What do we aim to achieve?	How are we going to measure it?
1. 95% of children and young people on CAMH waiting list will be risk assessed in accordance with agreed management guidance (carried over from 2018-19).	Service line reporting and self-monitoring audits
2. Increase the proportion of incidents relating to self-harm that lead to no/low harm in our inpatient units.	Incidents data reporting

Baseline data

Self-harm	17/18	18/19	variance
Number of incidents	1225	1112	(113)
% low harm	98%	95%	(3%)

Older People and Adults Community Directorate (OPAC)

What do we aim to achieve?	How are we going to measure it?
1. Reduce the number of patient falls across all inpatient units.	Incidents data reporting
2. 85% of all target staff will complete Falls Prevention training*	Service line reporting
3. Develop a Quality Improvement project around the deteriorating patient, which will include implementation of NEWS2 (National Early Warning Score 2) across all our services.	Achievement of agreed outcomes

Baseline data

Total inpatient falls 2018-19 = 649

Apr18	May18	Jun18	Jul18	Aug18	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19	Mar19
53	53	41	48	39	67	62	58	64	73	41	50

* Some work is required to quantify the target staff for Falls Prevention training to obtain the percentage of staff who have completed the Falls prevention training as of March 2019.

Clinical Effectiveness

Quality Goal 2: *Improve health outcomes*

Trust wide

What do we aim to achieve?	How are we going to measure it?
1. Strengthen the processes for addressing and/or mitigating gaps in the delivery of NICE-concordant care.	Increase in completed NICE reviews with agreed improvement actions.
2. Introduce electronic data reporting of validated outcome measures more widely across the Trust following the pilot.	Dashboard reporting

Adults and Specialist Mental Health Directorate (ASMH)

What do we aim to achieve?	How are we going to measure it?
1. Support accreditation programmes for Adult Locality Teams and maintain existing accreditation of other services.	Accreditation programme

Children, Young People and Families Directorate (CYPF)

What do we aim to achieve?	How are we going to measure it?
1. We will involve patients and carers in agreeing outcome measures to use in our services.	Staff, patient and carer feedback

Older People and Adults Community Directorate (OPAC)

What do we aim to achieve?	How are we going to measure it?
1. We will increase the proportion of Band 6 nurses trained in chronic oedema management.	E-academy training records
2. We will increase the number of staff in our mental health services who have received Level 3 Suicide Prevention training.	E-academy training records

Baseline data

- Approximately 30 staff (all bands) have competed the chronic oedema management training as of March 2019. Further work is required to obtain accurate baseline data for 2019-20.
- 40 staff have completed the Leve 3 Suicide Prevention training as of March 2019.

Patient, Carer and Staff Experience

Quality Goal 3: *Improve experience of care*

Trust wide

What do we aim to achieve?	How are we going to measure it?
Caring	
1. We will increase recording of carer details to 80%.	Mi reporting.
2. We will develop a consistent framework across all three directorates around identifying and supporting young carers.	Development of framework

Adults and Specialist Mental Health Directorate (ASMH)

What do we aim to achieve?	How are we going to measure it?
Caring	
1. We will improve practice on the development of person-centred care plans which are meaningful to those receiving care and guide those delivering care to achieve the best outcomes.	Audit of care records at Q1 and Q4
Responsive	
2. Develop a communication strategy to proactively manage carer expectations relating to unmet needs.	Communication Strategy Reduction in the number of complaints related to access to services

Children, Young People and Families Directorate (CYPF)

What do we aim to achieve?	How are we going to measure it?
Caring	
1. We will improve practice on the development of person-centred care plans which are meaningful to those receiving care and guide those delivering care to achieve the best outcomes.	Audit of care records at Q1 and Q4
Responsive	
2. We will use demand and capacity modelling to improve waiting times.	Mi reporting

Older People and Adults Community Directorate (OPAC)

What do we aim to achieve?	How are we going to measure it?
Caring	
1. We will implement the 15 Steps Challenge across all our inpatient and community services.	Directorate reporting
2. We will deliver the Schwartz Rounds programme to our services throughout the year.	Directorate reporting
Responsive	
3. We will identify if patients who have expressed their preferred place of death have had their wishes met.	Audit of care records
4. Care plans for patients who have Dementia will include the needs of the carer.	Audit of care records

Workforce Development

Quality Goal 4: *Develop & support staff*

Trust wide

What do we aim to achieve?	How are we going to measure it?
1. We will create a safe environment for staff to raise concerns and reduce the experience of bullying and harassment.	• Reduction in National Staff Survey and internal staff survey scores on staff experiencing bullying, harassment and abuse from colleagues and managers • Continue to promote Freedom to Speak Up Guardian process and strengthen the process for identifying and embedding learning
2. We will support the improvement of health and wellbeing of our workforce.	• Improvement in in National Staff Survey and internal staff survey scores on staff view that the Trust takes positive action in relation to health and wellbeing • Reduction in National Staff Survey scores on the number of staff experiencing musculoskeletal issues • Sickness absence and wellbeing activity data

Baseline data

- Staff experiencing bullying, harassment and abuse from colleagues – 18.6%
- Staff experiencing bullying, harassment and abuse from managers – 14.3%
- Staff view that the Trust takes positive action in relation to health and wellbeing – 31%
- Staff that experience MSK issues – 25.8%

Adults and Specialist Mental Health Directorate (ASMH)

What do we aim to achieve?	How are we going to measure it?
1. We will make better use of longitudinal data alongside other qualitative information to measure progress and monitor overall performance.	Increase the number of team managers using Plot the Dot/SPC (Statistical Process Control) charts to monitor the quality of their services.

Children, Young People and Families Directorate (CYPF)

What do we aim to achieve?	How are we going to measure it?
1. Increase the number of staff who receive monthly clinical and managerial supervision.	Mi report
2. Staff will feel that supervision has been effective in supporting them to fulfil their role.	Staff survey conducted at Q1 and Q4

Baseline data

Overall annual average of 64% supervision compliance rate

Apr18	May18	Jun18	Jul18	Aug18	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19	Mar19
66.52%	64.48%	67.42%	68.33%	62.90%	69.23%	71.04%	68.78%	66.29%	67.19%	56.33%	45.02%

Older People and Adults Community Directorate (OPAC)

What do we aim to achieve?	How are we going to measure it?
1. Improve compliance rates with competency and proficiency for role-specific training.	Training compliance report
2. Improve staff awareness of the patient's psychological needs.	Evaluation on training and availability taken in Q1 and Q4
3. Increase the number of Allied Health Professionals (AHPs) in the service with a job plan.	Number of AHPs recorded with a job plan on E-roster system

Baseline data

- Role specific mandatory training compliance for 2018-19 = 88.67%.
- AHP staff with a job plan as of March 2019 = none

2.2 Statements of Assurance from the Board

In this section we report on the mandatory statements concerning our services in 2018/19.

Reporting requirements for Quality Accounts 2018/19

Alongside the requirements which are based on the quality accounts legislation and those mandated by NHS Improvement (NHSI, previously Monitor), new reporting requirements for 2018/19 set out by NHSI in the letter dated 17 December 2018 are as follows:

- In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS Trusts and NHS Foundation Trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of such legislation, NHS Trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust. See **2.2.10**.
- Schedule 6, paragraph 11b of the *Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016* requires "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account". See **2.2.11**.

2.2.1 Review of Services

During 2018-19 CPFT provided and/or sub-contracted 77 relevant NHS health services.

CPFT has reviewed all the data available to us on the quality of care in 77 of these relevant NHS health services.

The income generated by the relevant health services reviewed in 2018-19 represents 100% of the total income generated from the provision of relevant health services by CPFT for 2018-19.

We have reviewed the data available to us during the year covering the three dimensions of quality – 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.

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 2018-19, 10 national clinical audits and one national confidential enquiry 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 2018-19 are as follows:

National Clinical Audits
1. Sentinel Stroke National Audit Programme 2018-19
2. National Clinical Audit of Psychosis - EIP Spotlight
3. National Audit of Anxiety and Depression - Core Audit
4. National Audit of Anxiety and Depression - Psychological Therapies
5. National Diabetes Footcare Audit 2018-19
6. National Audit of Intermediate Care 2018
7. National Audit of Care at the End of Life
8. National Audit of Inpatient Falls 2018-19
9. Prescribing Observatory for Mental Health (POMH) 6d: Assessment of the side effects of depot antipsychotics
10. POMH 18a: Prescribing Clozapine
National Confidential Enquiries
1. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that CPFT participated in during 2018-19 are as follows:

National Clinical Audits
1. Sentinel Stroke National Audit Programme 2018-19
2. National Clinical Audit of Psychosis - EIP Spotlight
3. National Audit of Anxiety and Depression - Core Audit
4. National Audit of Anxiety and Depression - Psychological Therapies
5. National Diabetes Footcare Audit 2018-19
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7. National Audit of Care at the End of Life
8. National Audit of Inpatient Falls 2018-19
9. Prescribing Observatory for Mental Health (POMH) 6d: Assessment of the side effects of depot antipsychotics
10. POMH 18a: Prescribing Clozapine
National Confidential Enquiries
1. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential inquiries that CPFT participated in, and for which data collection was completed during 2018-19, 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.

Audit title	Cases submitted	Status as of 31 March 2019
1 Sentinel Stroke National Audit Programme (SSNAP) 2018/19	360/388 cases (93%)	Continuous Audit
2 National Clinical Audit of Psychosis - EIP Spotlight	101 cases (100%)	Data Analysis
3 National Audit of Anxiety & Depression (NCAAD) - Core Audit	55 cases (100%)	Data Analysis

4	National Audit of Anxiety & Depression (NCAAD) – Psychological Therapies	75 cases (100%)	
5	National Diabetes Footcare Audit (NDFA) 2018/19	2017-18 - 58 cases submitted in June 2018 NHS Digital report 2018-19 sample size not yet available	Continuous Audit
6	National Audit of Intermediate Care 2018	Bed based units - 178 returns Home based units – 52 returns	Report writing
7	National Audit of Care at the End of Life	Community Hospitals – EOL care units (2) Case Note review - 6 across EOL care units (100%)	Report writing
8	National Audit of Inpatient Falls 2018/19	Commenced January 2019 – 2 eligible patient falls in the period	Continuous Audit
Prescribing Observatory for Mental Health (POMH)			
9	POMH 6d: Assessment of the side effects of depot antipsychotics	55/94 cases (59%)	Data Analysis
10	POMH 18a: Prescribing Clozapine	42/49 cases (86%)	Data analysis
National Confidential Enquiry			
1	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	20 suicide questionnaires received, 14 sent back (70%) as of 31 March 2019	

In addition, we participated in five national audits under the CQUIN (Commissioning for Quality and Innovation) programme during 2018-19:

Audit title		**Status as of 31 March 2019**
1	CQUIN 3a: cardiometabolic assessment - EIP Services	Data analysis
2	CQUIN 3a: Cardiometabolic Assessment - Inpatient & Community 18/19	Data Analysis
3	CQUIN 3b: Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness (SMI): Collaborating with primary care clinicians	Planning
4	CQUIN 5: Transitions out of Children and Young People's Mental Health Services (CYPMHS) 2018-19	Q4 in data collection
5	CQUIN 10: Tissue Viability Nurses/wound assessment chart 2018-19 Re-Audit Q2 & Q4 2018/-19	Data Analysis

The reports of four national clinical audits were reviewed by CPFT in 2018-19:

1. POMH 15b: Prescribing sodium valproate for people with bipolar disorder
2. POMH 17a: Use of Depot
3. Sentinel Stroke National Audit Programme (SSNAP) 2018-19
4. 2017 UK Parkinson's Audit Patient management: elderly care and Neurology

The reports of five national CQUIN audits were reviewed by CPFT in 2018-19.

1. CQUIN 3b: Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness (SMI) - Collaborating with primary care clinicians 2017-18

2. CQUIN 5: Transitions out of Children and Young People's Mental Health Services (CYPMHS) 2017-18
3. CQUIN 5: Transitions out of Children and Young People's Mental Health Services (CYPMHS) 2018/19 Q2
4. CQUIN 10: Tissue Viability Nurses/wound assessment chart Re Audit Q4 2017-18
5. CQUIN 10: Tissue Viability Nurses/wound assessment chart 2018/19 Re-audit Q2 2018-19

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

Audit title – National audits	Key actions
1 POMH 15b: Prescribing sodium valproate for people with bipolar disorder	• Update medicines monitoring guidelines to comply with Practice Standard 6 (*body weight and/or BMI, blood pressure, plasma glucose and plasma lipids should be measured at least annually during continuing valproate treatment*)
2 POMH 17a: Use of depot	• To implement consistent rating scales for side effects using a Trust-approved rating scale
3 Sentinel Stroke National Audit Programme (SSNAP) 2018-19	• Insufficient data to draw conclusions
4 2017 UK Parkinson's Audit Patient management: elderly care and Neurology	• Provide all patients with information packs at diagnosis • All staff to attend the Trust Coaching course and to adopt this approach during clinical consultations

Audit title – CQUIN audits	Key actions
1 CQUIN 3b: Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness (SMI)	✓ Amend discharge notification content (<2-day communication) whereas previously elements of the CQUIN information would be contained within the discharge summary (<14-day communication. **Note:** The timeliness of CQUIN-mandated discharge information has improved following implementation of this change in practice.
2 CQUIN 5: Transitions out of Children and Young People's Mental Health Services	• To establish a more reliable registry of transition cases from children to adult mental health services • To convene a time limited Task and Finish group between CYPF and ASMH directorates to address issues including - joint participation in service user transition meetings, enhancing the experience of transition as measured by pre/post surveys
3 CQUIN 10: Tissue Viability Nurses/wound assessment chart	• Promote and support staff to use the electronic wound assessment template (incremental change as all teams become agile). • Training to use wound assessment template to be integrated into the pressure ulcer mandatory training and Continuing Professional Development group meetings

The reports of 13 local clinical audits were reviewed by CPFT in 2018-19 and CPFT intends to take/has taken the following actions to improve the quality of healthcare provided:

Audit title – Local projects	Key actions
1 Medical Devices – Inpatient Units/Community/Podiatry	• Isolated instances of required maintenance updates and availability of specific equipment in some areas
2 Medicines Management – Antimicrobial	• Tailored feedback provided to each ward and specific reminders via Medicines Bulletin
3 Cognitive Assessment Re audit - Willow Ward	• Improvement sustained in assessment target. • Junior Doctor booklet to be developed
4 Antipsychotic and Hypnotic prescribing - impact on falls. Denbigh and Willow Ward	• Staff seminar held for specific wards. • Liaison with pharmacy to discuss monitoring of PRN usage. • Re-audit.
5 Non-Medical Prescribing Audit (NMP)	• To increase numbers accessing supervision. • Buddy system to be introduced.
6 OPAC Consultant Work Peer Audit	• Themes discussed at Consultant away day, individual feedback given
7 Joint Emergency Team (JET) Notes Audit	• Training to be considered in relation to pain scoring and pressure prevention documentation. • Monthly audits to be undertaken by the team
8 First Response Triage Audit	• Areas for improvement in documentation related to several topic areas
9 Eliminating Mixed Sex Accommodation Audit	• Compliance poster to be available on wards
10 Suicide Prevention Audit - 2015/16	• Trust level clinical risk training updated to incorporate outcomes
11 Antenatal and Postnatal Mental Health (South) Re Audit	• Outcomes maintained. End of audit cycle
12 Medicines Management - Community Team	*Each of the 52 units has an individual report with specific itemised actions. Key actions include:* • Pharmacy team will expedite the injectable medicines template and disseminate to all areas where injectable medicines are administered. • The pharmacy team will contact the teams who hold FP10 prescription pads and arrange for the address to be corrected for teams that have moved and the address is incorrect.
13 Temperature Monitoring Audit	• Advise wards on the appropriate thermometers to use and how to reset in line with guidelines. • Wards with room temperature excursions – review temperature monitoring and assess whether these are acceptable and appropriate actions are taken. • Wards with fridge temperature excursions – ensure these are serviced and calibrated by a suitably qualified technician.

In addition, we supported the completion of five service development projects.

Service development projects	Key actions
1 Epilepsy and pregnancy pathway, Is the service compliant with guidance?	Various service improvements identified - additional checks, provision of patient information, modification of screening and signposting.
2 Does a seven-week Mindfulness Based Intervention (MBI) reduce symptoms of anxiety and depression in older adults?	• Outcome of review used to evaluate course content
3 Continuous subcutaneous insulin infusion service evaluation to assess current service provision and service development	• Introduction of a patient reported experience measure (PREM). • Changes to current educational sessions made.
4 A service evaluation: Cambridge Centre for Paediatric Neuropsychological Rehabilitation	• To begin using the Family Needs Questionnaire Paediatric tool. • Use results to discuss commissioning.
5 Use of Seclusion - A Qualitative Service Evaluation	• Optimise patient comfort within the seclusion environment (safe but comfortable furniture). • Introduce prompt sheet for staff- 'top tips' to improve communication. • Integrate patient feedback from debriefing into weekly supervision group

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.

CPFT is the top performing NHS Trust for mental health research in the East of England

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 older people's mental health. We are also one of a few Trusts leading on the development of clinical informatics nationally.

20% **more studies**

70% increase in research participants

As of March 2019, there were 156 active studies in CPFT - 38 were approved in 2018-19, of which 26 were adopted on the NIHR (136 in 2017-18).

The number of patients receiving relevant health services provided or sub-contracted by CPFT in 2018-19 that were recruited during that period to participate in research approved by a research ethics committee and portfolio adopted is currently 2,461 (compared to 1,450 in 2017-18, 841 in 2016-17 and 983 in 2015).

Examples of CPFT research studies that are making a difference…

Finding new treatments for depression

CPFT R&D director is leading the NIMA consortium - funded by the Wellcome Trust which is a large academic-industrial consortium - investigating the role of the immune system in depression and Alzheimer's disease and how this could lead to new drug treatments for these disorders. In 2019, CPFT will lead as co-sponsor on a clinical trial of an investigational medical product (CTIMP), a new anti-inflammatory drug that is being tested as an anti-depressant for the first time. This is is the first time that CPFT has sponsored a CTIMP study.

Improving mental health assessments for young people

CPFT is s part of a new £1.5m study to help children and adolescents receiving care by improving diagnosis of emotional disorders. One of our consultant child and adolescent psychiatrist is leading the study for Cambridge and Peterborough, working with the national lead from The Institute of Mental Health, to evaluate an assessment tool used by mental health clinicians working with children and adolescents to diagnose emotional disorders like anxiety and depression, working closely with health professionals and patients. The STADIA study (STAndardised DIagnostic Assessment for children and adolescents with emotional difficulties) is funded by the NIHR and aims to evaluate whether the DAWBA standard assessment tool is clinically effective and good value in diagnosing emotional disorders in children and adolescents (aged 5-17 years), referred to Child and Adolescent Mental Health Services (CAMHS) with emotional difficulties. By evaluating different approaches to assessment within CAMHS, this research will help improve care and inform clinical guidelines, and help the NHS decide how to ensure diagnosis of emotional disorders is effective and value for money.

Tailoring new therapies for recovery

Major funding was awarded from the NIHR Programme Grants for Applied Research (PGfR) for the TYPPEX programme, co-led by CPFT consultant psychiatrist and Lead Clinical Director of the Eastern Clinical Research Network, and Director of CLAHRC EoE and CPFT non-executive director, to develop a new form of talking therapy for people with common mental health disorders and unusual experiences using IAPT. This study is supported by CPFT's Psychological Wellbeing Service, Norfolk and Suffolk NHS Foundation Trust, and Sussex Partnership Foundation Trust.

Changing care practice for dementia

Studies conducted by CPFT clinicians and researchers, working closely with people living with dementia, have contributed to the knowledge base behind the new 2018 guidelines from the National Institute for Health and Care Excellence (NICE). Research informed best clinical practice through several studies - including the DOMINO-AD (Donepezil & Memantine in moderate to severe Alzheimer's Disease) study looking at how to best use anti-dementia drugs, and the SADD (Study of the use of Antidepressants for Depression in Dementia) study that looked at the effectiveness of antidepressants in treating depression that occurs in dementia.

Research innovation using data to improve healthcare

A university lecturer in clinical informatics and honorary consultant liaison psychiatrist at CPFT secured a £1.5 million Medical Research Council (MRC) pathfinder grant from the Medical Research Council for mental health clinical informatics. The programme focuses on how best to collect, link, anonymise, select, and analyse data to improve diagnosis and predict outcomes in mental health conditions. The research group is helping to build the systems, infrastructure, and insight to help make the best secure use of NHS data to improve healthcare. Academic teams are working collaboratively with industry partners in preparation for a future Mental Health Research Platform. CPFT is investigating ways to expand the use of the Trust's innovative research database – CRATE - and reviewing opportunities to forge collaborations with academic and industry partners to further optimise the clinical and research potential of our data, using technologies such as artificial Intelligence (AI).

B. CLAHRC EoE

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

Running since 2011, the CLAHRC's successful *Fellowship Programme* is now in its 9th cohort. Fellowships have been awarded to **105** professionals from **40** partner organisations, with **35** fellows from CPFT.

CPFT projects from the scheme have included:

- Involving Experts by Experience in identifying mental health research topics and priorities
- The Identification of Adverse Childhood Experiences by CAMHS Clinicians
- Optimizing and validating the MARSI MEWS scoring system in an inpatient eating disorder setting.

As of 31 March 2019, CLAHRC EoE has **59** projects, **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

Examples of CLAHRC studies that have improved or have the potential to improve outcomes of care:

Evaluation of Interpersonal Counselling (IPC) – this project looked at the effectiveness and acceptability of IPC in young people with depressive symptoms. Youth workers received a two-day training course in IPC, followed by regular supervision. They delivered IPC to young people they would normally see in their service with primary depressive symptoms. Participants detailed specific advantages of IPC above standard counselling, including practical help, the use of goals, psychoeducation and integrating a self-rated questionnaire into treatment.

Supporting young people with learning disabilities and/or autism and 'challenging behaviour' - this study used an evidence-based approach to promote good local support for a group of young people with disabilities at high risk of exclusion. As a result of this project the local authority funded a two-year Positive Behaviour Support project to work intensively with eight young people with 'challenging behaviour' at high risk of exclusion from local educational, respite or other provision. The team demonstrated inclusion is possible, supporting the national 'Transforming Care' agenda, and this work is now being rolled out across another area in the Eastern region.

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 still 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. The project team are following up with the implementation of findings on how staff "view" frailty with a frailty training (delivered in spring 2019) in line with the needs and preferences identified by the study at multidisciplinary team meetings across all 14 Neighbourhood Teams in CPFT.

Impact of Patient and Public Involvement (PPI): Completing the Feedback Cycle – this project explored the definition of feedback and the types, extent, importance of and satisfaction with feedback given by researchers to Patient and Public Involvement representatives on their contributions. The project involved CPFT patients and the public, amongst others, across the eastern region. The PPI Feedback Guidance and Process resulting from the project have had regional and national recognition and usage INVOLVE newsletter Times Higher Health Service Journal.

C. Service User and Carer Engagement in Research

Involvement of people with lived experience of mental health issues in research 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 2018/19

- we supported **48** Experts by Experience (EbEs) to be involved in **34** research or research-related activities
- we provided advice and support to **26** researchers
- **18** EbEs were involved for the first time
- **11** Lived Experience Advisory Groups (LEAG) were set up to help researchers with their projects and most of them (10) were co-ordinated by CPFT R&D

Key achievements in 2018-19 include:

EbE representation at CPFT R&D Strategic Funding Allocation Committee. Engaging with EbEs at all levels of decision making is important to strengthen relevance, responsiveness and accountability, and to build trust. To maximise patient leadership in R&D, an EbE was recruited to join the CPFT R&D Strategic Funding Allocation Committee to bring a patient and/or carer perspective to the discussions and decisions made at the meetings.

Research conducted on involvement of EbEs in identifying mental health research topics and priorities. As part of her CLAHRC Fellowship the PPI Lead and four members of the SUCRG conducted a scoping review to gain a better understanding of the strengths and weaknesses of different approaches and assess whether any could be used to identify patient focused research topics and priorities in our area, or if better results may perhaps be achieved through combination of strengths of several methods. This work was built on the recognition of the benefits of PPI at early stages of research and the recommendations of the PPI Strategy/Task and Finish Group (2017) on the way we can enhance person-centred research at CPFT.

Strengthen interdisciplinary team working and research. Members of the SUCRG and the PPI Lead supported researchers from the Department of Geography (University of Cambridge) to develop a successful funding application to carry out a conference on "Social Power and Mental Health", a topic of particular importance to EbEs.

Successful continuation of a PPI training programme. Approximately 120 researchers attended 12 teaching sessions co-delivered with EbEs, which included:

- the user-led teaching programme called *Conversations with Experts by Experience (CEbE)* which aims to help non-clinical researchers understand the symptoms and conditions they study from the service user perspective. All nine sessions were well attended and received excellent feedback. The CEbE programme was presented at the "International Perspectives on Evaluation of PPI in Research" Conference on 15th November 2018 in Newcastle.
- a workshop delivered in collaboration with Recovery College East and focused on the way we can develop a recovery environment in mental health research by using recovery language.

Examples of research with patient and carer involvement:

- Pathways to care in at risk mental states and first episode psychosis
- Studying resilience after individual stress exposure
- Evaluation of Brief Psychological Interventions
- An investigation of the use of psychological formulation in ward settings to reduce restraint
- CBT to Reduce Insomnia and Improve Sleep in Early Psychosis (CRISP)
- Involvement of Experts by Experience in identifying mental health research topics and priorities: a scoping review
- Genetic determinants of common clozapine-induced side effects
- Dementia Care, Research and Technology funding application
- ENtorhinal CoRtex Structure and Function in PREVENT (ENCRYPT)
- Development and evaluation of Compassion Focused Group Therapy
- A more efficient journey: improving the autism pathway for adults
- Clinical Informatics for Brain and Health Research (CLIMB), MRC Mental Health Data Pathfinder Award

LEAP/PPI Case Study: Randomised Study of Web-based CBT Intervention (Sleepio) to Reduce Insomnia and Improve Social Recovery in Early Psychosis (CRISP)

This research was initially motivated by conversation with Experts by Experience (EbE) on sleep at a service user led teaching session called *Conversations with Experts by Experience* in 2015. The discussion prompted the analyses of sleep and social recovery in psychosis within the National EDEN cohort data that has ultimately led to the current study.

A Lived Experience Advisory Panel (LEAP) was set up in February 2017 to help shape the study during its development. Two members of the LEAP had contributed to the original conversation that prompted this research path. Since then the LEAP research partners have provided key input on the study design, recruitment strategies, surveys on sleep and its treatment, the Patient Information Sheets (PIS) and consent forms.

Five members of the LEAP participated in a practice run of the study and gave meaningful and real-world feedback on each component of the study process, ensuring practical challenges in the design, assessment methods and survey wording were addressed, reinforce the acceptability and feasibility of the study, and increase the likelihood that the full study process ran smoothly.

Ideas were exchanged through email, telephone conversations, texts and in person. Input was considered and ideas implemented before taking the protocol further. This allowed us to achieve our aim of ensuring that the experiment design and goals were established and developed in a way that is participant focused.

Members of the LEAP have expressed enthusiasm at their thoughts and opinions being translated into action and research.

The majority of the original LEAP members have maintained involvement in the study development over the last two years and have been an integral part of the progress to date. Members will be encouraged to maintain involvement throughout the research and dissemination of findings.

2.2.4 Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of CPFT's income in 2018-19 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 2019-20 and for the following 12-month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

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 2018-19.

In 2017-18 we received £2,999,418, out of a possible £3,479,946, 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 2018-19

In April 2018 we agreed 12 CQUIN (Commissioning for Quality and Innovation) targets with our commissioners. Our performance on our quality goals is outlined below.

CQUIN 2018/19 Indicators & Goals	Performance
Goal 1. Improving Staff Health and Wellbeing (National) **1a: Improvement of health and wellbeing of NHS staff** Requirement to **achieve at least a 3% improvement** in two of the three NHS annual staff survey questions on health and wellbeing: • Question 9a: Does your organisation take positive action on health and well-being? • Question 9b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? • Question 9c: During the last 12 months have you felt unwell as a result of work-related stress? **1b: Healthy food for NHS staff, visitors and patients** 100% of outlets on provider's premises to be compliant against seven criteria that ensure that High in Fat Salt or Sugar (HFSS) and Sugar Sweetened Beverages (SSB) are limited in supply. **1c- Improving the uptake of flu vaccinations for frontline clinical staff** Achieving a 75% uptake of flu vaccinations by frontline clinical staff.	✘ Not achieved ✓ We expect full achievement ✓ **77%** achieved
Goal 4: Improving services for people with mental health needs who present to A&E To reduce the number of A&E attendances from a selected cohort of frequent attenders by 20% from both Peterborough City Hospital and Hinchingbrooke Hospital.	✓ **100% in Q2** 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 partially met in Q2** 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, Q2 and Q3.** ✓ We expect full achievement.
Goal 10: Improving the assessment of wounds The indicator aims to ensure that 60% of patients with a chronic wound receive a full assessment.	✓ **100% in Q2** We expect full achievement
Goal 11: Personalised Care and Support Planning This CQUIN has an aim of embedding personalised care and support planning for people with long-term conditions.	✓ **100% in Q1** We expect full achievement
NHSE Safer staffing To improve safer staffing levels on our NHSE commissioned inpatient wards.	✓ **100% in Q1, Q2 & Q3** We expect full achievement

The following CQUIN goals were removed in 2018-19:

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:
Part 2 – Collaborating with primary care clinicians
Rationale: This was removed from the contract as investment was made by our commissioners into primary care to support physical health checks.

Goal 8b: Supporting Proactive and Safe Discharge – Community Providers
Rationale: This was suspended nationally and was written into the contract.

B. Our CQUIN Goals for 2019-20

As part of our contractual agreement with Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England (NHSE) for 2019-20, 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.

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.

A. CQC Inspection

The Trust was last rated by the CQC in June 2018, following the inspection in March/April 2018, and received a rating of 'Good'. Please see page 4 for copies of our ratings table.

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 2018-19.

CPFT has not participated in special reviews or investigations by the Care Quality Commission during 2018-19:

We are very proud to say that the CQC highlighted numerous areas of outstanding practice in CPFT.

Outstanding practice

Trust wide

- ✓ Participation in a wide range of audits, research and accreditation schemes and shared learning.
- ✓ Positive partnership working cited by the police with CPFT around the recent changes to Section 136 of the Mental Health Act.

Acute wards for adults or working age and psychiatric intensive care units

- ✓ Clinical Nurse Specialist (CNS) supported to develop weekly sexual health clinics for patients, which was presented at a conference at the Royal College of Psychiatry.
- ✓ Debating workshop developed by staff for patients to encourage creative thinking on topical issues and identify improvements on the quality of the service.

Children and adolescent mental health wards

- ✓ Innovative approaches in supporting young people with de-escalation.
- ✓ High regard for staff development, reflective practice and clinical supervision.

Community health inpatient services

- ✓ Numerous examples of staff going the extra mile to support patient's dignity and wellbeing, including:
    - sourcing regular donations of clothing for patient who did not have relatives to bring them in for them
    - regular activities to support wellbeing and rehabilitation, and
    - arranging a bedbound patient to go to the dayroom to watch the football world cup on a big screen television.

Specialist mental health service for eating disorders

- ✓ Engaging young people in music activities with members of the Royal Philharmonic Orchestra in a series of workshops to promote social, physical and emotional rehabilitation.

Community health services for children young people and families

- ✓ A 'Safeguarding satchel' developed for staff containing comprehensive online tools.
- ✓ Innovative Video Interaction Guidance (VIG) used by health visitors to improve mother and baby interactions.
- ✓ Provision of integrated neuro-disability clinics for children with cerebral palsy spasticity.

Key areas for improvement highlighted were around:

- Ligature review process in our mental health wards
- An isolated infection control issue in one adults ward
- Environmental issues in our seclusion room and seclusion records
- Privacy and dignity, Duty of Candour, governance and safeguarding processes in our older people's mental health wards
- Environmental risks, lone working, care planning and record keeping in our community learning disability service
- Assessment of risks for young people on the waiting list, capacity assessments and staffing in our child and adolescent mental health (CAMH) community services
- Environmental risks and access to suitable searching equipment in our children's eating disorder unit

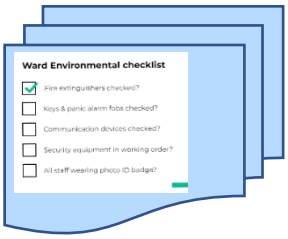
…**and from our Well Led review**

- Improved transparency and objectivity in recruitment
- Equal opportunities and reducing bullying and harassment of black and minority ethnic (BME) staff
- More robust approach to making reasonable adjustments for disabled people
- Improved inclusivity of language used in our policies and procedures
- Strengthen Equality and Diversity processes within the clinical services

We welcome this feedback and the opportunity to further improve our practice and the quality of our services.

These are some of the improvements we have made during the year:

- ✓ Ligature review policy and procedures revised and strengthened. An independent qualitative review commissioned to evaluate the impact of the changes made.
- ✓ Process chart updated in the contract specification to clarify responsibilities for cleaning and re-hanging of Trust-owned curtains, and disposable curtains provided to all wards.
- ✓ Face to face training on Duty of Candour delivered to wards by our Family Liaison and Investigation Facilitator.
- ✓ A Lessons Learned bulletin was written up on the safeguarding case highlighted by the CQC. Supervision sessions were provided by Safeguarding Leads to all wards. Safeguarding Adults policy updated and an audit of practice undertaken in March 2019.



✓ Using the principles of QI, the *Ward Environmental Checklist* (risk module) was revised and tested with the full involvement of all ward managers, pulling together key elements from all environmental checklists in the Trust. This was developed into an electronic format and performance reported in **Mi Report** to provide transparency.

- ✓ **Within the ASMH service:** The CCTV screen was repositioned in the seclusion room, and business case approved to install remote operated bathroom door; a seclusion audit of care records was completed, and findings used to make improvements.
- ✓ **Within our adults community learning disability service:** Interim measures were put in place to address risks identified in the patient's waiting area and a long-term plan to re-locate the service agreed; practice around lone working strengthened; and Standard Operating Procedures (SOP) developed to strengthen record keeping practices, monitored monthly through the QuIET (Quality Improvement Evaluation Tool) care planning module – an electronic review tool and reported via Mi Report.
- ✓ **Within the OPAC service:** A Dignity Lead was appointed, and ward dignity champions identified; Dementia Care Mapping in metal health wards to identify further areas for improvement in practice; 15 Steps Challenge and Schwartz Rounds introduced to all wards, and Schwartz Rounds training now opened up to all directorates; and resources developed including a Dignity video.
- ✓ **Within our CAMH community service:** All patients on the waiting list were reviewed, SOPs developed, and a new risk assessment process embedded within the service; the Trust Clinical Risk Assessment Policy was updated to reflect the new CAMH process; the Consent Policy was reviewed and an E-learning package and leaflets developed; and vacancies were reviewed and live demand and capacity trajectory agreed.

B. Mental Health Act Inspections

During the year, the CQC conducted **13** unannounced Mental Health Act visits to inpatient wards within CPFT (10 in 2017-18). No issues were reported in one of the visits.

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

The wards were found to be safe, spacious, clean and bright and provided a generous space for patients to walk around.

The majority of patients confirmed that the wards were a nice place to stay and felt they were very well looked after.

Good interaction between staff and patients was observed and patients had regular 1:1s with their doctor and primary nurse.

Other 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 a system in place to remind clinicians of detentions and initial treatment expiry dates.
- There was information on display on the local Advocacy Service and the Independent Mental Health Advocate visit the wards weekly.
- A range of information and posters for patients and carers were displayed and were available in different languages.
- 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 capacity to consent to admission, care and treatment, as well as the progress of DoLS applications.
- There is evidence of a robust process to coordinate and refer patients to the MHA Tribunal and 'Managers' Hearings.
- Patients had access to a range of therapeutic activities on the wards.
- No concerns were raised with reference to mixed sex accommodation.

Key actions for improvement

1. **'Consent to treatment' process at the point of admission:**
   Records of specific patients' capacity assessments were not found in four of the visits. Weekly audits have been introduced to ensure compliance in this requirement.

2. **Patient involvement in the development of their care plans:**
   This was raised in four of the wards inspected. The wards introduced a simplified and shorter version of the care plan which are more meaningful to patients and encourages their involvement; and established internal monitoring processes. A Trust wide review of care planning processes is currently in progress to ensure consistency in standards of practice.

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.**
   A weekly monitoring process has been established and a Trust-wide audit will be carried out in 2019-20 to focus on all Section 17 leave statutory requirements.

4. **Seclusion Room:** Concerns about the window blind and the en-suite toilet were raised. Short-term solutions have been put in place to address the immediate concerns around the privacy and dignity of patients and the safety of staff. The Trust is currently exploring long term solutions to these issues, including installing a remote operated bathroom door.

2.2.6 Data Quality and Information Governance (IG)

CPFT submitted records during 2018-19 to the Secondary Uses Service for inclusion in the Hospital Episodes 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 99.3% for admitted patient care**
- **which included the patient's valid General Practitioner Registration Code was 97.5% for admitted patient care**

It is worth noting that the Data Security and Protection Toolkit replaced the Information Governance Toolkit from April 2018. Previous Information Governance Assessment scores were 85% in 2017-18 and 82% in 2016-17 and 2015-16.

CPFT's Security and Protection assessment for 2018-19 was published as 'Standards Met'.

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:

- work with staff and services to develop clinical and non-clinical data relating to outcome, activity and other performance measures; and
- provide access to these data 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: Being open and honest with our patients, their families and carers

This means that when any patient is harmed by the provision of any of our services (deemed as **moderate harm, severe harm or death**), CPFT will investigate the incident and inform the patient or their next of kin and any other relevant person verbally and in writing, offering an apology, as soon as possible. This must be completed within 10 working days.

We have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred.

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' in relation to care and treatment.

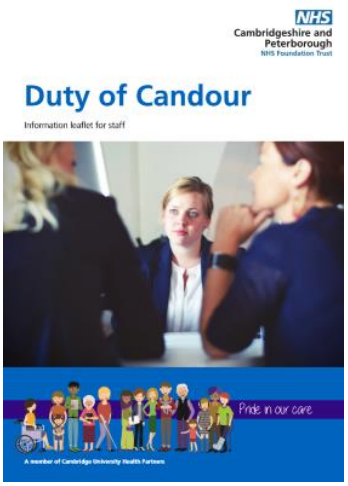
It sets out some specific requirements that providers **must** follow when things go wrong with care and treatment:

- 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.

Saying sorry is an important part of the Duty of Candour process.

How do we support our patients, carers and staff?

We developed leaflets for patients, carers and staff.



In 2017, we appointed a **Family Liaison and Investigation Facilitator** to embed Duty of Candour in the Trust and support patients, families and carers during a Serious Incident (SI) Investigation.

How have we improved?

- ✓ Networking with Family Liaison Officers from other NHS Trusts to support and further develop the role, as well as share best practice and learning.
- ✓ Duty of Candour (DoC) drop in sessions established to help staff gain a greater understanding of the DoC process and responsibilities under the regulation.

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 include:

- Continued reductions in the use of prone restraint in our wards
- Continued and significant reduction in avoidable Grade 3 or 4 pressure ulcers, with only 4 reported in the year from 10 in 2017-18 and 13 in 2016-17.
- 96%* of patient to patient physical assaults lead to *no/low harm*
- 96%* of patient to staff physical assaults lead to *no/low harm*
- 94%* of falls (all types) lead to *no/low harm*
- 92%* of self-harm incidents lead to *low harm*

* *Average over 2018-19* (12-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 **2.1.2**).

What we are doing:

- Continued production of quarterly *Learning in Practice Bulletins* setting out learning from Serious Incidents (SIs), Complaints, Mortality Review, Duty of Candour, Patient Experience and Freedom to Speak Up.
- *Stop the Line* process remains 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* Lead and process in place for staff to raise concerns about wrong doing or malpractice at work among others.
- Comprehensive programme of *clinical audit*, *service evaluations*, *service* dev*elopment* and *quality improvement* projects in place.
- Acting on feedback from *patient, carer and staff surveys*, complaints and PALS (see **3.3** for more details).

Moreover,

- The Serious Incidents Group (SIG) and Mortality Review Group (MRG), established in 2017, have continued to evolve and strengthen its role in supporting the identification and dissemination of learning within and external to the Trust.
- We have continued to develop electronic clinical and non-clinical dashboards, accessible by all staff via Mi Reports, providing an extensive range of activity and performance data to monitor the quality and safety of our services.
- The action plan module on Datix, our electronic incident reporting system, is now being used in the Trust. This allows staff to upload evidence of completed actions directly to Datix, thus helping to monitor outstanding actions from SIs and providing increased transparency and accountability.
- The revised governance process, introduced in late 2017-18, have considerably strengthened reporting and scrutiny of performance information within the clinical directorates and across the Trust enabling more meaningful and timely decision-making and action to improve services.

The care planning module of our new electronic Quality Improvement Evaluation Tool (QuIET), launched in July 2018, provides our clinical teams with a simple and easy way to review and monitor standards of practice and the quality of our care records including risk assessments.

We developed a Learning Framework, formally approved by the Board in March 2019, to help us strengthen how we identify, share and embed learning in the Trust, both from internal and external sources.

In 2019-20, SIG will focus on strengthening the investigation and action planning elements of the Serious Incident (SI) process.

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.

What we are doing:

- Embedding *Duty of Candour* and *Being Open* in our incident reporting process.
- Sharing findings from Serious Incidents (SIs) with patients and their families, with consent
- Posting dashboards presenting performance on key safety indicators on our wards
- Supporting patients to raise and resolve concerns through our Patient Advice and Liaison Service (PALS)
- Supporting and empowering patients to access Advocacy services

Patients, families and carers are now invited, with consent, to pose questions as part of the Serious Incident (SI) investigation process, thus giving them more opportunities to become involved and inform the investigation process.

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.

Our collaborative work within the health and social care system include:

- Continued involvement in the local Joint Cambridgeshire and Peterborough Suicide Prevention Strategy and action plan.
- Continued engagement in the Safeguarding Adult Review Panel, a subgroup of the Safeguarding Adults Board, which seeks to identify learning across agencies; and the Domestic Homicide Review Panels, facilitated by Community Safety Partnerships involving representatives from health, social care, police, probation, fire and housing agencies. We also made a significant contribution to the revision of the Safeguarding Adults Board policy and procedures in the year
- Continued involvement in Multi Agency Safeguarding Hub (MASH) – 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; and attending Multi Agency Risk Assessment Conferences to share learning.
- Continued membership in child safeguarding practice review panel and child death overview panel, and undertaking interagency safeguarding partnership audits
- Peri-natal partnerships with schools, police, maternity services, school nursing and the 3rd sector.
- Involvement in various multi-agency groups to share learning, such as
  - Crisis Pathway Steering Group with ambulance, police and MIND
  - Eating Disorder Steering Group with patients, carers and the voluntary sector
  - Domestic Abuse and Sexual Violence Partnership operational group

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:

- The Serious Incidents Group (SIG) provides an open and supportive forum to understand why things went wrong and support the development of actions. This has made a positive impact on our investigation and improvement framework.
- The Positive and Proactive Care (PPC) Group continues to monitor activity, identify learning and support embedding of best practice in restrictive interventions, and lead on the delivery of training on the use of restrictive interventions.
- Comprehensive programme of *clinical audit*, *service evaluations*, *service* deve*lopment* and *quality improvement* projects in place to examine and practice, care delivery and outcomes of care.

We are seeing a definite change in attitudes and behaviour in our journey towards embedding an improvement culture in the Trust.

- ✓ ***There is more curiosity and a willingness to examine data and understand the reasons behind sub-optimal practice and care delivery to ensure the right actions are developed and implemented.***
- ✓ ***Staff are taking more ownership of their improvement journey, reflected in the increasing number of projects initiated at service-level to review and improve care delivery and outcomes of care.***
- ✓ ***We have trained 20 staff from different roles and backgrounds in quality improvement methodology through the NHSI Quality, Service improvement and Redesign (QSIR) programme, with 6 more undergoing the training.***
- ✓ ***We are embracing the principles of co-production, developing our expertise and engaging our patients, staff, carers, Governors and other key stakeholders in our service development and improvement work.***

On 4 April 2019, we held a 'Learning Together to Improve Care' event providing a forum for staff, Governors and representatives from external organisations to come together to share examples of improvement stories from across the Trust in order to shape and inform our next steps in our improvement journey.

2.2.9 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 2018-19, 5800* patients of CPFT services died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
1505 in the first quarter;
1408 in the second quarter;
1480 in the third quarter;
1407 in the fourth quarter.

* *The total number of reported deaths during the year was 7692. This number includes any person who has had historical contact with any CPFT service. 5800 is the number of patients who had been referred to, or seen by, a CPFT service in the previous 12 month period* (all figures correct as of 7th April 2019).

2. By 31 March 2019, 200 case record reviews and 51 serious incident investigations have been carried out in relation to the deaths included in item 1 above. In 3 cases 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:
61 (SJR) + 10 (SI) in the first quarter;
55 (SJR) + 15 (SI) in the second quarter;
52 (SJR) + 18 (SI) in the third quarter;
32 (SJR) + 8 (SI) 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. *For 2018-19, CPFT set a target to review a random sample of 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 (SI) investigation and Clinical Review (CR) 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 national Learning Disabilities Mortality Review (LeDeR) Programme.*

3. 3 deaths, representing 0.05% 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:
1 representing 0.07% for the first quarter;
1 representing 0.07% for the second quarter;
0 representing 0% for the third quarter;
1 representing 0.07% in 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	• *Improvements needed in communication across all systems and services around acute suicidal risk management and referral criteria.* • *Clear communication required between CPFT assessing teams and other agencies involved in the patient's care to ensure all relevant information is shared between teams and services.* • *Out of Hours (OoH) services to have access to patients' electronic notes via agile devices so they can carry out a full risk assessment before each patient intervention.* • *For repeated presentations, additional consideration to be given to accessing historical information.*
Engagement of family and carers	• *All services should integrate carer/family concerns into the formulation of risk.* • *CRHTT to establish a robust plan to proactively engage with distressed family members; including a plan for continued engagement in the event patients withdraw consent to share information.* • *Teams to record carers' views clearly within the progress notes/carers record alongside the explanation of rationale surrounding decision making, where appropriate consent to share information is given.*
Service users who disengage	• *Consider introducing a telephone follow-up to check reasons for non-attendance.* • *Review of the criteria used to reach a decision to discharge service users who disengage and explore how this is communicated to the service user, GP and family/carers.*
Clinical documentation	• *All letters to be standardised to include crisis contact information.* • *Teams to be reminded to record next of kin in records.* • *Teams to understand the importance of documenting discussions around consent and mental capacity when consent to share information is withdrawn suddenly by a patient.* • *Staff to ensure that advice given to patients on how to maintain their own safety is documented clearly to ensure that evidence of safeguarding is present, to include whether the patient is concordant with the advice.*
Clinical processes and procedures	• *Review of the process of documentation for recording clinical decisions.* • *Past clinical documentation should always be reviewed.* • *Clearer communication required between CPFT services in respect to arrangements for joint assessments.* • *To continue with robust review of both physical and mental health medication in ward rounds.* • *To ensure that observation level requirements incorporate assessment of both physical and mental health need.*

Common themes from Structured Judgement Reviews

Communication	• *Poor communication at point of discharge from ward team to care agency (found to be an issue in 2 reviews – 1 in OPAC and 1 in ASMH).* • *Lack of evidence on any correspondence being sent to the patient's new General Practitioner (GP).*
Documentation	• *Patient's care needs not accurately recorded in discharge documentation. All patient contacts and discussions about care to be clearly documented in clinical notes.* • *Poor and ambiguous documentation of recent clinical contact.* • *Limited documentation to indicate that a detailed scrutiny of past risk behaviours completed.* • *Improvements required in terms of accuracy and timeliness in written communication via discharge summaries.*
Patients who disengage	• *Lack of evidence of a robust attempt to make contact or understand why the patient had not attended.* • *GP not contacted to discuss patient's non-attendance and to plan action.*
Clinical practice	• *Documentation of end of life care discussion should be shared across all involved services.* • *Family members did not feel staff obtained their views when considering patient leave arrangements.* • *Notable omissions regarding section 117 review processes.*
Concerns relating to other organisations	• *GP did not carry out a risk screen prior to the referral. This may have indicated a higher level of risk and triggered an earlier response from services.*

Actions we have taken in 2018-19, and propose to take following 2018-19, in consequence of the learning outlined above

Communication	• *A regular interface meeting between the adults community locality team, Crisis Resolution and Home Treatment (CRHT) team and the older people's Neighbourhood team (NT) has been introduced in order to enhance communication and ensure that a joined-up approach to managing identified complex cases can be agreed and implemented.* • *Team meetings now have a dedicated slot for Multi-disciplinary team (MDT) discussions to ensure concerns are escalated and shared.*
Engagement of family and carers	• *A prompt sheet has been developed to remind staff to obtain family/carer details at point of assessment, including consent to share information, and to check/update these at each clinical review and/or transfer of care.*
Service users who disengage	• *The Clozapine Steering Group has updated the protocol for patients who disengage to specifically identify actions to take.* • *A space in clinical meetings have been introduced 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 documentation	• *First Response Service (FRS) staff to ensure that all referrals are forwarded onto the relevant service and that this is logged in the patient's clinical records.*

Clinical processes and procedures	• *Joint guidelines that allow services to manage complex cases in a coordinated manner with clearly defined roles and responsibilities have been developed.* • *The on-call medical rota has been reviewed to ensure that Section 12 approved doctors are available to support the Approved Mental Health Professional (AMPH) and Emergency Duty Team (EDT) services.* • *Update to training module in use of National Early Warning Scores (NEWS)* • *Development of a joint protocol for discharge and transfer from community and ward teams, specifying where there are gaps in service provision at point of discharge and clearly outlining who is responsible for each aspect of aftercare.* • *The introduction of monthly workshops within the CRHT team to discuss complex cases and issues, including capacity assessments and care commissioning.* • *A checklist/flowchart has been introduced to support staff to accurately document capacity assessments and best interest decisions.* • *Psychiatric Intensive Care Unit (PICU) operational policy reviewed to ensure that it reflects best practice and relevant guidance.* • *A new FRS triage form has been created and introduced into practice.* • *FRS have developed a protocol to ensure that they monitor and update patients they have assessed on the progress of a referral to another clinical team and they remain a point of contact until the referral has been actioned.*

Examples of good quality care noted from the reviews

Synopsis of patient's presentation
The patient was admitted to the acute hospital after collapsing whilst intoxicated and was referred to the substance misuse Liaison Psychiatry service for advice on management of alcohol withdrawals.

Good practice
The patient was seen once by the substance misuse Liaison Psychiatry consultant psychiatrist. The review found that the response was prompt and appropriate to his presenting needs at the time. The patient and his adult son were given advice on ways to reduce alcohol use and information on support in the community. As the patient was a resident out of area, it is not clear whether he received further support from health services in his area following his contact with CPFT services.

Synopsis of patient's presentation
The patient was admitted to the acute hospital with a number of physical health conditions and was referred to the Child and Adolescent Mental Health service (CAMHS) by the paediatric psychology acute hospital service in July 2017 for assessment of mood.

Good practice
The review found that the patient received excellent care from CAMH doctor who liaised regularly with all services involved in his care and explored treatment and management options throughout. The patient was appropriately discharged from mental health services with a clear plan communicated to acute care colleagues to refer back to adult services if required. The patient was out of area and sadly passed away 5 months after he was last seen by CPFT.

Synopsis of patient's presentation
The patient had several chronic and enduring physical health difficulties (primary problem: ischaemic heart disease) and was seen by a number of CPFT services. His main contact was with the Respiratory and Cardiac Services. In May 2017, he was referred to the Continence Service and to the District Nursing service for wound management.

Good practice
The review found that the patient received good, holistic care from a range of CPFT services over several years, which was responsive, compassionate and empathetic.
Throughout the contact there was a good standard of documentation in the care records and clear rationale for decision-making in terms of identifying appropriate sources of support. Staff also provided good support and clear communication to the patient's family throughout all periods of contact.

Synopsis of patient's presentation
The patient was diagnosed with a malignant tumour of the cardia in April 2018 following a 10-week period of nausea, vomiting and abdominal pain. The patient was referred to the District Nursing service for end of life care in June 2018 and for medication monitoring in July 2018.

Good practice
The review found that the patient received good end of life care from all services, including the District Nursing service, and was able to attain a good death. The time from diagnosis to death was brief and the patient and her family were given a good level of pastoral care and support.

Synopsis of patient's presentation
The patient was admitted to the acute hospital with shortness of breath and likely chest infection and was referred to the CPFT liaison psychiatry for assessment as the GP felt her presentation may be related in some part to anxiety. The patient had previous history of delirium.

Good practice
The review found that the patient received good, responsive care provided by CPFT services. The referrer's concerns were responded to and advice given on ongoing management. There was appropriate discharge from the liaison service as the patient was transferred out of area. Assessment details were shared with the GP and local services. There was good standard of communication and care throughout.

How do we embed learning?

- ✓ Concerns raised and examples of good practice are fed back directly to the relevant clinical teams through their clinical managers.
- ✓ Findings of all concluded investigations are disseminated through the monthly Quality and Safety Report presented to the directorate Quality and Safety Groups, which are in turn, cascaded to frontline clinical staff.
- ✓ An action plan is produced for each Serous Incident and evidence for each action is provided to the Patient Safety Team by all relevant clinical teams.
- ✓ Key learning is featured in the bi-annual *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 assessment of the impact of the actions described above.
An evaluation of the success of this work is underway, led by the Mortality Review Group. We will report on these in future reports. This will be reported to the Board of Directors through the Mortality Review annual report.

2.2.10 Freedom to Speak Up

Within CPFT, we have different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment.

We believe that safety is everyone's responsibility.

provides staff with a safe environment to

- raise an objection and literally stop something that is happening in order to prevent a mistake being made, or
- 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.

The process involves sending an email to the Stop the Line inbox detailing the concern and contacting the line manager and General Manager who will raise the issue with an Executive Director. A 'swarming' meeting is held within one week to discuss the issue and plan the next steps. These are also discussed at the weekly Director's meetings.

Within one month of a Stop the Line being raised, lessons learned and changes made are communicated to all staff via the Trust intranet.

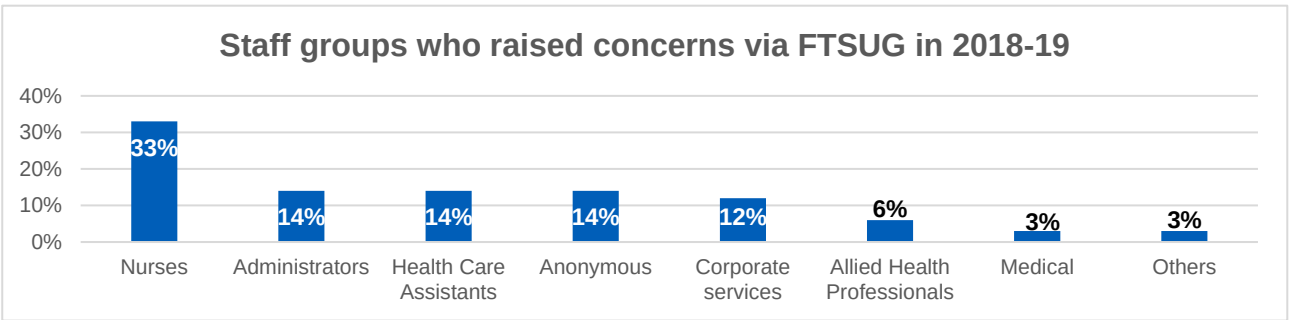
Freedom to Speak Up

All NHS provider Trusts are required, as part of the NHS contract, to have a Freedom to Speak Up Guardian (FTSUG) in place by April 2017. The creation of the FTSUG role was one of the recommendations of the Sir Robert Francis' Freedom to Speak Up review (2015) following the Mid Staffordshire Public Enquiry.

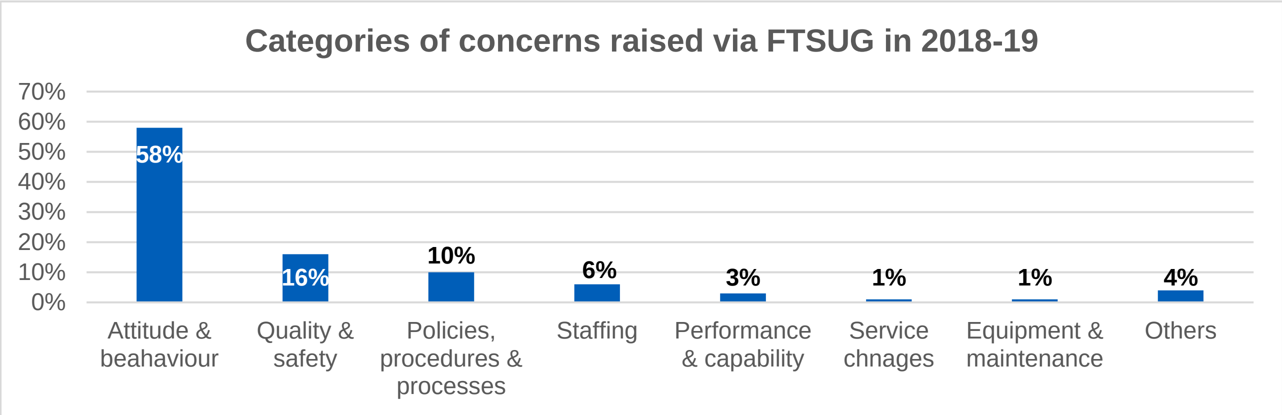
The FTSUG's role is to work with Trust leaders and staff to create effective local processes to enable staff to raise concerns and advice staff who seek to do so.

FTSUG contributes to the development of an open organisational culture by:	***By ensuring that:***
• protecting patient safety and quality of care, • improving the experience of everyone who works in health and care, and • promoting learning and improvement.	• staff are supported in speaking up • barriers to speaking up are addressed • a positive culture of speaking up is fostered, and • issues raised are used opportunities for learning and development.

There were 69 concerns raised via the FTSUG process in 2018-19. Of these, a third were made by nurses.



On average, the Trust quarterly staff barometer surveys indicate that 96% of Trust staff know how to raise concerns in 2018-19.



Two thirds of concerns raised were about attitude and behaviour.

Examples of improvements made in response to concerns made vie FTSUG

- ✓ E-rostering practice reviewed, and improvements implemented in a service team, including further training for staff responsible for e-rostering in the team.
- ✓ Clarity of role requirements following temporary role changes for staff.
- ✓ Review of staff exit interview process, procedures and data and improvements implemented, including a streamlined process that sends a link directly to leavers to complete an exit interview upon receipt of their notification to leave their team or the Trust.
- ✓ Adherence to recruitment practices and processes reinforced.
- ✓ Trust infection control policy in relation to having pets in the work environments consistently applied.
- ✓ Conflict resolution training developed and implemented for Trust staff in dealing with situations of bullying and undermining behaviour.
- ✓ Caseload for a specialist service area reviewed and collaborative plans put in place to maintain support for the team to manage its ongoing caseload.

The 'Be Nice' campaign, developed as a result of the FTSUG process, was launched in September 2018 to raise awareness of bullying and harassment and signpost staff on where to go for support, with real life examples from CPFT staff.

2.2.11 NHS Doctors and Dentists in Training – consolidated annual report on rota gaps and the plan for improvement

During 2018-19, there were 2,183 rota gaps in the Trust, a large proportion of which is due to consultant and Specialty Doctor grade vacancies. Other reasons are short and long-term sickness and absences.

Reason for rota gaps	Consultant	Specialty & Associate Specialist	Training Grade
Long-term sickness	NIl	NIl	74
Short-term sickness	22	NIl	24
Vacancies	1148	508	40
Absence	193	NIl	41
Deanery	0	NIl	133

There were 133 rota gaps for training grade doctors as a result of a national deficiency of doctors in training provided by Health Education England of East of England deanery.

The Trust have endeavored to fill gaps in the supply of junior doctors through advertising Locum Appointment for Service (LAS) posts, covering the shifts through our internal Medical Bank and through Agency doctors.

Vacancies	WTE filled As of March 2019	WTE appointed (yet to commence)	WTE vacancies in recruitment process
Consultant	7.68	4.00	3.00
Locum Consultant	2.00	Nil	Nil
Specialty Doctor	1.00	2.00	2.60

Plans for improvement

- Each of the directorates are supported by the Medical Services team to regularly review and manage the use of agency locum doctors.
- The Medical Services team also continue to appoint medical staff onto our medical bank.
- The Clinical Directors for each directorate continue to consider alternative ways of covering posts and to drive down the use of agency staff.

2.2.12 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.

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 United Kingdom (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 have consistently exceeded 95% over the last two years.

	2017-18				2018-19			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CPFT (submitted data)	**95.6%**	**96.4%**	**95.3%**	**96.1%**	**95.9%**	**95.8%**	**95.2%**	**96.1%**
CPFT (national data)	**95.6%**	**95.3%**	**95.2%**	**96.1%**	**95.60%**	**95.80%**	**95.20%**	**96.10%**
National average	96.7%	96.7%	95.4%	95.5%	95.80%	95.70%	95.50%	95.8%
Highest nationally	100%	100%	100%	100%	100%	100%	100%	100%
Lowest nationally	71.4%	87.5%	69.2%	68.8%	73.40%	83.0%	81.60%	83.5%
CPFT annual average	**96%**				**96%**			
Target	**95%**				**95%**			

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

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

Nationally reported data presents our performance at 100% for the first three quarters of the year which is an improvement from the previous year.

	2017-18				2018-19			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CPFT (submitted data)	**100%**	**99.6%**	**100%**	**99.6%**	**99.5%**	**100%**	**100%**	**99.6%**
CPFT (national data)	**100.0%**	**99.6%**	**100%**	**99.6%**	**100%**	**100%**	**100%**	**99.6%**
National average	98.7%	98.6%	98.5%	98.7%	98.1%	98.4%	97.8%	98.1%
Highest nationally	100%	100%	100%	100%	100%	100%	100%	100%
Lowest nationally	88.9%	94.0%	84.3%	88.7%	85.1%	81.4%	78.8%	88.2%
CPFT annual average	**99.8%**				**99.9%**			
Target	**95%**				**95%**			

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 100% (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.

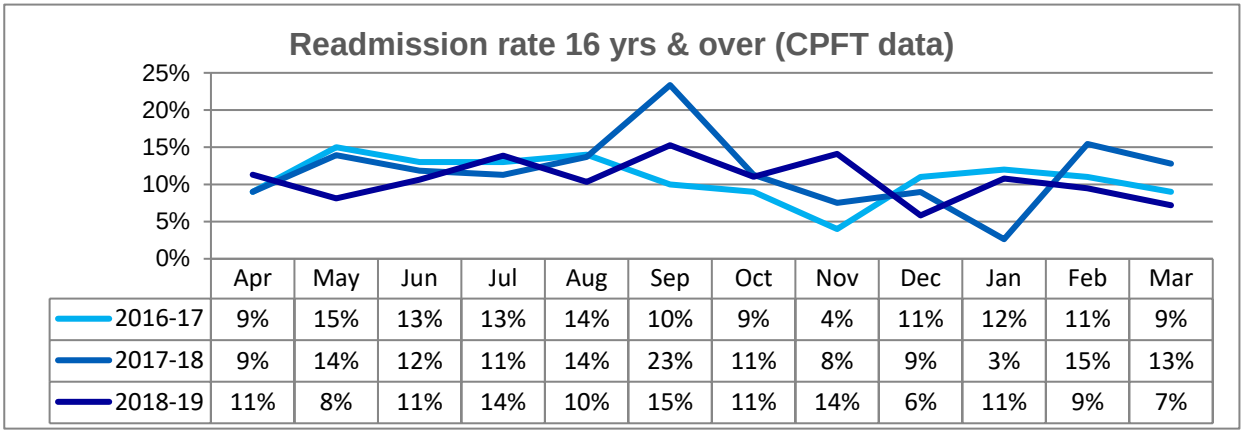
3. *The percentage of patients aged:*
(i) 0 to 15 and
(ii) 16 or over
readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

The national benchmark data has not been updated since December 2013.

The data presented are from CPFT internal reporting system.

There were no readmissions for patients aged 0 to 15 yrs in 2018-19, compared with 1 (out of 10 discharges) in 2017-18 and 1 (out of 15 discharges) in 2016-17.

Annual average readmission rates for patients aged 16 and over have remained static in the last three years, at 11% in 2016-17, 12% in 2017-18 and 11% in 2018-19.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17	9%	15%	13%	13%	14%	10%	9%	4%	11%	12%	11%	9%
2017-18	9%	14%	12%	11%	14%	23%	11%	8%	9%	3%	15%	13%
2018-19	11%	8%	11%	14%	10%	15%	11%	14%	6%	11%	9%	7%

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.*

Data is taken from the National NHS Staff Survey. It is worth noting that the way national staff survey results are presented have changed in 2018. 'Key Findings' have been replaced by 'themes' that cover ten areas of staff experience.

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)
2018	**66%**	**67%***	**70%**	**79%**	**95%**	**57%**	**36%**
2017	**67%**	**66%***	**70%**	**76%**	**93%**	**55%**	**42%**
2016	64%	66%*	69%	75%	95%	55%	45%
2015	62%	66%*	69%	75%	93%	50%	37%

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

Themes	2017 Score	2017 Respondents	2018 Score	2018 Respondents	Statistically Significant Change
Equality, Diversity & Inclusion	9.1	1903	9.0	1919	Not Significant
Health & Wellbeing	6.1	1923	5.9	1938	↓
Immediate Managers	7.0	1907	7.1	152	Not Significant
Morale	0	0	6.1	1913	N/A*
Quality of Appraisals	5.4	1721	5.5	1688	Not Significant
Quality of Care	7.3	1708	7.3	1719	Not Significant
Safe Environment - Bullying and Harassment	8.4	1889	8.1	1902	↓
Safe Environment - Violence	9.5	1882	9.5	1901	Not Significant
Safety Culture	6.8	1915	6.8	1924	Not Significant
Staff Engagement	6.9	1949	6.9	1990	Not Significant

CPFT's response rate was 53% which equates to 2,000 individuals, an increase from 51.8% in 2017, compared with the national average of 45%. Overall CPFT is comparable to similar mental health, learning disability and community organisations.

The survey findings for the Trust show that the majority of the scores for the themed areas in 2018 have remained the same as compared to 2017. This has to be seen in the context of an extremely challenging period for the NHS both locally and nationally.

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

The scores for two areas have disappointingly dropped compared with 2017 - **Health & Wellbeing** from 6.1 to 5.9; and **Safe Environment (Bullying and Harassment)** from 8.4 to 8.1. However, this does match the national trend, and the average theme scores for 2018 are 5.9 and 8.0, respectively.

Top five scores

No.	Question	2017	2018	National average	Trend
22b	I receive regular updates on service user experience feedback in my department.	63%	67%	61%	↑
10b	On average, how many work additional PAID hours in a week?	80%	81%	78%	↑
18b	I would feel secure raising concerns about unsafe clinical practice.	77%	78%	73%	↑
28b	Has your employer made adequate adjustment(s) to enable you to carry out your work?	81%	80%	77%	↓
20	Have you had any non-mandatory training or development in the last 12 months?	75%	77%	72%	↑

Bottom five scores

No.	Question	2017	2018	National average	Trend
21c	I would recommend my organisation as a place to work.	54%	54%	59%	→
11c	During the last 12 months have you felt unwell as a result of work-related stress?	43%	46%	41%	↓
19b	The review or training helped me to improve how I do my job.	21%	19%	21%	↓
19d	The review or training left me feeling that my work is valued by my organisation.	24%	28%	31%	↑
23a	I often think about leaving this organisation.	N/A	32%	30%	N/A

Additional information requested by NHS England for the Workforce Race Equality Standard (WRES)
Reporting requirement added in 2016-17

Key Finding	Race	CPFT 2017	Nat'l Ave	CPFT 2018
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	**19%**	20.8%	**24.7%**
	BME	**22%**	26.2%	**30.5%**
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	**88%**	87.7%	**87.9%**
	BME	**75%**	76.2%	**62.2%**

CPFT considers that this data is as described for the following reason:
These are the figures presented in the National NHS Staff Survey 2018 report.

CPFT intends to take the following actions to improve this 66%, and so the quality of its services.
The results continue to be analysed and the Workforce Executive will oversee the development of an appropriate action plan, in consultation with Staff Side, directorates and staff, and will link to both the Workforce Strategy, the Organisational Development Strategy and other work taking place within the Trust. These will be shared with Staff Governors for feedback and input.

The Trust Staff Survey action plan will focus on the following themes:

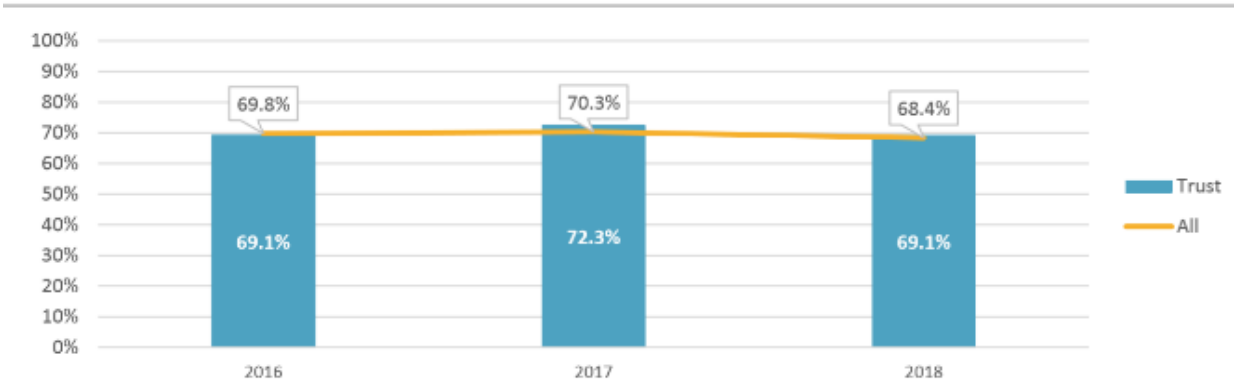
- Health & Wellbeing
- Safe Environment (Bullying & Harassment)
- Engagement
- Morale
- Quality of Appraisals

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 scale score of 1-10 with 0 being "*I had a very poor experience*" and 10 being "*I had a very good experience*".

We scored 69.1% in 2018 compared with 72.3% in 2017, showing a 3% reduction. While these are higher than the national average scores in both years, this places us within the average range.

37. Overall... (Scale score from 0-10. 0 = "I had a very poor experience", 10 = "I had a very good experience").



	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2018		
					Number of Respondents	Score	RAG Rating
37. Overall... (Scale score from 0-10. 0 = "I had a very poor experience", 10 = "I had a very good experience").	56.3%	66.4%	70.4%	75.3%	241	69.1%	

Our internal patient experience survey (Meridian) shows a much higher average score of 97% during the year for 'overall experience of care' (see 3.3.5), while the average score for 'rate the quality of care /service received' was 93%, across all of our community services in 2018-19.

CPFT considers that this data is as described for the following reason:
These are the figures presented in the National Community Mental Health Patient Survey 2018 report.

CPFT intends to take the following actions to improve this 69.1%, and so the quality of its services by focusing on three areas for improvement:

- Care planning
- Support and wellbeing
- Dignity and respect

Both the Older People, Adults and Community (OPAC) and the Adults and Specialist Mental Health (ASMH) directorates have developed actions specific to their services.

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,

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

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)
Apr18-Sep18*	**3094**	**3541**	**9204**	**42**	**70.00%**	**51.50%**	**96.60%**	**24.90%**
Oct17-Mar18*	**4351**	**3258**	**8134**	**22**	**91.17%**	**52.00%**	**96.72**	**14.88%**
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%

* *Data published by NHS Improvement (previously HSCIC up to 2015)*

There was a reduction in the number of Patient Safety Incidents (PSIs) reported in the first six months of 2018-19, and the rate of PSIs per 1,000 bed days also went down to 70% compared to 91% in the previous six months. This is largely due to reductions in our Adults and Specialist Mental Health (ASMH) services.

Trust reported data shows continued reduction in our PSIs for the remaining six months of the year. This is a positive movement and we will continue to monitor our incidents data to maintain improvements seen in the year.

b. Number and percentage of PSIs that resulted in severe harm or death

Patient Safety Incidents (PSIs) that resulted in severe harm or death per 1000 bed days

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)
Apr18-Sep18*	6	3	9	0.30%	**37**	**1.02%**	**239**	**3.70%**	**2**	**0%**
Oct17-Mar18*	7	1	8	0.20%	**37**	**1.16%**	**259**	**4.40%**	**2**	**0%**
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%

* *Data published by NHS Improvement (previously HSCIC up to 2015)*

These show that CPFT figures are consistently below the national average which is a significant achievement for the Trust.

CPFT considers that the data presented in this section is as described for the following reasons:

- The data is taken from NHS Improvement and is verified.

CPFT has taken the following actions to improve this 0.30% (rate of patient safety incidents that resulted in severe harm or death in April – September 2018), and so the quality of its services, by continuing to:

- strengthen the role and function of the Serious Incident Group (SIG) to provide guidance and support to Serious Incident (SI) investigations and development of improvement actions, as well as in identifying and dissemination of learning from SIs.
- work closely with clinical directorates in the development of meaningful actions and ensuring these are embedded in practice and care delivery
- strengthen our work around our Zero Suicide Strategy

We will implement our Learning Framework in 2019-20 to further strengthen our process for identifying, sharing and embedding learning within and external to the Trust, including our partners.

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.

From 2016-17, NHS Improvement (NHSI) has mandated additional performance indicators for NHS Foundation Trusts. The indicators that are applicable to CPFT are listed below.

Quality Indicators	Year added
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
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
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
4. Care programme approach (CPA) patients, comprising: a. having formal review within 12 months	16-17
5. Admissions to adult facilities of patients under 16 years old	17-18
6. Inappropriate out-of-area placements for adult mental health services	17-18

3.1 Patient Safety

3.1.1 Suicide Prevention

Suicide is an avoidable death, and suicide prevention is a complex and challenging task which requires a co-ordinated approach

We believe that good care and effective partnership working 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.

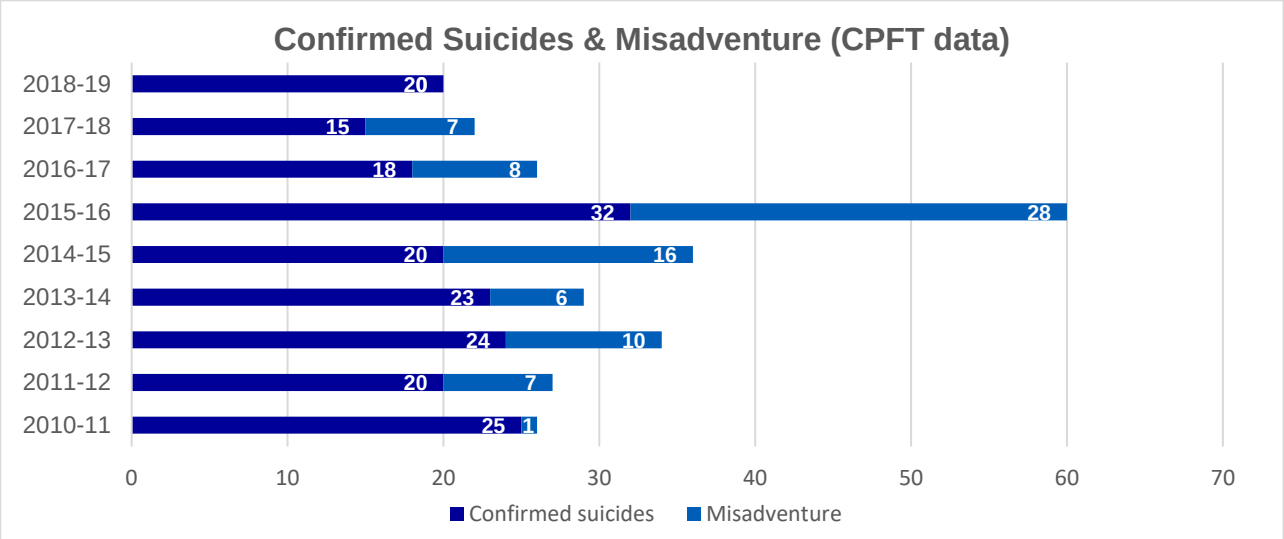
We developed a **Zero Suicide Strategy**, ratified by the Board in November 2017, with seven key work streams. Key actions and progress in 2018-19 include:

- Audit of case notes and NICE guidelines relevant to the Zero Suicide programme
- Qualitative research project currently being designed
- Review of Consent and Carer Awareness training
- Review of Clinical Risk Assessment Policy
- Collaborative work with Loughborough University to develop training materials for suicide prevention
- Continued development of the role of the Serious Incident Group and Mortality Review Group

7 work streams of the Suicide Prevention Strategy

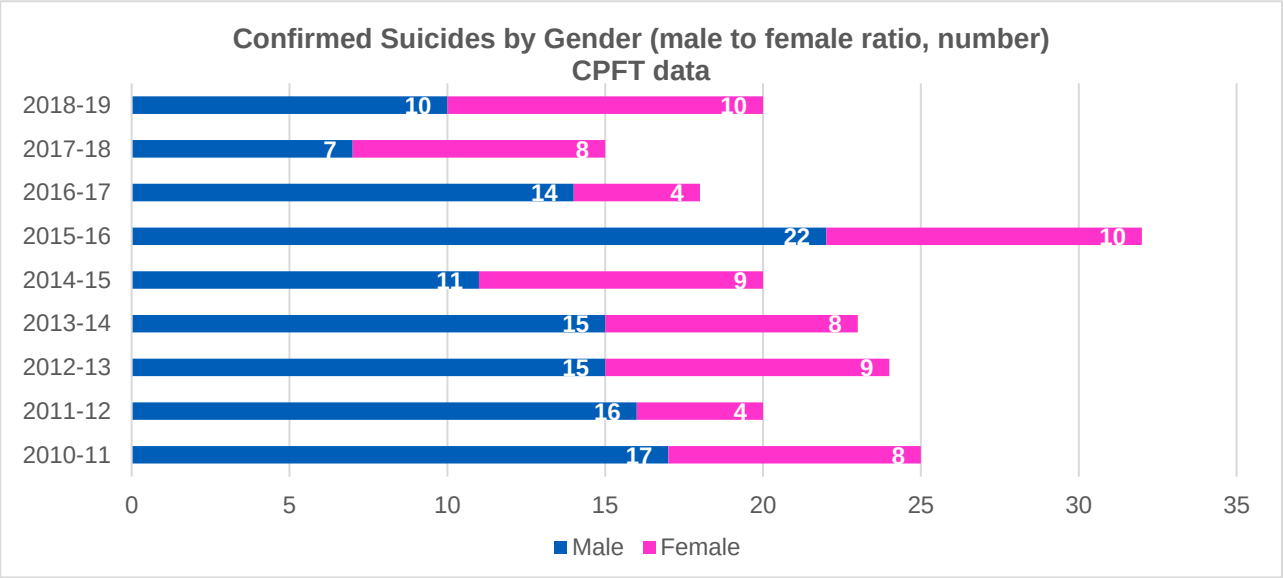
1. Working with carers and families
2. Review of risk tools and approach
3. Substance misuse
4. Children and young people
5. Reducing means and learning from incidents
6. Post suicide support
7. Research and data

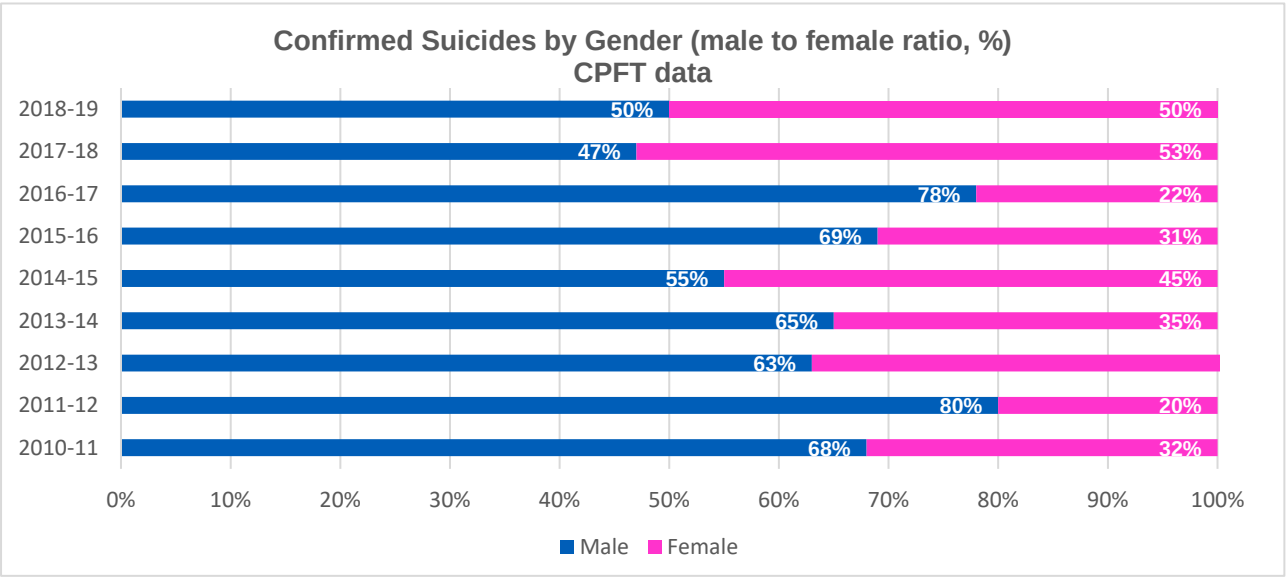
Confirmed suicides are those where we have received the coroner's verdict about the circumstances relating to the incident. Some deaths, initially recorded as 'probable' suicide, may not be confirmed as such following the coroner's investigation. A death by **misadventure**, is one that is primarily attributed to an accident that occurred due to a dangerous risk that was taken voluntarily.



There are no obvious reasons for the spike in the number of suicide and misadventure incidents in 2015-16.

The total number of confirmed suicides and misadventure have been reducing since 2015-16.





Whilst there was an equal split between male and female suicides in CPFT in the last two years (fiscal year), annualised data below shows a reducing trend from 2015, a 42% reduction in the number of suicides overall in 2018, and a significant reduction in the number of female suicides, bringing it in line with national trends.

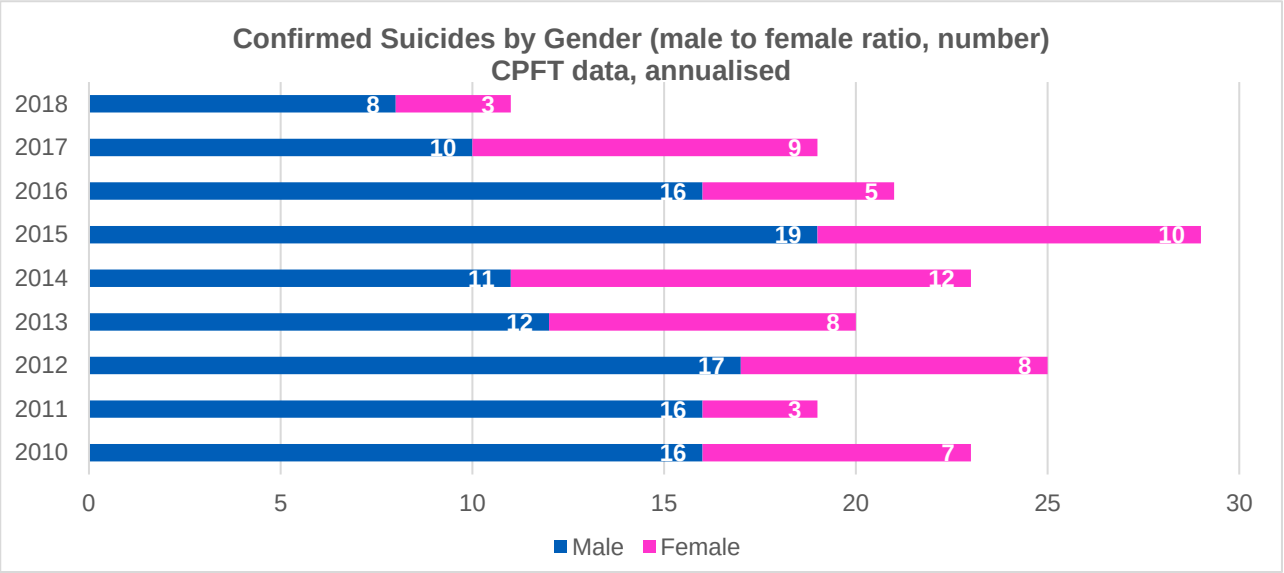
CPFT data (annualised)

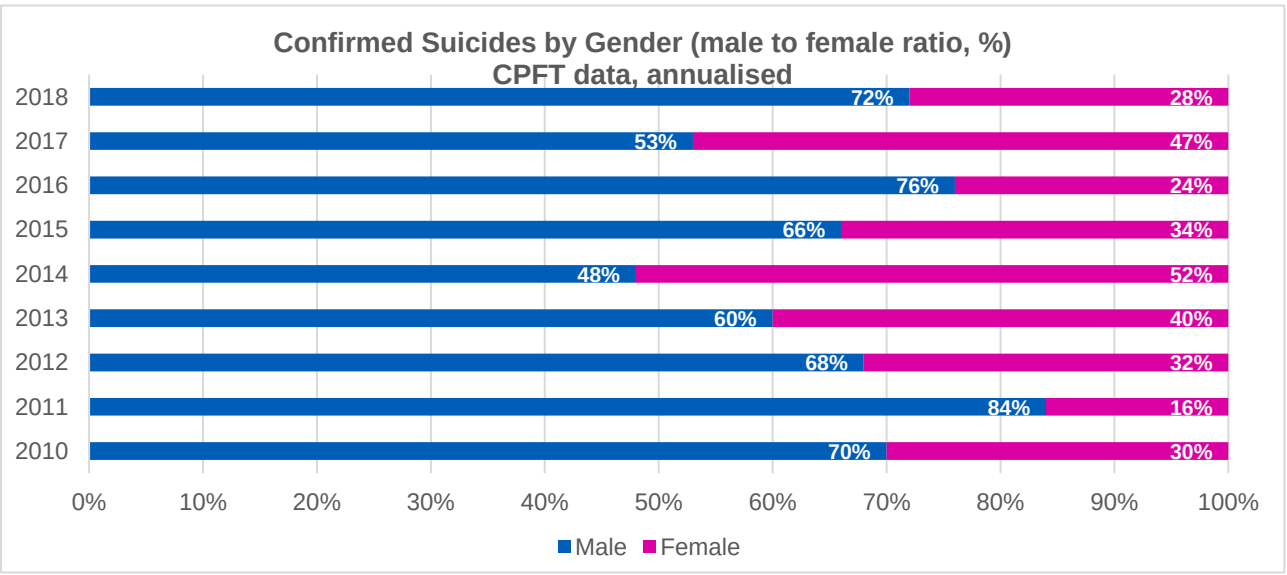
Gender	2010	2011	2012	2013	2014	2015	2016	2017	2018
Male	16 (70%)	16 (84%)	17 (68%)	12 (60%)	11 (48%)	19 (66%)	16 (77%)	10 (53%)	8 (72%)
Female	7 (30%)	3 (16%)	8 (32%)	8 (40%)	12 (52%)	10 (34%)	5 (24%)	9 (47%)	3 (28%)
Total	**23**	**19**	**25**	**20**	**23**	**29**	**21**	**19**	**11**

National Confidential Inquiry into Suicide and Homicide annual report 2018

Gender	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
Male	3202 **76%**	3233 **76%**	3475 **75%**	3305 **76%**	3295 **75%**	3451 **77%**	3776 **78%**	3633 **77%**	3464 **76%**	3541 **75%**	3352* **75%**
Female	1025 **24%**	1017 **24%**	1148 **25%**	1044 **24%**	1097 **25%**	1035 **23%**	1086 **22%**	1091 **23%**	1113 **24%**	1163 **25%**	1108* **25%**
Total	**4227**	**4250**	**4623**	**4349**	**4392**	**4486**	**4862**	**4724**	**4577**	**4704**	**4460***

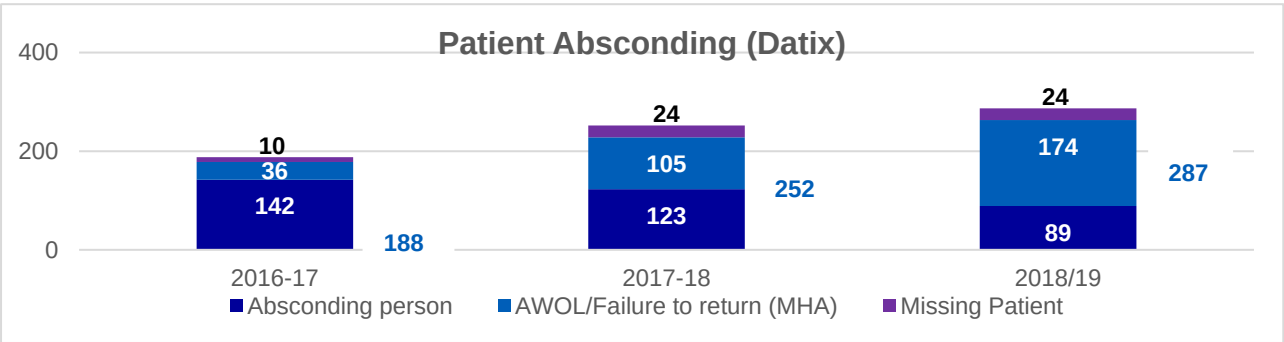
* *National data for 2016 are based on estimate due to outstanding returns.*





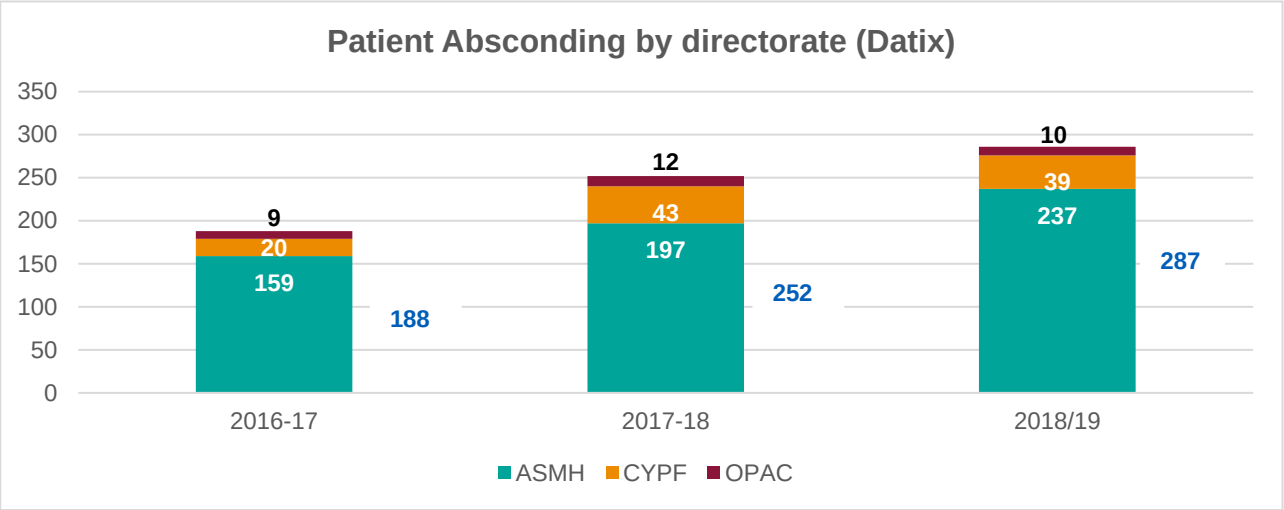
3.1.2 *Patient Absconding, including MHA AWOL (Absent Without Leave)*

Patient absconding or 'unauthorised absence' from a mental health hospital has potentially serious negative consequences, with the patient being at greater risk of suicide. A fifth of all inpatient suicides occur among patients who have absconded from hospital (*National Confidential Inquiry into Suicide and Homicide Annual Report 2018*).



The rate of increase between 2017-18 and 2018-19 is much lower at 14% compared with the 34% increase between 2016-17 and 2017-18, which is a positive improvement.

Of the 287 incidents of patient absconding in 2018-19, 61% related to '*absent without leave*' (AWOL) or '*failure to return from leave*' on the agreed time, which increased by 66% overall. The increase has largely been due to the 20% increase in ASMH services – the main reason for patients absconding still appears to be related to the implementation of the Smoke Free Policy in the wards. We have introduced a number of initiatives in the year to support our ward staff and patients.



All wards now have 'e-burn' electronic cigarette reserves in stock to support patients who want to stop smoking. Smoke-free signs are now displayed in the entrance to Trust locations in the North and South.

Other improvement actions and initiatives in 2018-19

- ✓ Smoking cessation Level 2 training provided to a mixture of staff from different roles.
- ✓ Making every contact count (MECC)and Very Brief Advice (VBA) training is also provided, which looks at all aspects of physical health and wellbeing.
- ✓ Wellbeing display boards and leaflets are available, including display screens with healthy lifestyle messages.
- ✓ Some wards have implemented 'Wellbeing Wednesdays', and a trial is in progress in the Recovery ward around a smoking cessation drop in clinic every Wednesday.

Plans for 2019/20

- We are looking into providing a 'Train the trainer' smoking cessation course to enable us to provide training in-house to our staff.
- A proposal was made to add a "*We are a smoke-free Trust*" to Trust-headed paper.

3.1.3 Physical Health Assessments

The life expectancy for people with severe mental illnesses (SMI) is 15–20 years lower than the general population. (NHS England February 2018).

This disparity in health outcomes is largely 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.

CQUIN: Cardio Metabolic Assessment and Treatment for Patients with Psychosis Reporting requirement introduced in 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, community and Early Intervention in Psychosis (EIP) services. Data is collected through a national audit.

Cardio Metabolic parameters

1. *Smoking status*
2. *Lifestyle (alcohol/substance misuse)*
3. *Weight and Body Mass Index (BMI)*
4. *Blood pressure*
5. *Glucose regulation*
6. *Blood lipids (cholesterol)*

The results from the 2016/17 and 2017-18 national audits are shown below. The results of the 2018-19 audit are not yet available at the time of writing this report.

Cardio metabolic audit results – screening & attempted screening

Standards	2016-17 Screening/Attempted Screening			2017-18 Screening/Attempted Screening	
	EIP**	Inpt***	Comm***	EIPN**	Inpt/Comm (NCAP)***
Smoking status	81%	95%	75%	93%	88%
Weight and BMI	75%	97%	41%	88%	50%
Blood pressure	75%	95%	45%	88%	59%
Glucose	67%	62%	18%	67%	24%
Blood lipids (cholesterol)	56%	64%	11%	66%	20%
Lifestyle					
• *Alcohol*	84%	92%	68%	92%	86%
• *Substance misuse*	81%	95%	64%	94%	86%
% screened for all 6 parameters		**14%***	**3%***		**4%***

Notes:

* *Figures provided by the Royal College of Psychiatry's Centre for Quality Improvement through the National Clinical Audit of Psychosis (NCAP)*

** *EIP was a local audit in 2016-17, and a national audit by the Early Intervention in Psychosis Network (EIPN) in 2017-18. It is worth noting that EIP and EIPN figures are not directly comparable.*

*** *In 2017-18, NCAP presented combined results for inpatient and community services.*

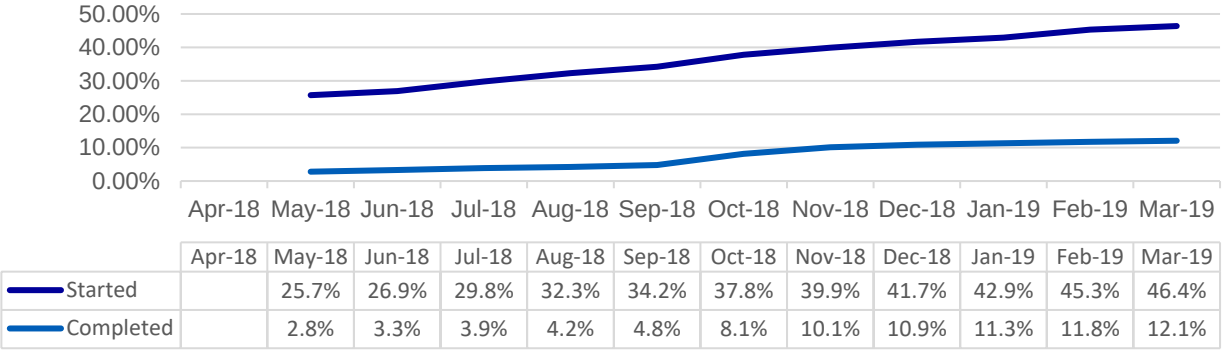
Cardio metabolic audit results – evidence of interventions

Standards	2016-17 Evidence of Interventions			2017-18 Evidence of Interventions	
	EIP**	Inpt***	Comm***	EIPN**	Inpt/Comm (NCAP)***
Smoking status	89%	57%	44%	93%	55%
Weight and BMI	64%	39%	23%	12% (target 65%)	84% >25kg/m2
Blood pressure	0%	38%	13%	87%	33%
Glucose	0%	41%	0%	83%	25%
Blood lipids (cholesterol)	0%	0%	0%	82%	30%
Lifestyle					
• *Alcohol*	100%	35%	58%	92%	50%
• *Substance misuse*	100%	59%	41%	97%	40%

Our scores have significantly improved in relation to our ability to demonstrate evidence of interventions in 2018-19. The average score on 'support with healthy living' in our internal patient experience survey (Meridian) was 83% in 2018-19.

In 2018-19, CQUIN Goal 3 (Improving physical healthcare to reduce premature mortality in people with severe mental illness) was removed from the CPFT contract as our commissioners made the decision to invest into primary care to support physical health checks for people with SMI. This covers the requirement relating to cardio metabolic assessments for patients with schizophrenia.

In May 2018, we created a new metric in our quality dashboard to report on our performance on the screening of all 6 cardio metabolic parameters to mirror the national audit.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Started		25.7%	26.9%	29.8%	32.3%	34.2%	37.8%	39.9%	41.7%	42.9%	45.3%	46.4%
Completed		2.8%	3.3%	3.9%	4.2%	4.8%	8.1%	10.1%	10.9%	11.3%	11.8%	12.1%

As of 31 March 2019, the Physical Health Check (PHC) form for patients with SMI was started on 48% of which 12% have been shown as completed. The low compliance rate is largely due to historical recording practices as blood results are recorded in the 'investigations' tab and not always reflected in the PHC form.

Improvement actions in 2018-19

The Trust's Physical Health Lead continues to raise the profile of physical health monitoring through

- ✓ Producing a Trust wide strategy to improve the physical health of service users with mental illness, developed through widespread consultation with service users
- ✓ Revising the Trust policy regarding physical health in mental health to ensure it reflects current best practice and commissioning arrangements
- ✓ Implementing a comprehensive training programme for all mental health clinicians to ensure they understand the issues regarding cardio-vascular health and mental illness - and the part they all play in addressing them.
- ✓ Developing a programme of physical health skills enhancement for mental health nurses who lead on physical health in their teams to support them in leading the delivery of the strategy and policy.
- ✓ Working closely with the Trust's Smoke Free Lead to ensure that measures to implement the Smoke Free policy are fully embedded in Well-being initiatives around the Trust
- ✓ Joint working with Public Health providers to ensure access to Health Coaching is easily available for people with mental illness
- ✓ Employing a small team of Health Care Assistants to work specifically with people who have mental illness in their primary care GP practice.
- ✓ Working with the Associate Director for Service User, Patient and Stakeholder Partnerships on a project to provide an internship for a patient-led project to identify practical, relevant and achievable wellbeing measures for patients.

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 ***Clostridium difficile*** in 2018-19 and 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 6 years.
- One ward closure due to **diarrhoea and vomiting** in 2018-19 and one confirmed case of Norovirus.
- Isolated cases of flu across our inpatient units 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.

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*.
- *Audit of catheter care* 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.
- E-*learning modules* 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 campaign for staff.

Hand hygiene audits now form part of the IPaC annual training.

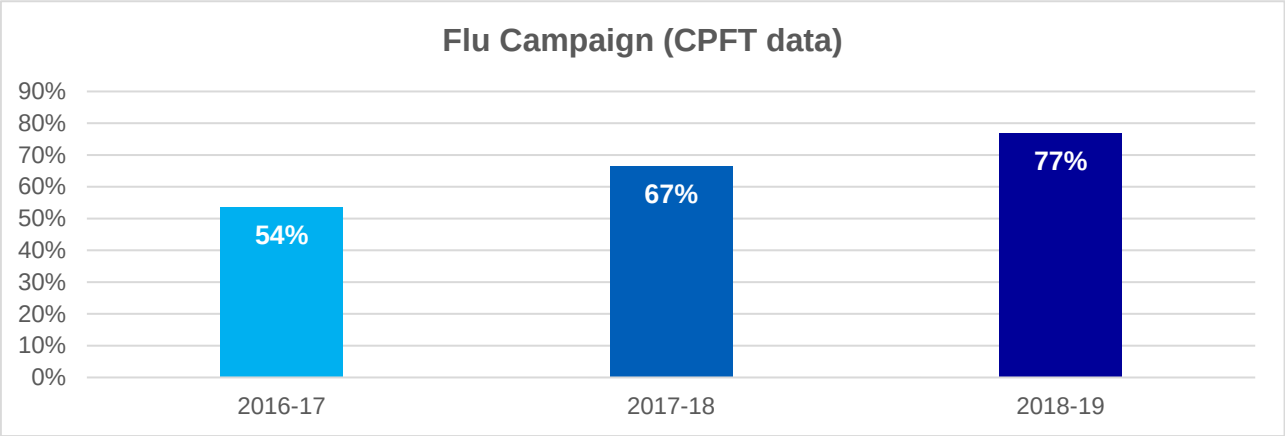
Priority for improvement in 2019-20

The IPaC team will act as a resource for, and provide specialist advice to, clinical and non-clinical staff, managers, contract workers, patients and their carers, relatives and/or visitors.

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.

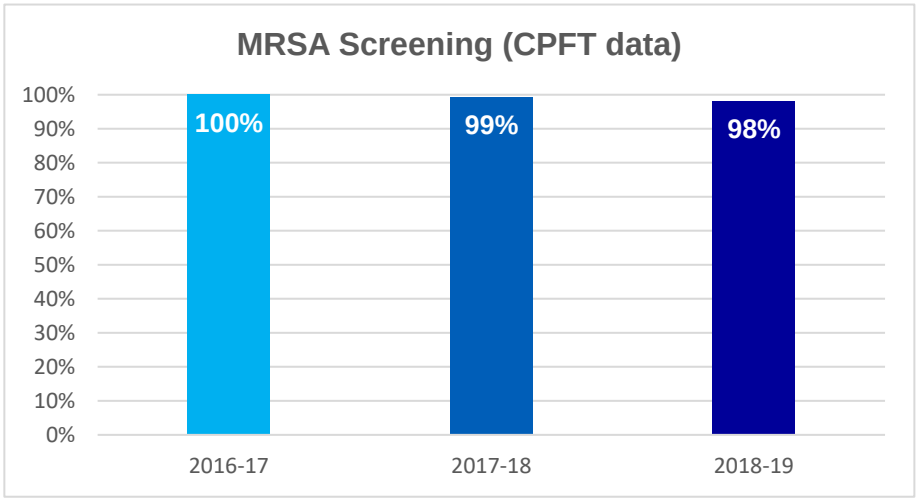
For the first time, we achieved the national CQUIN on improving the uptake of flu vaccinations for frontline clinical staff, achieving 77% against the target of 75%.



How did we do it?

- ✓ Administrative support provided for data inputting of completed vaccinations.
- ✓ Support from our Business Informatics team through monthly reporting of performance.
- ✓ Increased support from our Communications team, which included creating short films to encourage staff to have the flu vaccine.

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.

In 2018-19, there were five occasions where a ward did not submit an MRSA screening return and 13 late submissions, thus contributing the 1% reduction in the overall score.

3.2 *Clinical* Effectiveness

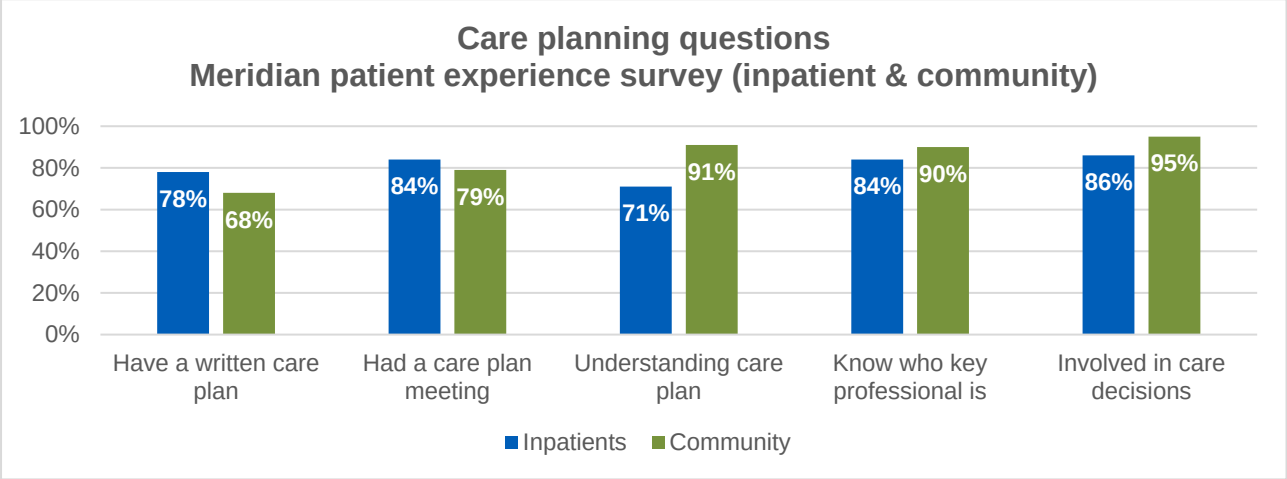
3.2.1 Care Planning

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.

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.*

In CPFT, we monitor care planning from the perspective of our patients through the monthly Meridian patient experience survey.



The survey questions were changed in January 2018 following a comprehensive review involving patients and staff to ensure these were in line with national and statutory requirements and reflects what matters to our patients, hence there are no comparative figures for 2017-18.

It is worth noting that the scores from our internal patient survey are, on average, higher than the scores from the National Mental Health Community Patient Survey 2018.

In July 2018, we launched a new electronic care planning monitoring tool, which is the first module in our Quality Improvement Evaluation Tool (QuIET), based on core care planning standards agreed by our physical and mental health services and was developed with the full involvement of staff across the different services from our three clinical directorates.

QuIET provides our staff with a tool to regularly evaluate and monitor care planning and documentation against good practice standards to support improvements and consistency in standards of practice.

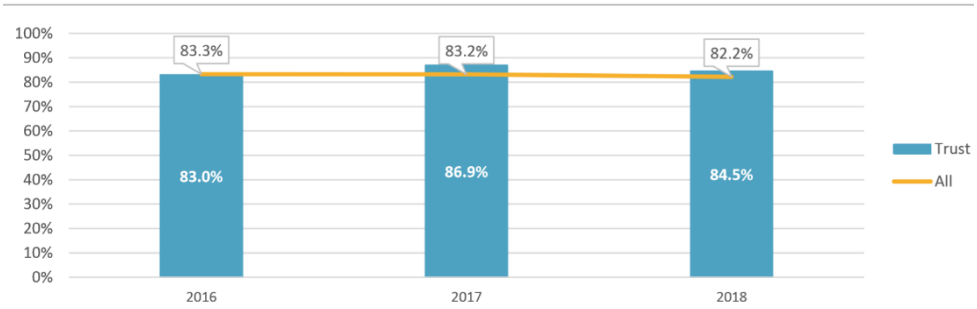
National Mental Health Community Patient Survey 2018

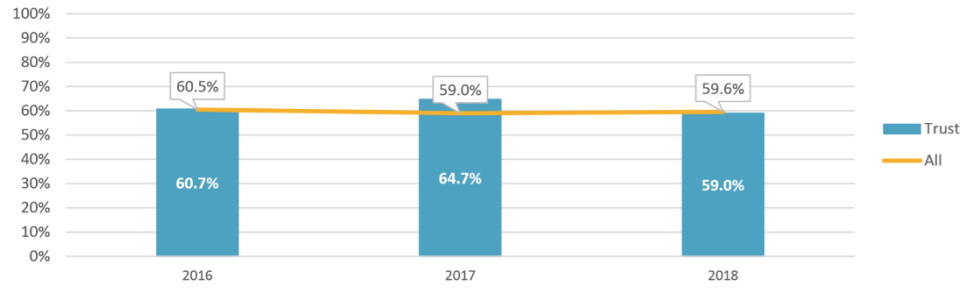
Planning and organising care

We scored higher than the national average in relation to how well we organise care, and we are just under the national average in relation to agreeing care.

Our score in Question 9 places us in the highest scoring 20% of Trusts, while our scores on Questions 10 and 11 places us in the intermediate 60% of Trusts.

9. How well does this person organise the care and services you need?

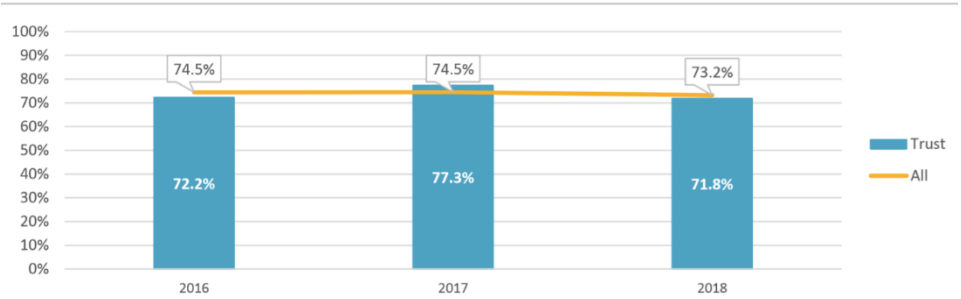




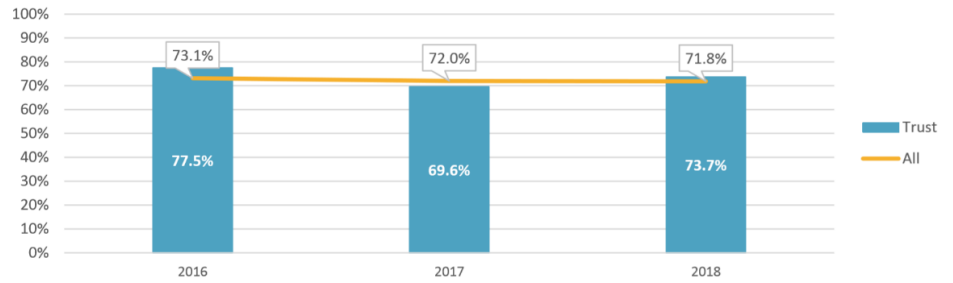
Reviewing care

On the other hand, our score has improved Question 13 in relation to reviewing care and is higher than the national average placing us in the intermediate 60% of Trusts in this area.

11. Were you involved as much as you wanted to be in agreeing what care you will receive?



13. 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?



How do we improve?

A comprehensive action plan has been developed by the ASMH and OPAC services.

Improvement actions for 2019-20

Adults and Specialist Mental Health (ASMH)

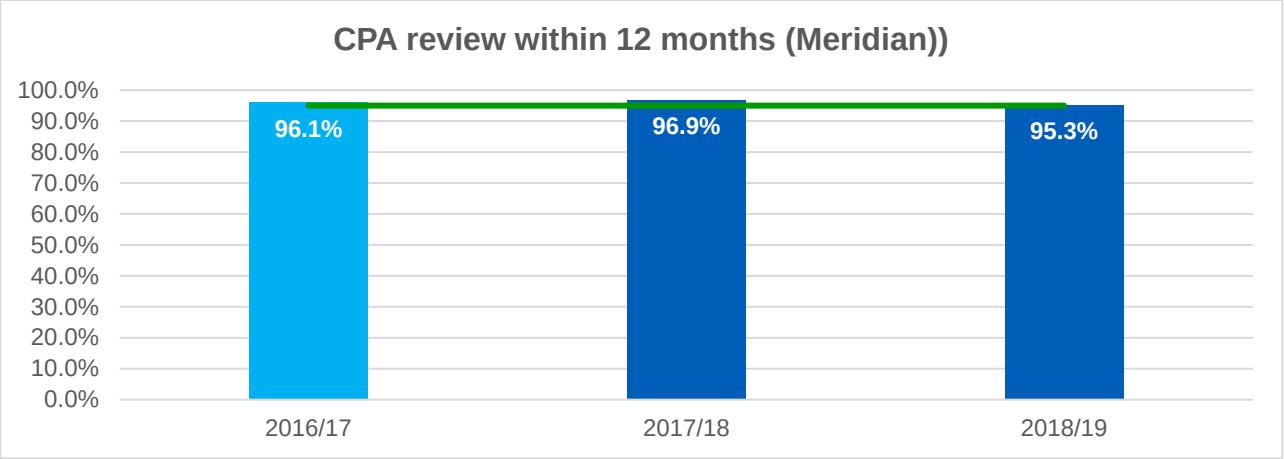
Improve practice on the development of person-centred care plans, providing patients with the opportunity to be involved in decisions about their care at the level they wish (This is also the quality priority of the directorate). See **2.1.6**.

Older People, Adults and Community (OPAC)

Roll out the QuIET monitoring tool to all teams to improve the quality of care planning in the service, and actively speak to patients about planning and reviewing care.

Additional information requested by NHS Improvement for CPA patients having formal review within 12 months (inpatients and community)
Reporting requirement added in 2017-18

We have consistently met the 95% target over the last three years.



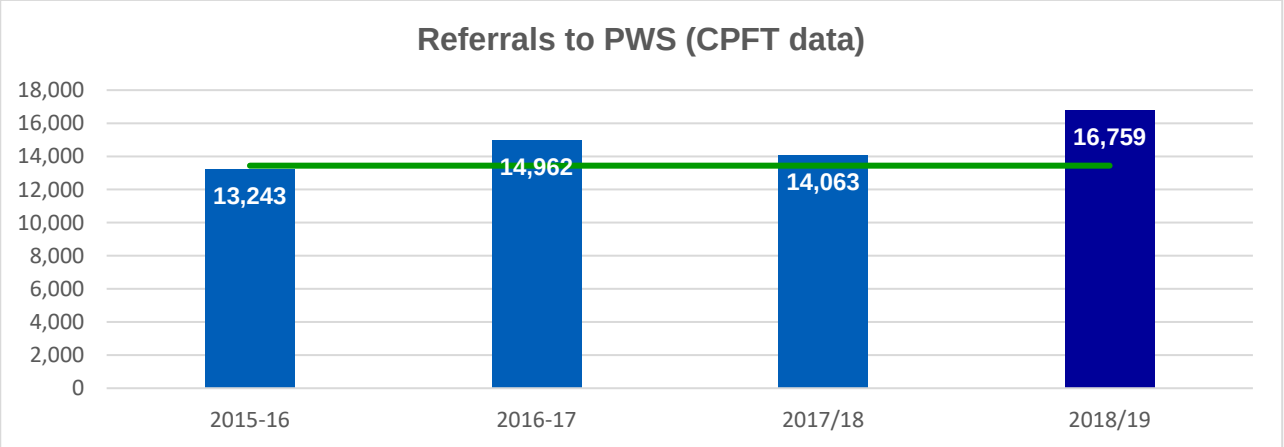
Our score on the National Mental Health Community Patient Survey 2018 also shows an improvement in relation to '*having a formal meeting to discuss care in the last 12 months*' from 69.6% in 2017 to 73.7% in 2018, which is higher than the national average of 71.8%.

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)** 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.



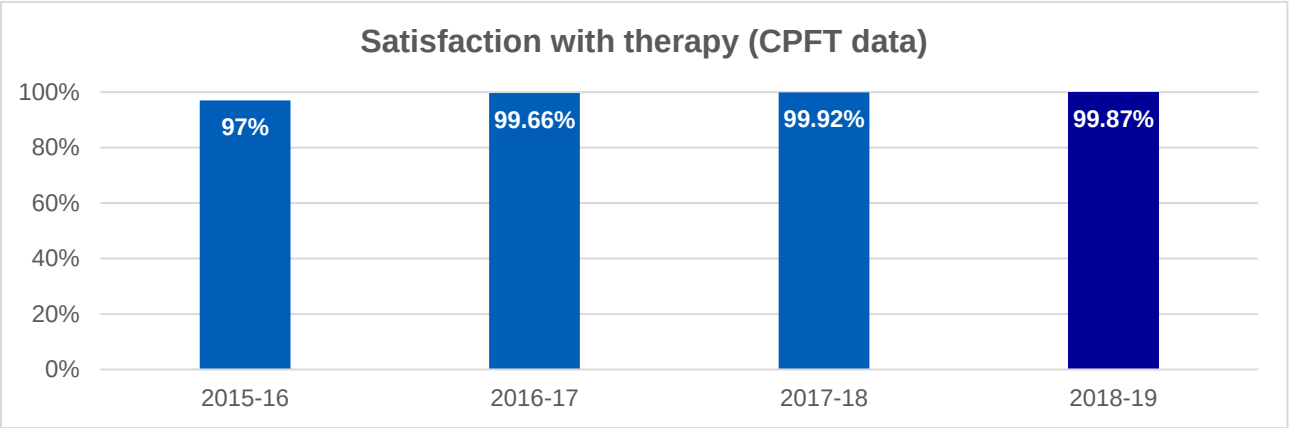
* *The staffing model for PWS is based on the access target of 13,440 per year. However, actual referral numbers have consistently exceeded these in the last three years.*

Referrals to PWS increased by 19% 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 (COPD).

Satisfaction with therapy

The increased level of referrals has not seen the quality of the service deteriorate.

Satisfaction with therapy has been consistently above 99% in the last three years.

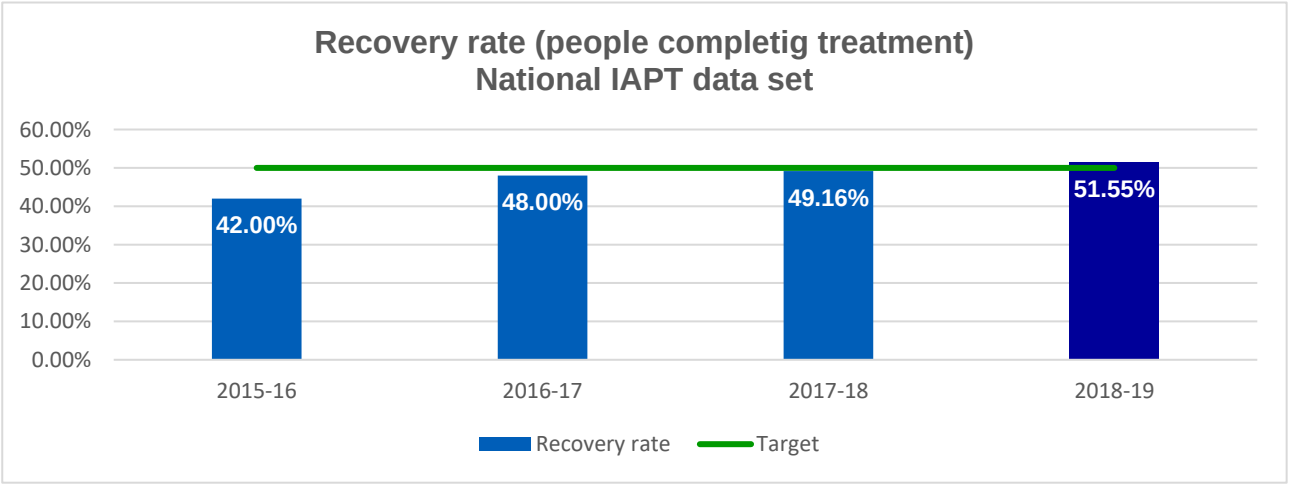


Additional information requested by NHS Improvement for Improving Access to Psychological Therapies (IAPT)

a. *People completing treatment who move to recovery (from IAPT dataset) Reporting requirement added in 2017-18*

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.

Our recovery rate has steadily increased since this was introduced in 2015-16, and we exceeded the 50% target in 2018-19.



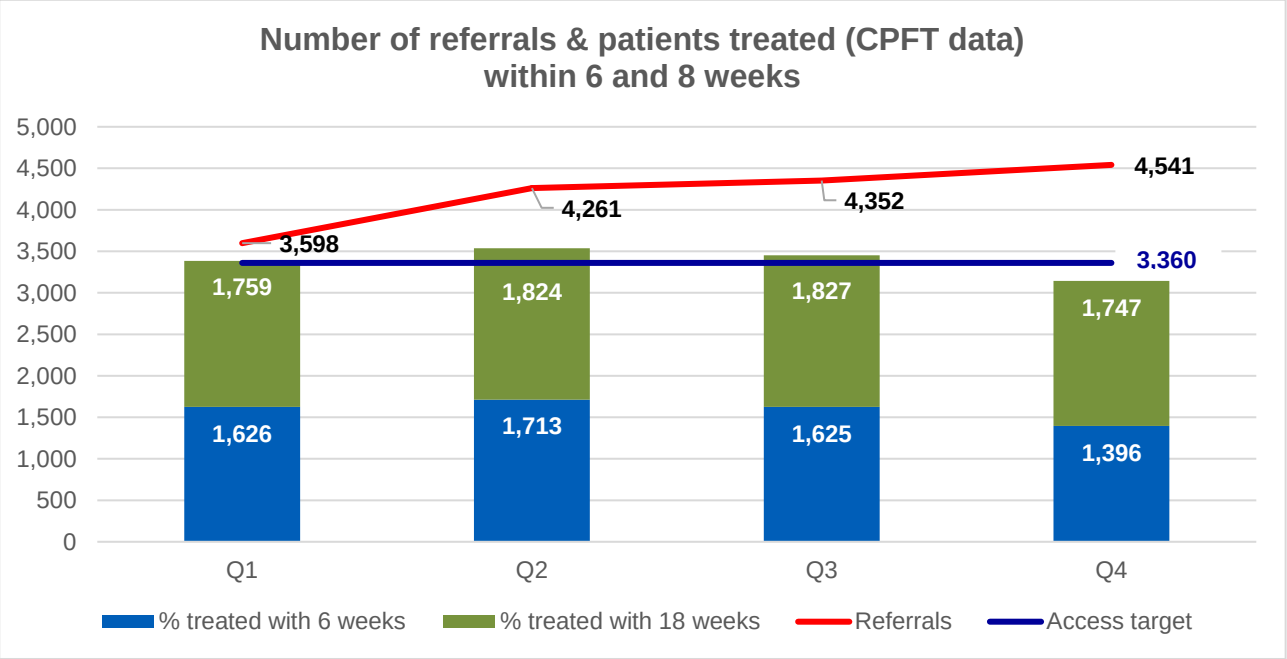
b. *People referred to the IAPT programme treated within 6 and 18 weeks of referral Reporting requirement added in 2016-17*

The staffing model for PWS is based on the access target of 13,440 per year. However, actual referral numbers have consistently exceeded these in the last three years.

In 2018-19, actual referrals (n=16,759) exceeded the target by 25% thus putting a strain on the system which resulted in patients not receiving treatment as quickly as we would like. Whilst we have consistently exceeded the national targets over the last three years, our performance in relation to the 6-week target declined from 93.6% in 2017-18 to 88.2% in 2018-19.

Performance on 6 and 18-week waiting time to treatment (CPFT data)

Waiting time standard	Target	Performance 2016-17	Performance 2017-18	Performance 2018-19
a. Treated within 6 weeks of referral	75%	88.86%	93.6%	88.2%
b. Treated within 18 weeks of referral	95%	98.74%	99.2%	99.2%



The data below, taken from the NHS Digital portal, shows that CPFT performance exceeded the national average in the first half of the year.

Performance declined in relation to 'finished courses of those entering treatment at 6 weeks' in the second half of the year as referral numbers continued to rise, while maintaining its performance in relation to 'finished courses of those entering treatment at 18 weeks'.

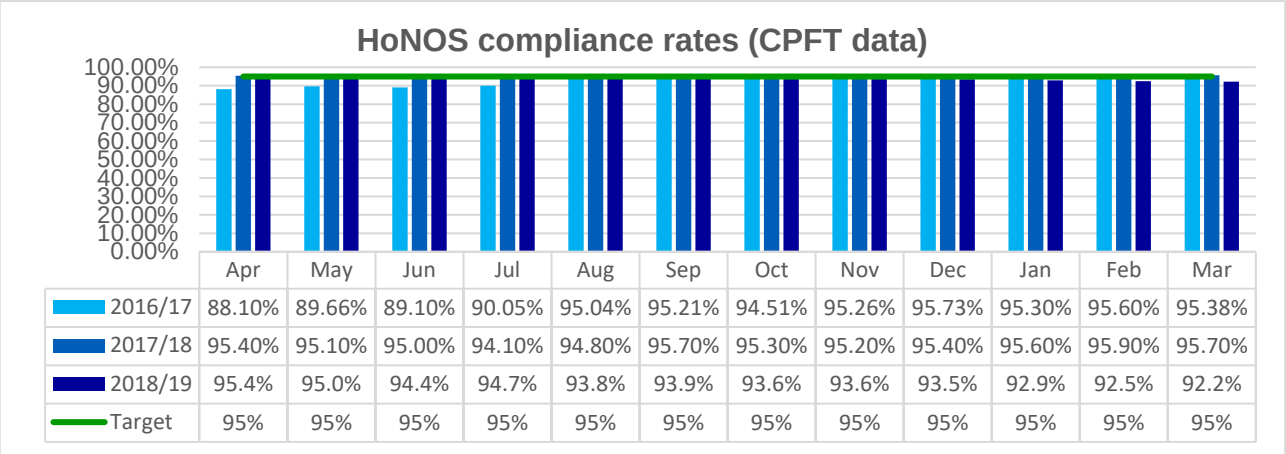
Performance on 6 and 18-week waiting time to treatment (NHS Digital data)

First treatment (Finished Course)	Q1 18-19		Q2 18-19		Q3 18-19		Q4 18-19	
	CPFT	England	CPFT	England	CPFT	England	CPFT	England
a. 6 weeks	91.6%	89.5%	93.1%	89.50%	88.4%	89.5%	79.5%	Data not available
b. 18 Weeks	99.0%	99%	99.0%	99.1%	99.3%	90.00%	99.4%	

3.2.3 HoNOS (Health of the Nation Outcome Scales)

HoNOS was developed by the Royal College of Psychiatrists' Research Unit to measure the health and functioning of people with severe mental illness in order 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*'.

HoNOS consists of 12 items measuring behavior, impairment, symptoms and social functioning, and completed as part of routine clinical assessments. It 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.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	88.10%	89.66%	89.10%	90.05%	95.04%	95.21%	94.51%	95.26%	95.73%	95.30%	95.60%	95.38%
2017/18	95.40%	95.10%	95.00%	94.10%	94.80%	95.70%	95.30%	95.20%	95.40%	95.60%	95.90%	95.70%
2018/19	95.4%	95.0%	94.4%	94.7%	93.8%	93.9%	93.6%	93.6%	93.5%	92.9%	92.5%	92.2%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Compliance rates declined overall to 92% in 2018-19 compared with 95% in 2017-18 and 96% in 2016-17.

HoNOS was originally developed as an outcomes measure, and not as a tool to predict costs.

Therefore, its utility within the context of 'clustering' and Payment by Results (PbR) in mental health has lost some degree of relevance within the clinical setting due largely to the lack of evidence of its ability to reliably predict costs for patients with mental disorder; and the fact that PbR has not materialised and the continuing lack of clarity around this. This may, in part, explain the reduction in compliance rates over the last three years within a challenged health economy.

We are attempting to improve this by introducing the 'outcomes feedback cycle', whereby clinical staff are provided with electronic reporting of outcomes data via Mi Reports to support more meaningful use and inform the development and planning of care (see Quality goal 2.2 2018-19). This is being piloted in selected teams within the adults community services, and will be rolled out more widely in 2019-20.

The ***Adult Mental Health Clustering Tool*** is a needs assessment tool designed to rate the care needs of a patient based on a series of 18 rating scales.

The first 12 of these rating scales are the same as the HoNOS rating scales.

The mental health clusters were mandated for use from April 2012 to help services prepare for the introduction of a national tariff to bring it within the scope of ***Payment by Results*** (PbR). The expectation was that 'clusters' will form the basis of the contracting arrangements between commissioners and providers.

The ***Five Year Forward View for mental health*** sets out the need for more transparent payment approaches that support timely access to NICE-concordant care, thus resulting in better patient outcomes.

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.

Breastfeeding prevalence (CPFT data)

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Local target	**48%**	**48%**	**48%**	**45%**	**45%**	**45%**	**45%**
Prevalence of breastfeeding (totally plus partially) at 6-8 weeks from birth	38%	41%	42.1%	41.5%	42.6%	**43.2%**	**50.8%**
Local target	**-**	**-**	**95%**	**95%**	**95%**	**99%**	**99%**
Percentage of infants for whom breastfeeding status is recorded at 6-8 weeks from birth	93%	89%	98.0%	99%	98.5%	**95.94%**	**94.8%**

Whilst 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, we continue to improve upon our performance on recording breastfeeding status year on year and, not only met the target for the first time in 2018-19 but actually exceeded by over 5%.

National benchmark data below shows the performance of CPFT services in Peterborough, on average, to be in line with the national average in the last two years (Quarter 4 data not yet available at time of reporting).

Breastfeeding prevalence (National data – Public Health England)

Breastfeeding prevalence at 6-8 weeks after birth	2017-18				2018-19			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
England	41.6%	43.3%	43.6%	43.1%	44.9%	46.6%	46%	Data not available
East of England (aggregate value)	42.8%	45.5%	47.9%	48.4%	49.6%	50.9%	50.4%	
CPFT (Peterborough)	**48.1%**	**44.6%**	**42.0%**	**44%**	**45.7%**	**48.5%**	**46.7%**	

Despite the inherent challenges within which our Health Visiting service operates, it maintained its Level 3 United Nations Children's Emergency Fund (UNICEF) accreditation (re-assessed in November 2018), 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.

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 recognising and treating psychotic experiences early leads to better outcomes and an improved chance of recovery. For young people, this means increasing their chances of getting into employment and building the lives they want for themselves.

In CPFT, EIP is provided by the CAMEO team, a service for people aged 14-65 years old who are experiencing symptoms of psychosis for the first time.

Cambridgeshire and Peterborough
Assessing
Managing and
Enhancing
Outcomes

Services provided by CAMEO include:

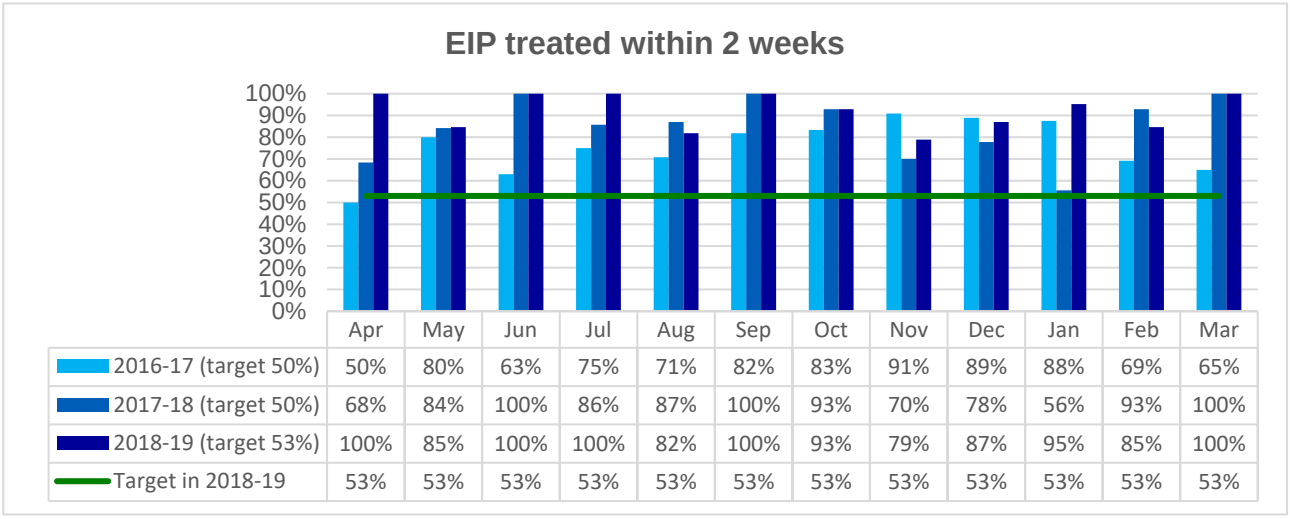
- focused triage via a daily duty clinician system
- comprehensive specialist assessments (up to one month) for people 'at risk, and extended assessments (up to six months)
- support over a minimum two-year period with regular reviews
- support for people with their educational, vocational, leisure, housing, financial and employment plans
- seeing people where they are most comfortable
- engaging families and friends

CAMEO continues to provide the 'At Risk Mental State' (ARMS) service, established in 2017-18, for people who do not meet the threshold but are considered to be at 'ultra-high risk' of developing psychosis who would have been turned or signposted to other services.

Below shows CPFT performance in relation to the proportion of people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral.

The national target was changed to 53% in 2018-19 from 50% in the previous two years. We met the target in April 2016 and have since consistently exceeded this in the next three years.

EIP people experiencing 1st episode psychosis treated within 2 weeks



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17 (target 50%)	50%	80%	63%	75%	71%	82%	83%	91%	89%	88%	69%	65%
2017-18 (target 50%)	68%	84%	100%	86%	87%	100%	93%	70%	78%	56%	93%	100%
2018-19 (target 53%)	100%	85%	100%	100%	82%	100%	93%	79%	87%	95%	85%	100%
Target in 2018-19	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%	53%

Annual performance was 75% in 2016-17 and 86% in 2017-18 against the target of 50%, increasing to 92% in 2018-19 against the target of 53%.

3.2.6 Admissions to Adult Facilities of Patients Under 16 Years Old Reporting requirement added in 2017-18

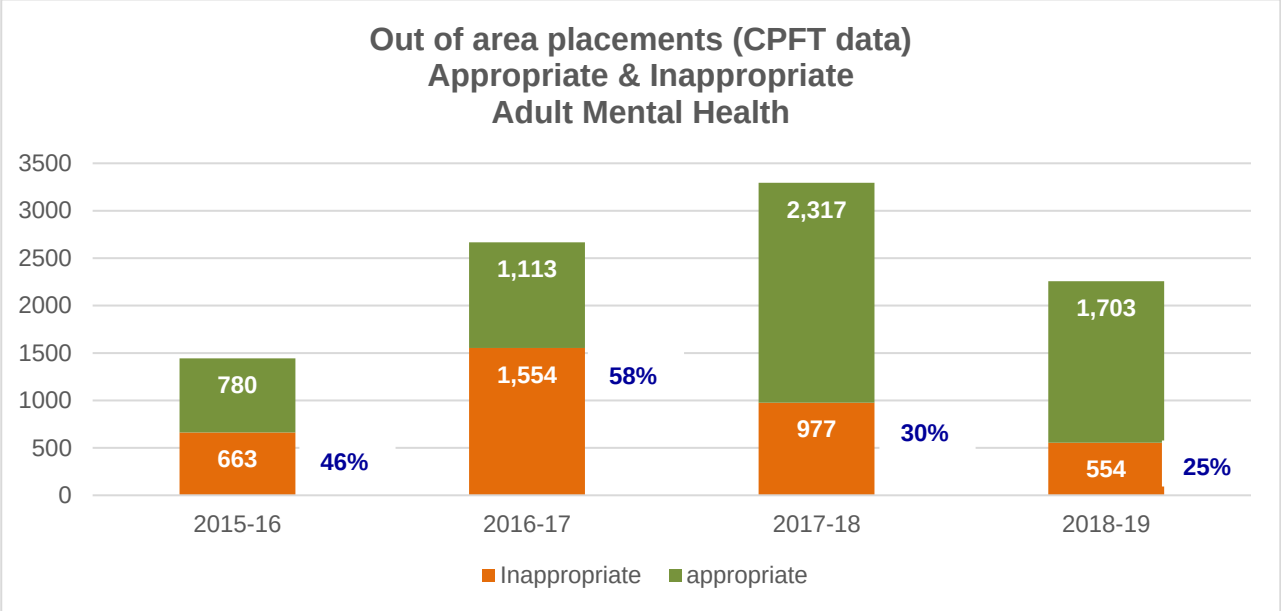
None in the last four years.

3.2.7 Inappropriate Out-of-Area Placements for Adult Mental Health Services. Reporting requirement added in 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.

Our inappropriate out of area placements have been steadily decreasing since 2016-17, both in terms of numbers and as a proportion of the total out of area placements. In 2018-18, inappropriate out of area placements decreased by 43% and only accounted for 25% of the total out of area placements, down from 58% in 2016-17.



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.

Accreditation schemes 2018-19

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	Accreditation paused due to temporary closure in 2018.
		The Croft Child and Family Unit	Participating but not yet accredited
	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 1	**Accredited**
		Mulberry 2	**Accredited**
		Oak 1	**Accredited**
		Oak 3	**Accredited**
		Mulberry 3	Accreditation process put on hold in 2018-19 due to query about the nature of service provided (not rehabilitation). To restart process in 2019-20 under the acute programme.
		Oak 4	
	Quality Network for PICU (QNPICU)	Poplar (PICU)	**Accredited**
	College Centre for Quality Improvement for Forensic Inpatient Services (CCQI)	George Mackenzie House	**Accredited**
	Quality Network for Eating Disorder Services (QED)	S3	**Accredited**
	Enabling Environments Accreditation	Springbank	Working towards accreditation
	Home Treatment Accreditation Schemes (HTAS)	CRHTT South	**Accredited**
		CRHTT North	**Accredited**
	Psychiatric Liaison Accreditation Network (PLAN)	Cambridge Liaison Psychiatry Service	**Accredited as excellent**
		Peterborough Liaison Psychiatry Service	**Accredited**
		Huntingdon Liaison Psychiatry Service	Commenced accreditation process in January 2019
	ECT Accreditation Scheme (ECTAS)	Addenbrookes ECT Clinic	**Accredited**
		Cavell ECT Unit	**Accredited**
	Early Intervention in Psychosis Network (EIPN)	CAMEO	Working towards accreditation
OPAC	Accreditation for Inpatient Mental Health Services (AIMS) Older People	Willow	Working towards accreditation

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. Reviews are undertaken every four years.

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 standards and sharing the work we are doing around support for staff.

Employer recognition scheme (Armed Forces)

EMPLOYER RECOGNITION SCHEME
BRONZE AWARD
Proudly supporting those who serve.

The Trust obtained the Bronze Award under the Employer Recognition Scheme for the Armed Forces in November 2017 and continue to support army reservists to find meaningful employment in our services.

The award means the Trust is proud to be armed forces-friendly, including open to employing reservists, armed forces veteran 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 2017-18 for achieving Triangle of Care in the specialist community health services for adults and older people.

3.3 *Patient* Experience

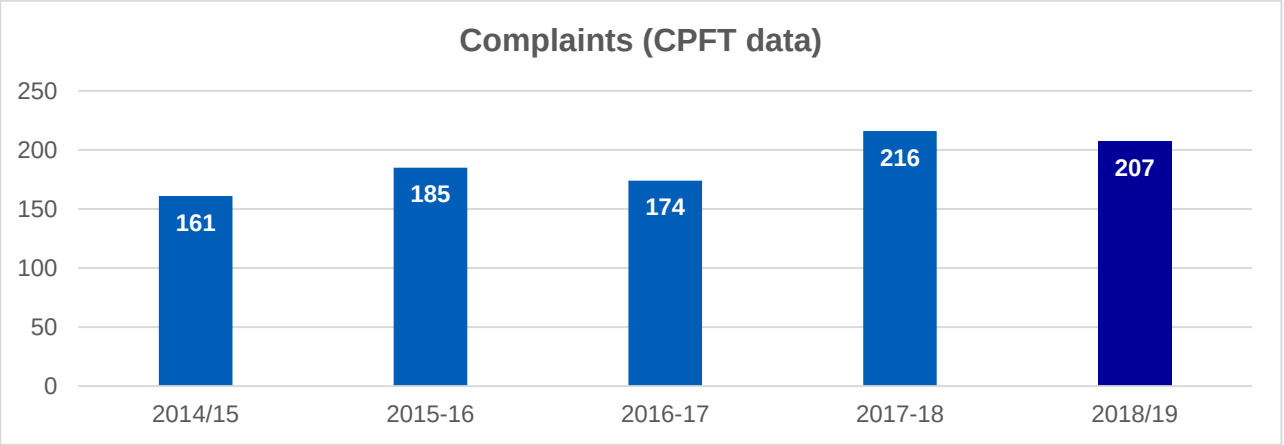
3.3.1 Complaints

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.

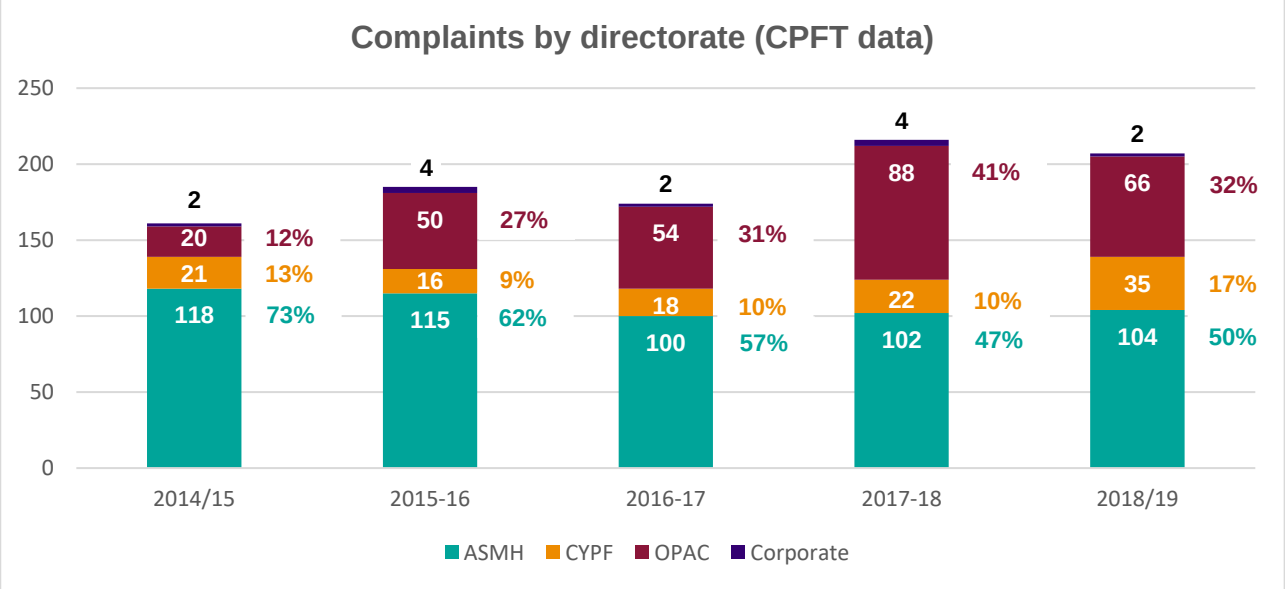
'A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment.'
Francis report, 2013

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*

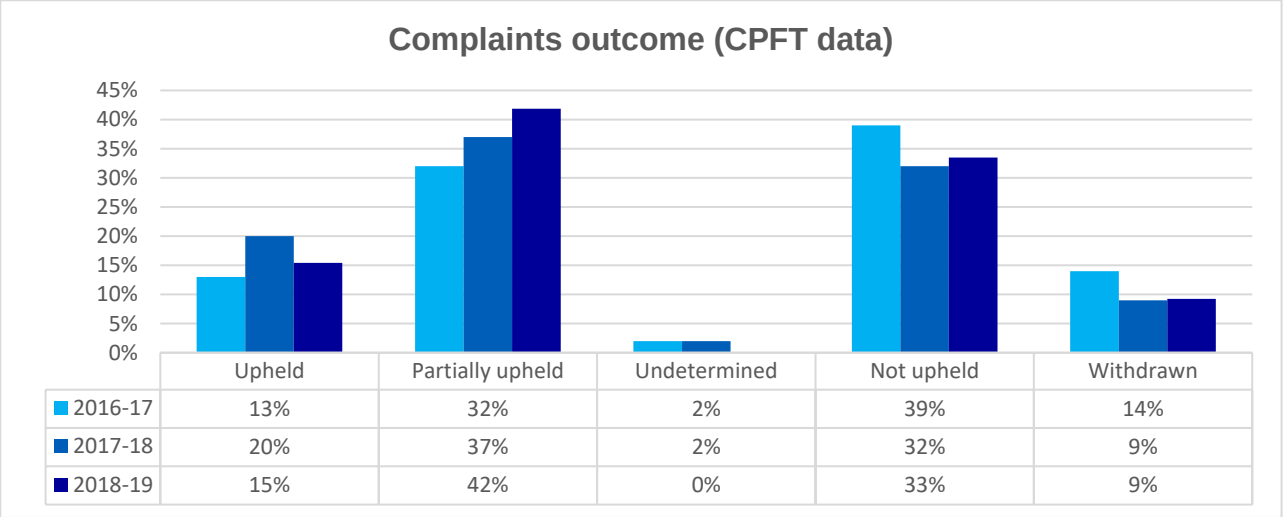


In 2018-19, CPFT received 207 complaints, which is 4% less than the previous year. The majority of complaints continue to come from ASMH services, which accounted for 50% of total complaints during the year.



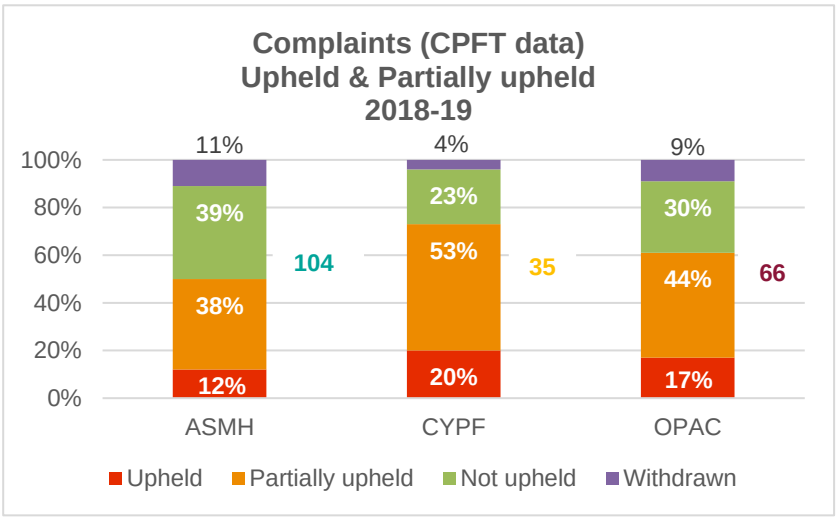
Complaints outcomes

A total of 227 complaints were closed in 2018-19 compared with 196 in 2017-18, which is an increase of 16%. Of these 57% were either upheld or partially upheld, which is the same as in the previous year.



	Upheld	Partially upheld	Undetermined	Not upheld	Withdrawn
2016-17	13%	32%	2%	39%	14%
2017-18	20%	37%	2%	32%	9%
2018-19	15%	42%	0%	33%	9%

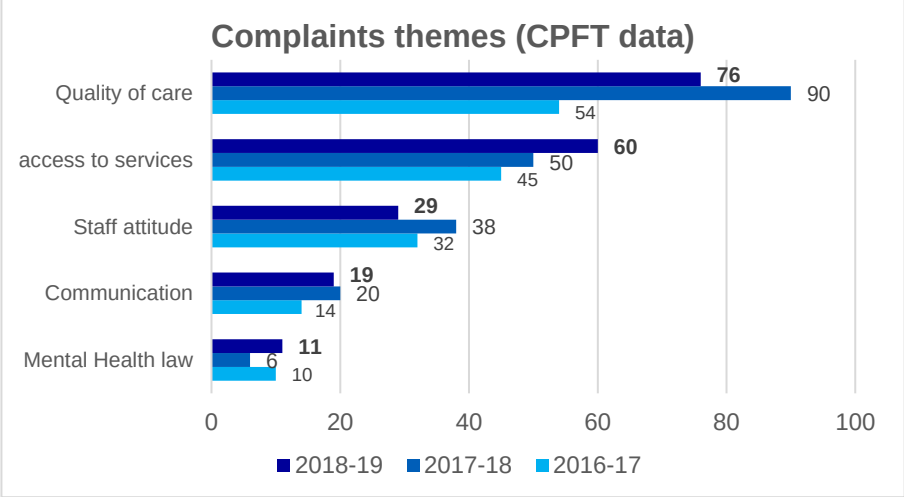
Whilst the CYPF directorate receive the least number of complaints, equivalent to 17% of all complaints in 2018-19, almost three quarters of these were either upheld or partially upheld, compared with around a third in OPAC and only half in ASMH.



Complaints by theme

The top five complaint themes, comprising 94% of all complaints, have remained unchanged in the last two years; and the top two have remained the same in the last four years:

- Quality of care
- Access to services
- Staff attitude
- Communication
- Mental Health Law



'Quality of care' comprised 37% of all complaints in 2018-19, generally related to dissatisfaction with treatment, clinical care, diagnosis and inadequate/insufficient care.

Examples of learning and improvements made

Quality of care
Delay in the review of a patient's CT head scan results.
Action taken: *The team introduced a system to monitor and manage breaches in the four-week receipt of CT scan results. A database has been implemented to identify breaches in requests and ensures early escalation for follow up.*

Access to services
Unhappy with the system for accessing community clinical staff
Action taken: *A Standard Operating Procedure (SOP) was developed setting out the process and timeframes for responding to allocated tasks and patient contact requests.*

Delay in a child's referral to continence services and access to appropriate services.
Actions taken: *Stronger links established between the school nursing service and the Continence service to improve timeliness of the continence aid home delivery service. Regular meetings to be held to ensure ongoing communication and early resolution of issues.*

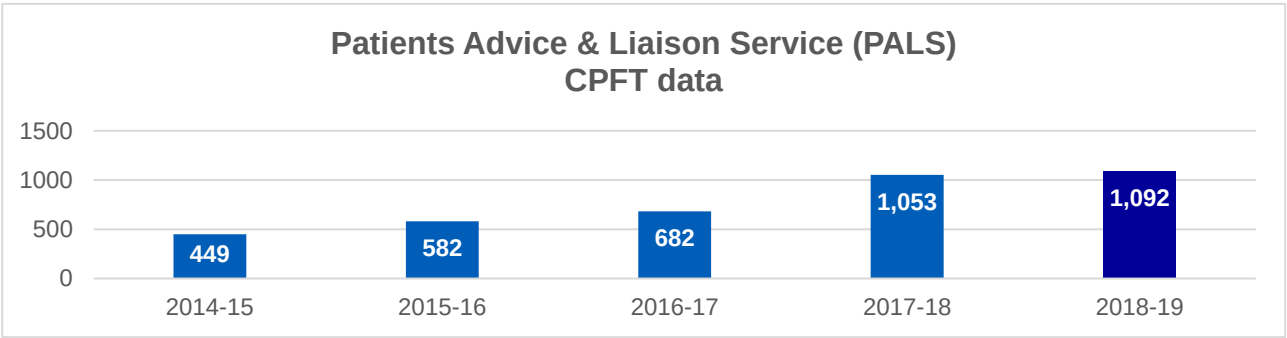
Improvements planned for 2019-20

1. To implement the standard NHS England Complaints Satisfaction Survey, originally planned in 2017-18.
2. To continue to develop various ways of sharing themes and learning from complaints both within and external to the Trust.
3. To work with directorates to improve response times for complaints and review the process to enable more timely responses.
4. To review the quality of action plans to improve bedding in of learning.

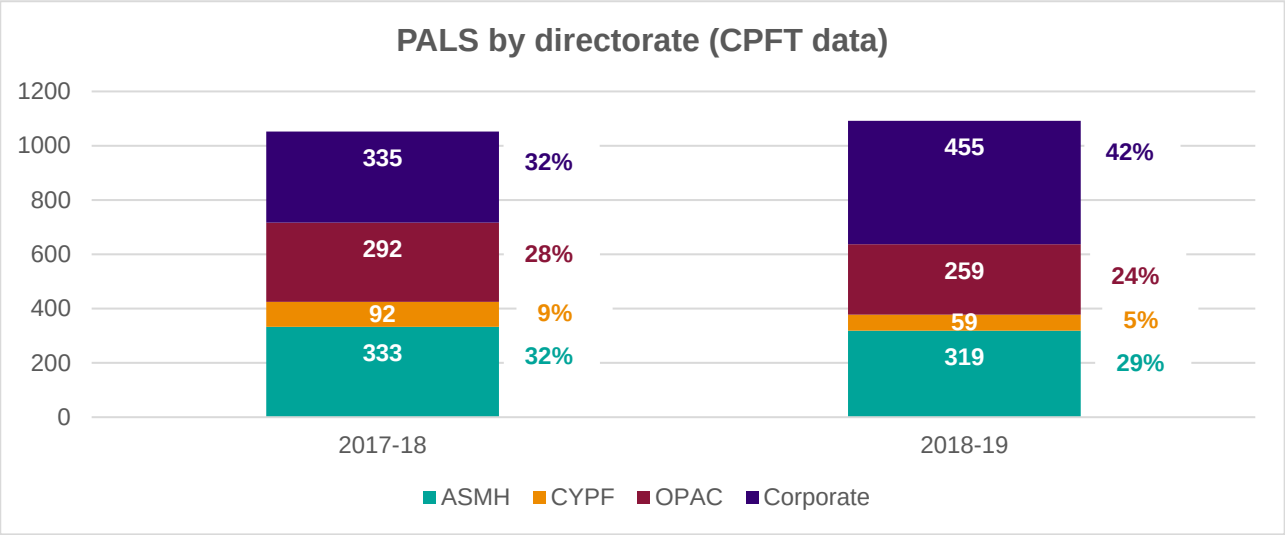
3.3.2 PALS (Patients Advice and Liaison Service)

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.

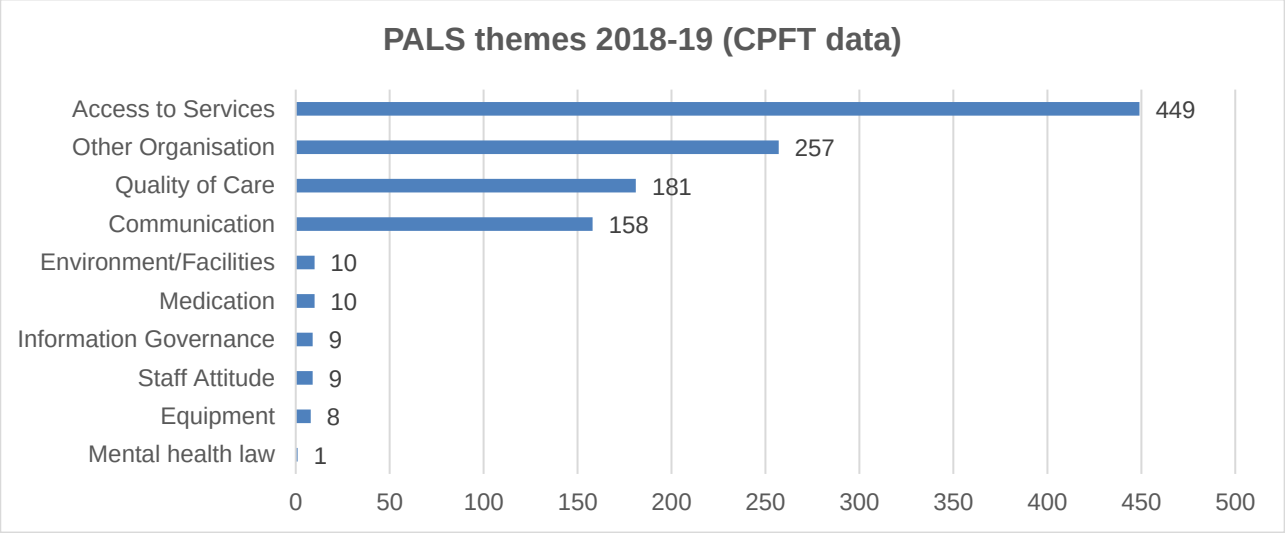
PALS provide us with the opportunity to use the information gained from comments and feedback from our patients and their carers to make improvements to our service.



The number of contacts increased by 4% in 2018-19, compared to the 54% increase in 2017-18 from the previous year. 29% were in relation to ASMH services, 24% to the OPAC services and just 5% to the CYPF services. There was an increase in the number of contacts in the year which were not related to CPFT services, classed as Corporate, and required signposting and accounts for the increase in the year.



41% (n=449) of contacts were in relation to 'access to services' while 17% (n=181) were in relation to 'quality of care'. A quarter (n=257) of contacts were about other organisations (not CPFT).



Examples of learning and improvements made

Within the ASMH services,

- the Psychological Wellbeing Service have improved their appointment texting service which now includes the venue of the appointments and service contact details.
- Wards have moved away from primary nursing and all patients are now nursed under 'care teams' which has seen an increase in 1:1 time with patients and collaborative working as well as paperwork compliance and activity reporting.

Within the CYPF services,

- More art material has been provided in the wards following feedback from young people

Within the OPAC services,

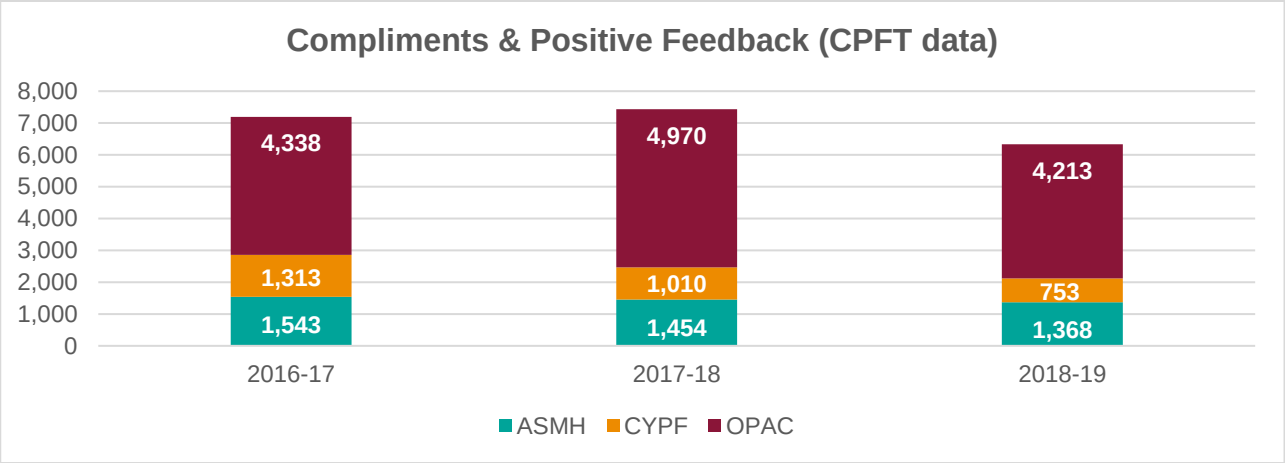
- service leaflets have been improved providing contact details of the local community teams.
- In the Continence service, appointment letters were reviewed, and appointment details clarified to avoid potential confusion, and training was provided to administrative staff to improve awareness of pre-appointment requirements from patients.
- Community teams are now offering morning or afternoon calls to patients to help reduce the time patients are waiting in for their visits.

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.

In addition, 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 2018-19 a total of 6,334 compliments and positive feedback were recorded compared with 7,434 in 2017-18 – equivalent to a 15% decrease from the previous year.

The large majority of our compliments are collected through the monthly Meridian patient experience survey, where patients are asked to provide a comment to '*What has been good about the service you received from this team?*' Responses are summarised in a word cloud below.

Analysis of the data shows that the reduction in the number of compliments received in the year is spread evenly across the three directorates and there does not appear to be any obvious reasons for this.

3.3.4 National Mental Health Community Patient Survey

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

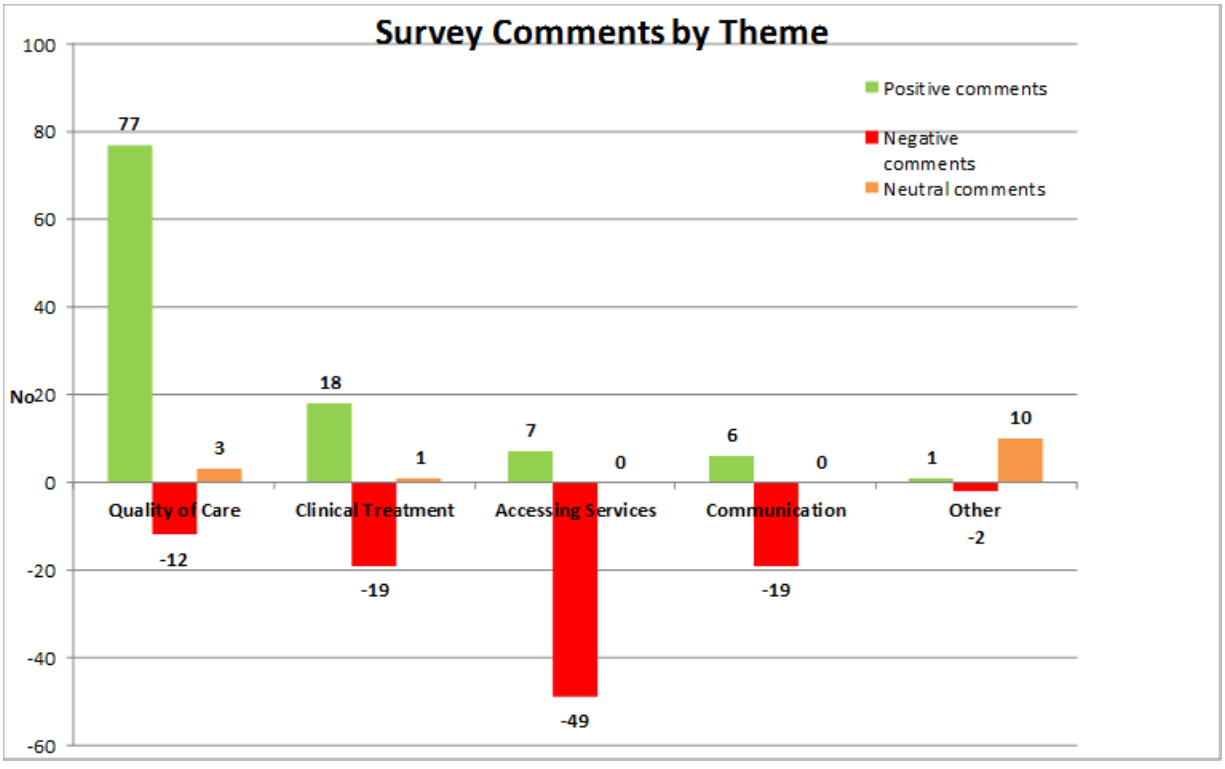
2.1.5: Quality Priorities 2018-19, Goal 3
2.2.12: NHS England Core Quality Indicators, number 4
3.2.1: Clinical Effectiveness, Care planning

Key findings…

- *CPFT was rated in the **top 20%** for **four** questions of all 53 Trusts (as surveyed by Quality Health) based on standardised scores. These were on:*
  - *Care and services organised to meet the person's needs*
  - *Reasons for changes in who the patients see for care or services explained*
  - *Know who to contact out of office hours in a crisis*
  - *In the last 12 months an NHS mental health worker has checked how the patient is getting on with medicines*
- *CPFT was rated in the **bottom 20%** for **five** questions, which are:*
  - *Personal circumstances were not taken into account when agreeing care*
  - *Decisions made together with the person reviewing care*
  - *Help and advice given with finding support with physical health needs*
  - *Help and advice given with finding and/or keeping work*
  - *Information on getting support from people with similar mental health needs*

In general, our scores were 'about the same' compared with other Trusts. These were based on responses from 254 people who received care from CPFT which is equivalent to 31% of the total usable sample.

There were approximately 230 comments provided by the survey respondents. An analysis of the themes based on positive and negative feedback is shown below.



The highest number of comments (n=77) consisted of positive feedback on 'quality of care'. This was followed by 49 comments relating to negative feedback on 'accessing services'. There were equal numbers of comments relating to positive and negative feedback on 'clinical treatment'.

Another way of summarising the comments is through a word cloud below.

"The follow up came, when I got home from hospital, from the crisis team was thorough, thoughtful and excellent. I have no complaints at the level of care I received from the team, only gratitude."

"My doctor is very good and has time for me when I visit him. He sits and listens to me and my CPN is very good and helpful."

"I received very good support from mental health team. This enabled me to cope with everyday life. They have encouraged and supported me through my crisis. While in my darkest moment I looked forward to my care workers visit when everything else felt pointless. They have been with me on every step which enables me to put my feet outside my home."

An action plan has been developed focusing on three key areas for improvement:

- Care planning
- Support and wellbeing
- Dignity and respect

3.3.5 Meridian Patient Experience Survey (CPFT)

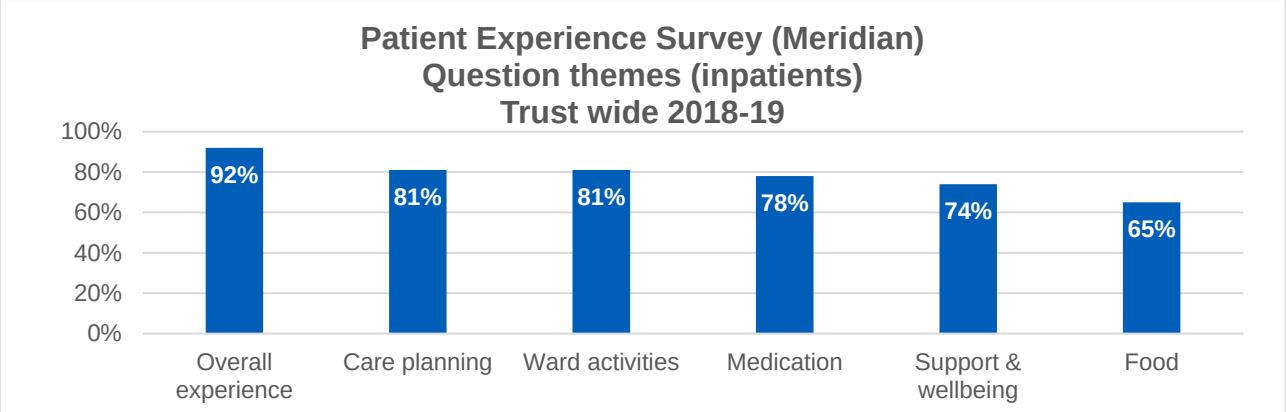
Finding out what our patients and carers think about their care and treatment through our monthly in-house surveys continues to be an integral part of understanding their experience of care and of our services to inform our improvement programme.

The directorate-wide surveys consist of core questions which build upon the principles of national and Trust-agreed quality standards. Data presented in this section relates to the **directorate-wide surveys** during 2018-19.

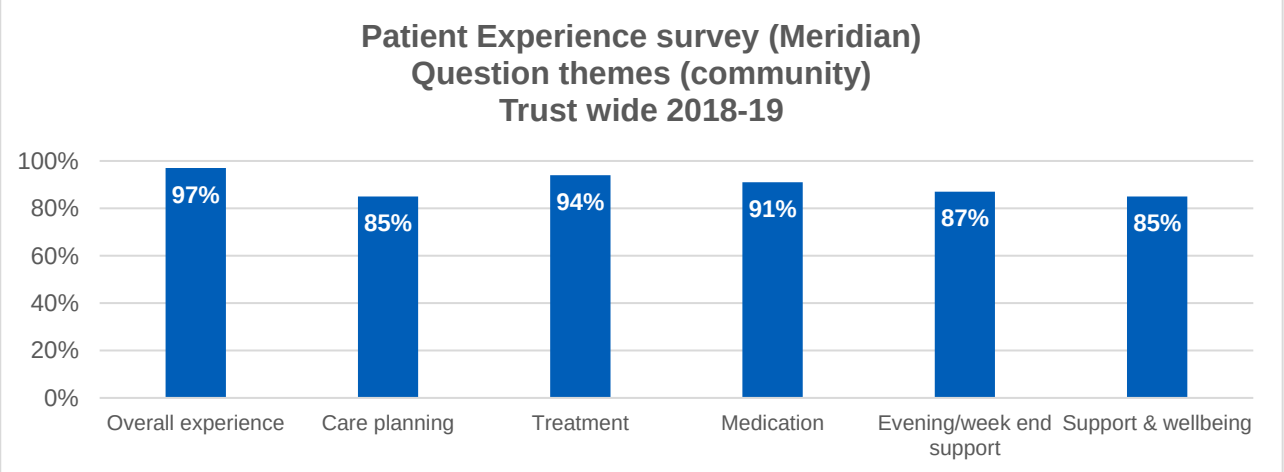
In total, 23,631 surveys were completed during 2018-19. This includes both directorate-wide surveys and team-specific surveys

It is important to note that the survey questions were changed in January 2018 following a comprehensive review involving patients and staff to ensure these were in line with national and statutory requirements and reflects what matters to our patients. Hence there are no comparative figures for 2017-18.

For the purpose of this report and into 2019-20, we are changing the way we report on our patient experience surveys by aggregating questions into themes to bring it in line with national trends, increase transparency, and link it with the CQC Key Lines of Enquiry (KLoE).

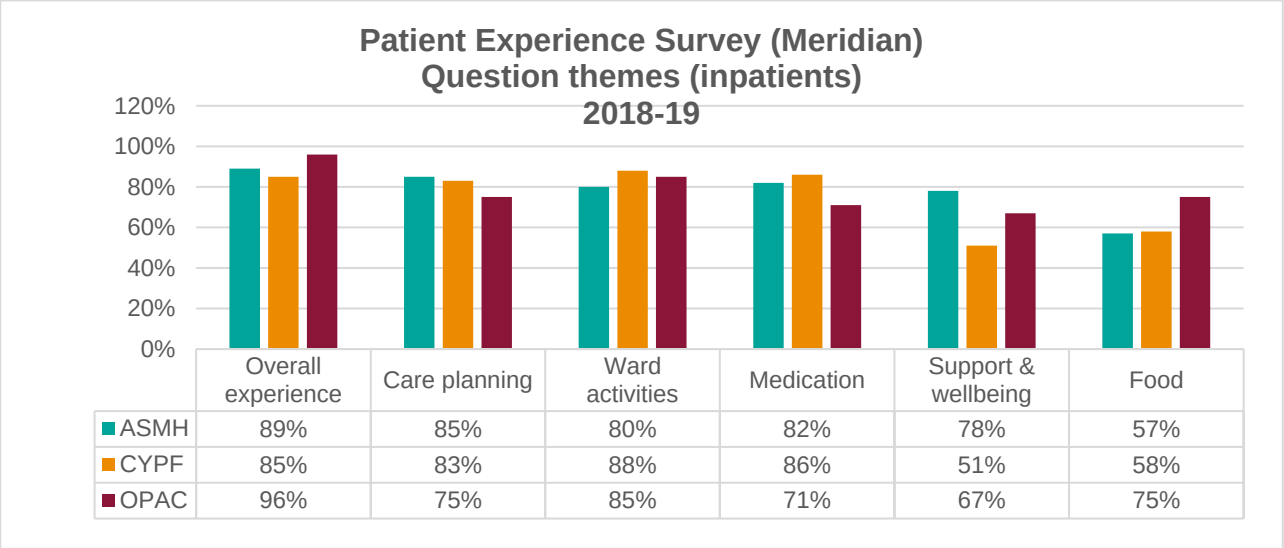


Our surveys show that our patients rate their overall experience of care highly in both the inpatient and community settings.



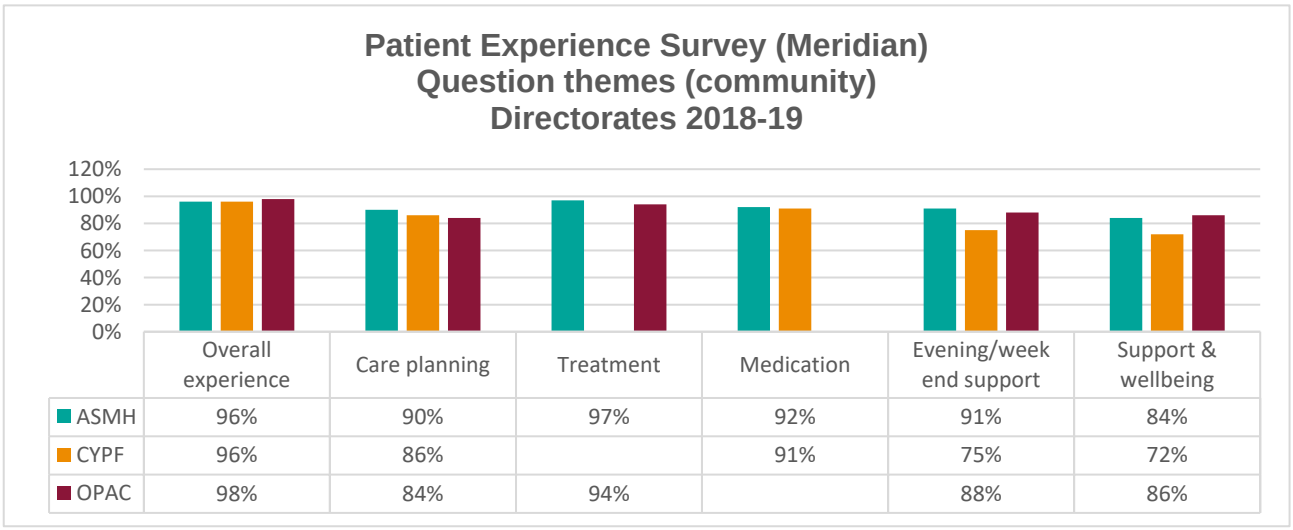
Directorate scores are presented below. 'Food' is discussed as a separate item in **3.3.7**.

Of the three directorates, OPAC has received the highest rates for 'overall experience' and 'food', and also rate quite highly in relation to ward activities; while CYPF is rated highly in relation to 'ward activities' and 'medication'.



	Overall experience	Care planning	Ward activities	Medication	Support & wellbeing	Food
ASMH	89%	85%	80%	82%	78%	57%
CYPF	85%	83%	88%	86%	51%	58%
OPAC	96%	75%	85%	71%	67%	75%

In the community, whilst OPAC has the highest rate in relation to the overall experience of care, all three directorates are rated very highly by their patients. The ASMH services have received the highest rate in relation to 'treatment' and have the highest scores overall.



	Overall experience	Care planning	Treatment	Medication	Evening/week end support	Support & wellbeing
ASMH	96%	90%	97%	92%	91%	84%
CYPF	96%	86%		91%	75%	72%
OPAC	98%	84%	94%		88%	86%

Notes:

1. *CYPF have decided to continue to focus on questions around 'medication' and exclude the treatment questions developed as part of the survey review in January 2018 to avoid making the survey too onerous for their patient group.*
2. *The questions around 'medication' were taken out of the OPAC survey as a vast majority of their patients have their medication prescribed by their GP. The question around 'treatment' was introduced to address this situation within the community services.*

Examples of comments made by our patients…

ASMH services

Inpatients

- *Care is great and everyone is lovely.*
- *The meals are good and there are plenty of snacks.*
- *It is a very safe environment. I don't feel I need support from staff to feel safe. The whole atmosphere created (but) staff and other patients make it a safe place to be. There is freedom to come and go as you please and having your own room with lock is important.*

Community

- *Crisis care, prompt response, and intervention. Mental health team all very good, the person who is care coordinator is excellent*
- *Non-judgmental, very specific to me and my issues/needs. Highly supportive and responsive. I feel they really want me to "recover" and be well and happy.*
- *I cannot imagine another service which would have given me the chance to explore my issues in such depth or with the level of support.*

CYPF services

Inpatients

- *The service has enabled our child to be assessed in a way that has never been completed in other settings. The understanding and compassion of staff has been excellent and have brought us as a family together and more understanding of our child's needs.*
- *Friendly supportive staff, fabulous to be able to stay with my child, and go home at weekend*

Community

- *Treatment has been discussed with us and options prior to commencing*
- *Effective treatment in a timely manner, communication and excellent strategies for getting my child motivated/engaged in therapy.*
- *Lots of support and sympathetic staff. Always have time to help. Lovely team.*

OPAC services

Inpatients

- *I have been well cared for. The staff are kind and friendly. The food has been very nice and on the whole I have been happy here.*
- *All care was very good, therapy was amazing*
- *I have been treated with dignity and respect by all staff. They have been very supportive.*

Community

- *I know each person by name that comes. Communication has been fantastic*
- *They brighten my day, does wonders for depression, especially when you are alone most the time.*
- *I have always been informed about medication, changes to, or addition of.*

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 identify key areas of development and improvement with our carers.

Responses to all questions have improved on the previous year.

Carer Experience survey 2017-18 and 2018-19 (CPFT data)

Question	2017-18	2018-19
1. Have you felt able to raise concerns about the care received for the person you care for?	93%	93%
2. Have you felt valued and listened to about the support the person you care for has received?	92%	94%
3. How would you rate the overall service received for the person you care for?	92%	92%
4. Have you felt included and involved in all stages of the journey for the person you care for?	89%	90%
5. How would you rate the support you receive as a carer?	85%	87%

Examples of comments made by carers

- *The care provided has been excellent.*
- *The team's attitude to the members of the household made us feel as if we had known them for years, making them very easy to communicate our needs to.*
- *Staff know the names of the people in their care, and the requirement of each person. Staff are patient and approachable.*
- *Very helpful and considerate team who cared for me as well as my husband.*
- *Staff have responded quickly and I am very happy how they have supported both of us. Everyone has shown great kindness.*
- *I always feel that I can discuss issues with the physio and my concerns are taken seriously.*
- *100% beyond the level I would have expected.*

Examples of actions our teams have taken in response to patient and carer feedback.

Care planning

- A ward has moved away from primary nursing and all patients are now nursed under **care teams** made up of nurses, healthcare assistants and nursing associates. This ensures a wider skill mix when caring for the patient and has seen an increase in paperwork compliance, 1:1 time and collaborative working.

Support and Wellbeing

- One ward has implemented **mindfulness groups** where staff and patients get together in the evenings and participate in the head space app. This has brought patients and staff closer together and allowed mindful reflection on events that have happened on the ward.

Overall experience

- One ward has recently purchased "Hello my name is….." name badges for all staff, these are easily seen by patients and relatives and immediately they know who they are talking to.

- A ward has purchased a very comfortable recliner chair for relatives who are staying with patients for long periods to aid their comfort, and also two pull out chair beds for relatives who wish to stay overnight with palliative patients.
- Young people on one ward can now bring in their own wall clocks for their room.

Food

- A ward operates a weekend programme where patients plan, budget, buy and prepare a meal they have agreed to as a group. Each week patients prepare afternoon tea where they bake scones and other snacks. Patients are asked to make their own toast in the morning and throughout the day should they want to. The ward manager purchases soup and fillings for sandwiches to promote independence and choice.

Activities

- Larger sized fancy costumes are now provided on a young person's ward following feedback from the young people.
- As part of the Occupational Therapy (OT) week a 'creation station' was placed in the main reception of one locality, which comprised of activities for patients to help reduce anxiety whilst waiting for their appointments. These included stress mats, sudoku puzzles, mindful colouring, crosswords, word searches, and postcards for patient feedback. Positive feedback was received so the stations have now been made a permanent resource in the reception area. Visitors are encouraged to participate whilst waiting and give suggestions on activities they would find helpful.

Medications Inpatients/Community:

- A Ward Clinical Nurse Specialist has set up psychoeducational teaching sessions for patients and carers. Medication side effect information is explained to patients in 1:1 sessions with staff and the medication team. Medication side effect information was also sourced in easy read format and other languages which are shared with patients on admission. Patients are reminded to raise any concerns they may have about worrying side effects as part of the morning community meetings.
- A ward has added discussions around medication and potential side effects to their wellbeing clinics at weekends to improve overall patient satisfaction in this area.

Carers

- Staff on a ward have developed a **carers' pack**, a bi-monthly **carers group**, and a monthly 'carers champion' calls to ensure carers are heard and are involved in the patients' recovery. The ward has been shortlisted for an 'Enabling Environment Assessment' for their work in this area.
- **Carer packs** have been created by one team and are emailed out to the carers at the point of admission. Each pack contains ward information, carer support and sign posting. They have also developed a debriefing sheet to allow carers to inform them of their preferences for receiving information. Carers have access to a' know me' sheet where they can share information vital to the care and treatment of the patient even when consent is not given. Carer feedback questionnaires are now sent by post to enable carers to complete this away from the ward and send this back.
- One ward has introduced a carers' phone call on admission which has improved relations between carer and staff, particularly in explanations around some of the restrictions on the ward and introducing oneself and the team to the carer. Carer contact sessions on Tuesdays and Saturdays have been introduced to give carer's update following on from clinical reviews on Mondays and Fridays. Information on medication are given to carers if needed.

3.3.7 Triangle of Care

Carers are vital partners in the planning and provision of mental and physical 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.

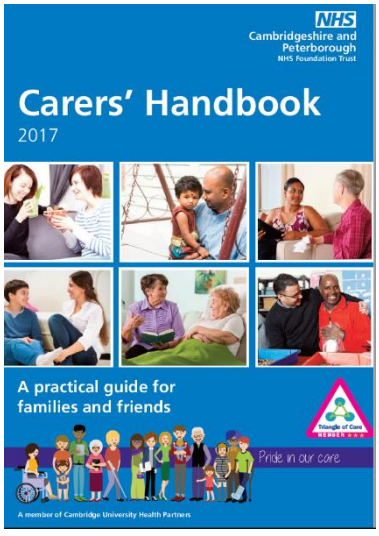
CPFT signed up to the *Triangle of Care* accreditation scheme in 2015-16. This was launched in the Trust with a series of workshops in October 2015.

We were awarded two gold stars in 2016 and a third star Trust in 2017-18 for achieving the Triangle of Care in the specialist community health services for adults and older people.

Examples of learning and improvements made in 2018-29

- ✓ Changes were made to the Core 2 assessment form in RiO, our electronic patient records system in our mental health services, to strengthen the Trust's compliance with the statutory requirements of the Care Act.
- ✓ Standard Operating Procedures were developed to support clinical staff with recording into the carers template within SystmOne, the electronic patient record system used in our physical health services.
- ✓ Delivery of training around consent and confidentiality. In line with the Triangle of Care principles, this was a collaboration between carers, service users and CPFT employees and provided an opportunity to bring together the different perspectives around consent and confidentiality to reach a consensus on what action would be in the best interest of patients.
- ✓ Development of a Consent and Confidentiality leaflet for service users/patients, carers and staff for both older peoples and community services and for adult specialist services

We have seen significant improvements in the recording of informal carers within both our mental and physical health services during the year. See pages 32 and 34.



Improvements planned for 2019-20

- We will ensure that there are clearly articulated processes for the completion of carer assessments.
- We will continue to monitor the number of carer assessments completed by staff where we have the responsibility for completing these.
- We will review the carer hand book to ensure this continues to reflect the needs of our carers.

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

Examples of initiatives we have implemented in the year to improve the experience of food in our wards include:

Trust level

- Menu changes in September 2018 following tasting events, and a further meu change in December for new patient sandwiches and desserts.

ASMH

- Activity coordinators have been appointed whose role include introducing cooking activities in the wards.
- 'Steamplicity' Tasting event at the Cavell Centre in October 2018 where patients and staff tasted the new range of food offered by one of our providers which informed the new menu.
- In one ward the patients cook meals for everyone three days a week and have individual cooking sessions. They also host 'Come dine with me' competition nights and have jacket potatoes two days a week.
- Another ward revised the rolling meal plan, provided additional fruit, cheese and meats to meet patients' preferences, purchased new tablecloths and cutlery and tried different ways of serving the meals (staff sitting with patients and varying mealtimes), and the housekeeper attempts to cater to patients' preferences.
- One ward operates a week end programme where the patients plan, budget, buy and prepare a meal they have agreed on as a group, each week patients prepare afternoon tea where they bake scones and other snacks, patients can make toast throughout the day and the ward purchases soup and fillings for sandwiches to promote independence and choice.
- In the eating disorder ward, the snack list was reviewed with the patients and new items added, salad was added with the evening meal in August 2018 and new midday hot meal items were added in December 2018 in response to requests from patients. A small working group was formed to look at ways to capture the experience of patients that reflect the nature of their needs, and regular meetings are held with catering colleagues at Cambridge University Hospitals (where the ward is located) to raise awareness on food portion guidelines.

CYPF

- The main area of discontent appears to be with the 'cook chill' provision. The wards have attempted to address this by providing condiments and fresh herbs and cooking the vegetable on site so it's not 'mushy'.

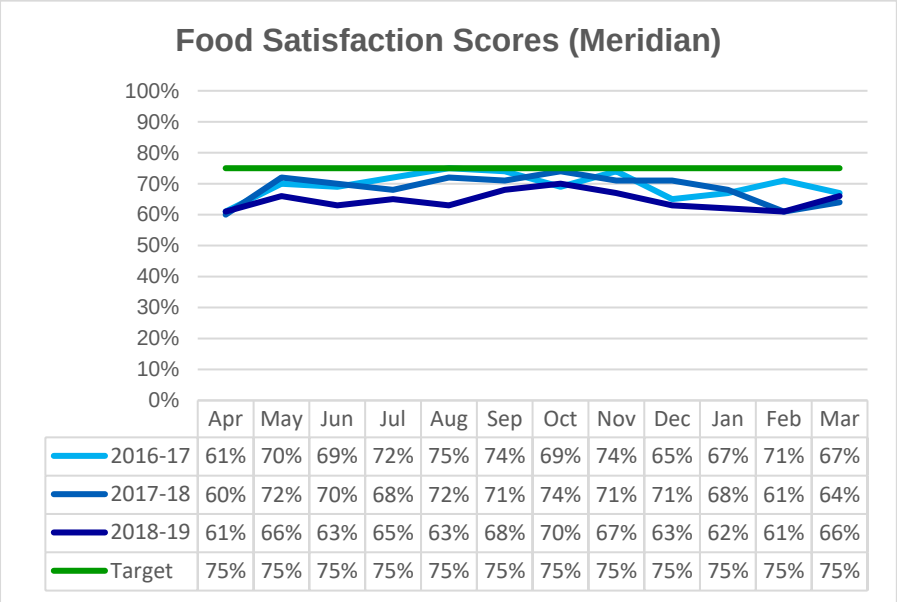
OPAC

- New blue crockery was introduced in the Maple wards

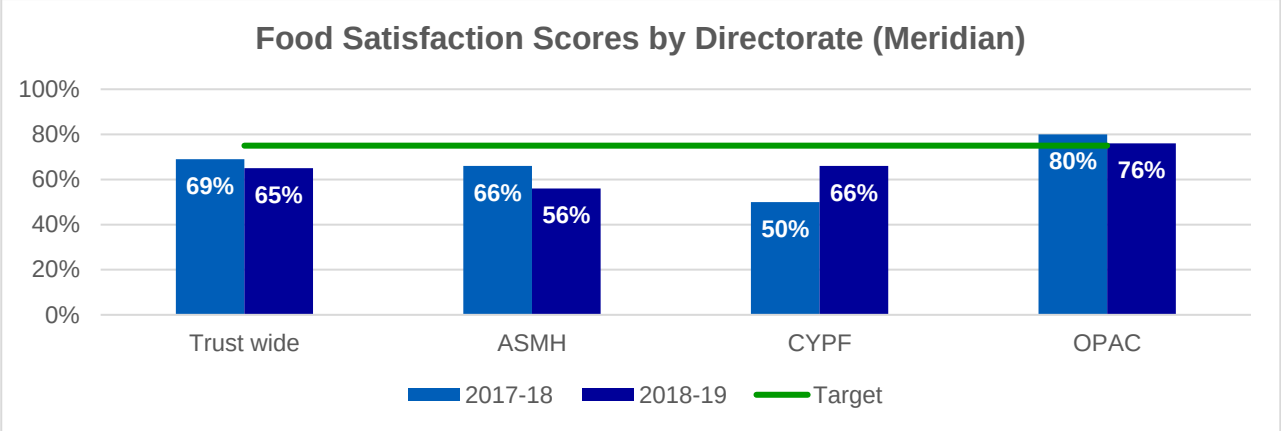
Food satisfaction scores have been declining for the last two years.

The overall average was 65% in 2018-19 from 69% in 2017-18 and 70% in 2016-17.

Directorate scores show a 10% decline in the ASMH services and a 4% decline in the OPAC services, while CYPF scores have increased by 16% during the year.



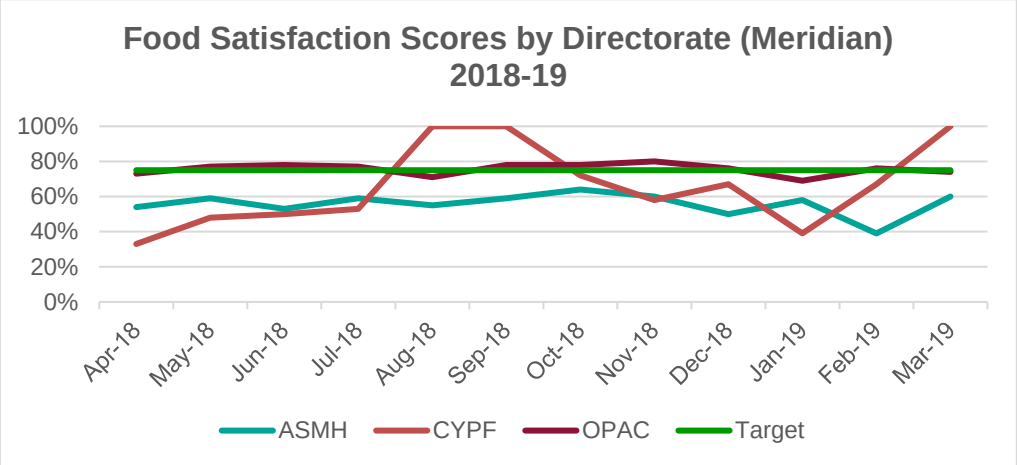
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17	61%	70%	69%	72%	75%	74%	69%	74%	65%	67%	71%	67%
2017-18	60%	72%	70%	68%	72%	71%	74%	71%	71%	68%	61%	64%
2018-19	61%	66%	63%	65%	63%	68%	70%	67%	63%	62%	61%	66%
Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%



The food scores in The Croft, our child and family unit, are consistently high because they do not have 'cook chill' meals whereas the other two wards in our children's services do. The spikes in the CYPF scores coincide with the period when the Phoenix Centre, our children's eating disorder unit, was temporarily closed and did not submit responses in March. ASMH and OPAC scores have been largely stable during the year.

How do we improve?

The Trust continues to collect and analyse patient feedback on their views on food and this is regularly reviewed within the directorates.



PLACE (Patient Led Assessments of the Care Environment)

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

It provides a snapshot of how an organisation is performing against a range of non-clinical activities that may impact on patient care. Twenty-one units across eight Trust sites were assessed, and the Trust overall scores for over three years are shown below, compared with the national average.

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 the wards providing this service only.*

Our PLACE scores have increased across all six domains in 2018 and are higher than the national average in five domains. Our score on 'Food' is the same as the national average at 90%.

PLACE 2018

	Cleanliness	Food	Privacy	Condition	Dementia	Disability
CPFT	100%	90%	92%	99%	93%	95%
Nat' ave	98%	90%	84%	94%	79%	84%

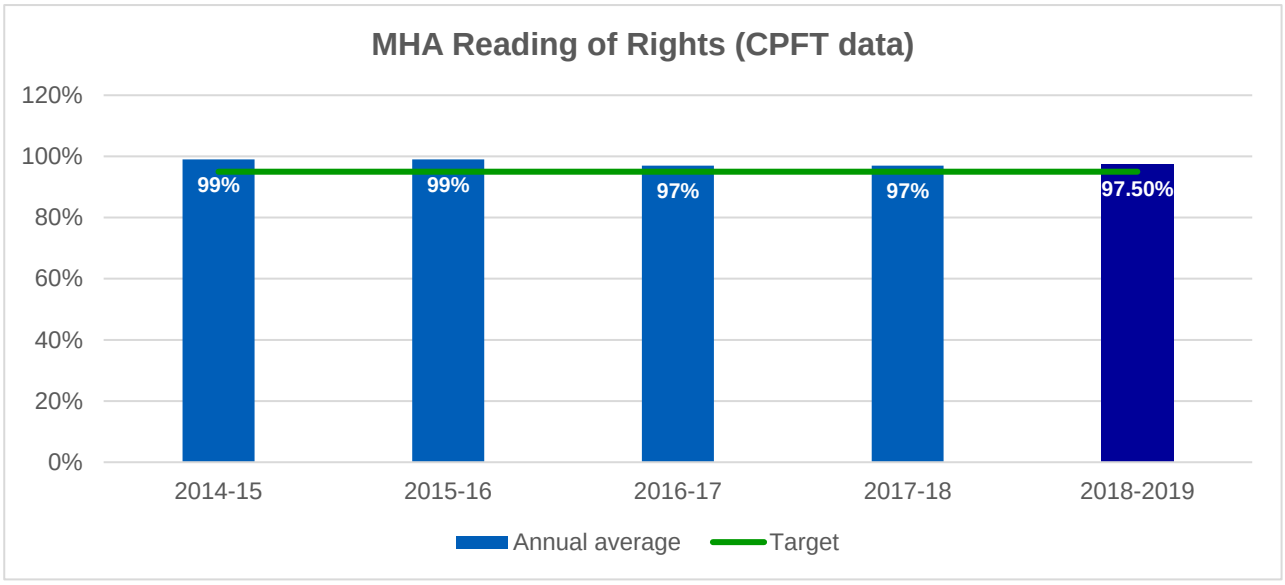
PLACE 2017

	Cleanliness	Food	Privacy	Condition	Dementia	Disability
CPFT	99%	87%	90%	96%	88%	91%
Nat' ave	98%	89%	84%	94%	77%	83%

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 97.5% compliance rate in 2018-19.



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 2018-19

- ***513 detained patients were referred to and seen by the Independent Mental Health Advocates (IMHA)***
- ***24 patients who lack capacity were referred to and seen by the Independent Mental Capacity Advocates (IMCA) and 106 children were referred and seen by the Children & Young People Advocates.***

'*VoiceAbility*'
is the commissioned Advocacy 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.

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

In collaboration with the Advocacy Service, the Trust continuous to develop processes and procedures, 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.

3.4 *Workforce*

3.4.1 Workforce Strategy

The CPFT Workforce Strategy 2016- 2021 was developed following consultation with staff, our governors and staff side in line with the implementation of the Trust's action plan from the national and internal staff surveys and identifies six key priorities which are shown below.

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.

During the year, we have reviewed our Workforce Strategy to support the long-term plans of the Trust in line with the new three-year Trust Strategy. This is being presented to the Board in May 2019 for ratification and sets out four strategic goals – **sustainable workforce for the future**, **healthy working environment**, **improved staff engagement** and **system partnership**.

We will report on this in the Quality Report 2019-20.

3.4.2 Integration

Integration and integrated care form an integral role in the future of the NHS and CPFT in order to face the challenges faced by the health and social care economy. This requires real partnerships and close collaborative working between services internally and external to the Trust.

In 2016, NHS organisations and local councils came together to form 44 ***sustainability and transportation partnerships (STPs)*** covering the whole of England and set out their proposals to improve health and care for patients.

Integrated care is care that is planned with people who work together to understand the needs of the patient and their carer(s), putting them in control, and coordinates and delivers services to achieve the best outcomes.

Local services can provide better and more joined-up care when different organisations and agencies work together. For staff, improved collaboration can help to make it easier to work with colleagues both within and external to the organisation support care delivery that is tailored to the needs of the individual, helping people to live healthier lives for longer and to stay out of hospital when they do not need to be there.

Integrated care offers the opportunity to make care closer to home a reality for the people who use our services.

Highlights of actions taken for improvement

- ✓ STP workforce governance structures have been reviewed and are in place with engagement across NHS providers, social and primary care.
- ✓ A system wide workforce plan has been developed for 2018-19 highlighting areas of focus in terms of shortage roles.
- ✓ A Memorandum of Understanding has been developed to enable and support the movement of staff across the system.
- ✓ An agency workstream is underway to understand usage across the system and develop proposals for more collaborative working.
- ✓ Terms and conditions have been reviewed across the system with a view to harmonise these, where appropriate.

3.4.3 Resourcing and Recruitment

The provision of high-quality care is dependent upon highly skilled, motivated and supported staff. Recruiting and retaining good quality staff is therefore integral to the provision of high-quality care.

We know that our staff stay with us when they feel that they can provide good quality care for their patients, when they can relate to our Trust's values, are recognised and supported in their roles, and when they are able to balance their work and home life, whilst continuing to learn, develop and remain safe and healthy.

During the year, we reviewed our **Recruitment and Retention Strategy**, and the 10-point plan was revised in collaboration with the clinical directorates to support the delivery of the strategy.

Values Based Recruitment (VBR)

The recruitment team is working collaboratively with patients and carers to ensure the Trust can recruit the right staff that live the Trust values, delivering training sessions in the Recovery College East to increase the number of patients and carers able to sit on interview panels.

CPFT achieved the Bronze Award under the Employer Recognition Scheme for the Armed Forces in November 2017 and continue to support army reservists to find meaningful employment in our services.

Other highlights of actions taken for improvement

- ✓ Implementation of a new recruitment system – TRAC - which has led to a more streamlined and effective recruitment process.
- ✓ An internal recruitment process was developed and launched, and a Peer Worker was employed to coordinate the activities of patients within the recruitment process.
- ✓ Attendance at targeted job fairs to increase exposure of CPFT employee brand.
- ✓ Participation in the NHS Improvement national retention programme.
- ✓ Recruitment open days and events carried out throughout the year with successful outcomes of appointing new starters across all professions.
- ✓ An *Exit interview* process is in place which provide valuable data to support future actions.
- ✓ A new '*Stay Survey*' was launched in February 2019 to understand what makes staff stay in the Trust and thus inform our strategy.
- ✓ A recruitment premia package is in place for hard to recruit to posts.
- ✓ A Staff Transfer Scheme was launched in the year.
- ✓ Continued recruitment of new apprenticeship posts.

The New Starter survey, launched in 2017, remains in place and informs actions to improve the experience of new starters. This includes:

- ***improving communication throughout the recruitment process***
- ***improvements made to streamline and speed up the recruitment process***
- ***development of on 'on-boarding' process to welcome and induct new starters prior to commencement, which include improved information for new starters and guidance for managers.***

3.4.4 Workforce Planning, Education, Training and Development

Effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high quality care to patients and service users. NHS Improvement 2019

At the beginning of the year, we submitted a 12-month **Workforce Plan** to the NHS Improvement (NHSI) and Health Education England (HEE), along with other NHS Trusts, to create a system wide plan over the next five years.

Other highlights of actions taken for improvement

- ✓ The *Allied Health Professionals (AHP) Strategy* and the revised *Nursing Strategy* were launched in the year.
- ✓ Further e-learning modules were developed for staff to support their continuous learning and development.
- ✓ We committed to a further cohort of trainees to support the *Nurse Associate* role.
- ✓ We continued to review and expand ways to fully utilise the *Apprenticeship Levy*.
- ✓ We have made clear improvements in our mandatory training compliance requirements in the year – achieving above 90% for all core mandatory modules.
- ✓ We made full use of the *Continuing Professional Development* (CPD) budget to ensure staff have access to CPD to support the delivery of personal and organisational aspirations and objectives.

A new Workforce Strategy has been developed and is currently under consultation.

3.4.5 Organisational Development

Organisation Development (OD) is the application of behavioural science to organisational and system issues to align strategy and capability and enhance people's collective capability to achieve shared goals.

In the NHS, Organisational Development is used to amplify the humanity in our organisations, enabling people to flourish, thrive and have meaning in their work in order to improve the quality and safety of patient care. NHS Employers 2019

During the year, we reviewed the **Leadership, Talent & Organisational Development Strategy 2019-22**, approved by the Board in March 2019, to provide a clear purpose for increasing capacity and capability across the Trust and embed a cultural shift and new ways of working.

Other highlights of actions taken for improvement

- ✓ The new Staff Handbook was updated in collaboration with staff from across the Trust and launched in July 2018.
- ✓ The Trust Leadership Development Programme and Management Development Programme were also launched in the autumn 2018, and formed part of our '*PRIDE in our Leadership*' offer to our staff.
- ✓ We have continued the development of the *Wider Leadership Team* meetings to be more inclusive and strategically focussed – linking with business and financial planning cycles and leadership competencies.
- ✓ The Cambridgeshire and Peterborough *Mary Seacole Leadership Programme* was launched in September 2018 which has seen significant numbers of staff participating in the programme across the system.
- ✓ Directorates and Teams have been supported throughout the year with a number of OD programmes and events.
- ✓ Personal and Leadership Development training modules are being developed

3.4.6 Supporting Staff

A significant body of evidence exists that links staff wellbeing at work to their productivity - staff who feel supported and secure with good work-life balance are more likely to have better physical and mental health and produce good work.

The latest NHS Staff Survey showed that less than a third of staff felt their organisation took positive action towards improving their health and wellbeing.

The survey findings for the Trust shows a drop in the 'Health & wellbeing' area from 6.1 in 2017-18 to 5.9 in 2018-19. Whilst this is in line with the national trend and is the same as the national average, we are disappointed with these results and we are working with our staff to develop an action plan to improve their experience of working in CPFT. See page 73 for more information.

During the year, we have implemented a number of programmes and initiatives to improve the support we provide to our staff.

New Equality & Diversity campaign

The Trust launched the equality, diversion and inclusion campaign in April 2018 to raise awareness of the equality, diversity and inclusion work within CPFT. This takes its principles from research that shows having a more diverse workforce increases employee satisfaction, fosters innovation and creativity, and improves decision making.

The 'Be Nice' campaign was launched in September 2018 to raise awareness of bullying and harassment and signpost staff on where to go for support. Posters with real life examples of working in CPFT from staff developed to support the campaign.

In 2016, the Trust funded four spaces on the Mindfulness 'train the trainer' course to support the sustainability of Mindfulness in CPFT. The Mindfulness team then developed an 8-week programme for all staff which included full 8-week courses, workshops, taster sessions and team sessions.

In October 2018, the Trust commissioned additional Mindfulness training.

What is Mindfulness?

Mindfulness is an ordinary experience (not a special state) of choosing to place one's awareness on the present moment, while gently acknowledging and accepting feelings, thoughts and bodily sensations. By being fully present in this way – not pushing feelings away or avoiding them, but actually being with them - we create space to respond in new ways to situations and make wise choices. Life can bring us trials and suffering, but with mindfulness we can work with our minds and bodies, learning how to live with more appreciation and less anxiety.

A new Health and Wellbeing Strategy was developed and ratified by the Board in in January 2019. A new Staff Wellbeing Lead was appointed to lead on the implementation of the strategy.

Other highlights of actions taken for improvement

- ✓ Successful implementation of the *Staff Wellbeing Service* pilot with confirmation of the service becoming permanent to support fast track physiotherapy, occupational therapy and wellbeing support.
- ✓ The *Wearing 2 Hats* group was successfully recognised via national awards.
- ✓ Exercise classes are being provided for staff, including yoga.
- ✓ Staff Matters on the intranet provide guidance and support for staff.
- ✓ The *Freedom to Speak Up Guardian* service is in place.
- ✓ The *Diversity Network* is growing and developing a new '*Embrace Campaign*'
- ✓ A successful Diversity conference was held in March 2018.
- ✓ A *Health and Wellbeing Week* was carried out in October 2018 with a number of wellbeing opportunities and events provided.
- ✓ An audit on Bullying and Harassment and violence against staff was completed with appropriate action plan developed.

3.4.7 Quality and Safety

We are committed to developing and training our staff to ensure that they maintain and develop the knowledge and skills they need to meet the requirements of their role and of the service and ensure the delivery of safe and high-quality care.

A new Coaching Strategy was agreed in December 2018 and was launched to support the development of our coaching culture in the Trust. This is supported by a coaching programme, commencing in January 2019 to develop a CPFT coaching pool.

Other highlights of actions taken for improvement

- ✓ Robust *Workforce and Recruitment* policies are in place which continue to be reviewed for improvements.
- ✓ The Trust's Training Needs Analysis (TNA) was reviewed and updated.
- ✓ Developments for the electronic *Health Roster*, the Trust's rostering system, was commenced to implement *HealthMedics* and *SafeCare* modules to support safer staffing and job planning.
- ✓ 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 refer 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 refer 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.

CRATE (Clinical Records Anonymisation and Text Extraction)
CRATE is published open-source de-identification software, developed by CPFT, that can take clinical records, remove identifying information to create a research database, automatically collate information such as questionnaire scores or blood tests from notes typed in by clinicians, and operates through CPFT’s pioneering consent system through which patients can choose to be contacted about research.

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.

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.

Quality Improvement (QI)
Quality Improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

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. In brief, an SI is an incident that occurred in relation to NHS-funded services and care resulting in: unexpected or avoidable death, serious harm, a provider organisation's inability to continue to deliver healthcare services, allegations of abuse, adverse media coverage and/or one of the core set of Never Events.

Social care
The provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.

TRAC recruitment system
TRAC systems provide an online software that can facilitate recruitment processes, from posting a new vacancy all the way to booking an applicant's induction course and start date.

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
16 May 2019

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) has reviewed the Quality Accounts produced by Cambridgeshire and Peterborough NHS Foundation Trust for 2018/19.

The CCG and CPFT work closely together to review performance against quality indictors and ensure any concerns or identified themes and trends are addressed to ensure that a high quality of care of the services CPFT provide is maintained.

CPFT is to be commended on a very readable and accessible Quality Account for 2018/19 which clearly outlines and demonstrates the hard work undertaken by the Trust and the direct impact this has on both patients and staff. CPFT have retained their rating of 'Good' following a CQC inspection published in June 2018 which highlighted numerous areas of outstanding practice including; debating workshop developed by staff for patients to encourage creative thinking on topical issues and identify improvements on the quality of service, innovation approaches in supporting young people with de-escalation and numerous examples of staff going the 'extra mile' to support patients' dignity and well-being. One of the key areas for improvement highlighted by the CQC was a Ligature review process within the Mental Health Areas, immediately on notification the policy and procedures were revised and strengthened, and the CCG supported the Trust in commissioning an independent qualitative review to evaluate the impact of the changes made. The CCG participated in area visits and was assured that significant progress had been made demonstrating positive steps in embedding an improvement culture within the Trust and consolidating their internal approach to Quality Improvement.

CPFT have a robust process to monitor and record Serious Incidents (SIs). The Trust provide quarterly learning events across directorates and a quarterly 'Learning in Practice' Bulletin setting out learning from SIs, complaints, Mortality review, patient experience and Freedom to Speak Up. The Serious Incident Group (SIG) and Mortality Review Groups (MRG) formed in 2017 have continued to evolve and strengthen its role in supporting the identification and dissemination of learning within and external to the Trust.

During 2018/19, 83 SIs were reported compared to 92 in 2017/18 and no Never events. The trust continues to be 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.

Significant improvements have been made at reducing avoidable harm and the Trust has seen a significant reduction in the number of Grade 3 and 4 pressure ulcers reported, with only 4 reported in the year from 10 in 2017/18. Although the number of incidents reported under slips, trips and falls has remained static there was reduction of 5% in the number of patient falls that led to moderate or severe harm. It is positive to see that falls remain a priority for 2019/20 with a target to increase staff training and awareness.

The CCG had been concerned at the number of incidents reported against 'actual/suspected self-inflicted harm' which has remained the highest reported category for the past 3 years. However, the number of confirmed suicides; which are those confirmed by the coroner have reduced since 2015/16. CPFT recognise that suicide prevention is a complex and challenging task and the CCG recognise the extensive work the Trust has undertaken with the development of the Zero Suicide Strategy and their open and collaborative approach to ensuring improvements are made and the learning from the SIs influence the wider system and focus priorities.

In spite of several initiatives in 2018/19 to support recruitment and retention and focus on staff wellbeing, it is disappointing to see that staff sickness has increased with a reason being related to work stress, there is also a decrease in staff satisfaction on communication between staff and senior managers within the Children, Young People and Families Directorate (CYPF). As with falls it is positive to see this as a priority for 2019/20 to ensure that high quality and compassionate care continue in a time of a challenging and constantly changing demand.

What comes across strong in the report is the high standards CPFT set for themselves and the extensive list of highlights demonstrating an innovative organisation. The First Response Service (FRS) which was established in 2016/17 continues to achieve National Recognition and is now being used as a model for National Implementation and The Windsor Ward Research Unit won the 'Celebration Award for Putting Patients First' at the clinical research network in October 2018 for their commitment to improving the patient experience. A huge success is that of a game developed by CPFT which gives insight into experiences of psychosis which has become a worldwide success earning 9 BAFTA nominations and winning 5 at the games award. There is excellent participation in clinical audit and research and CPFT was named top performing NHS Trust for mental health research in the East of England. The CCG would also like to congratulate the organisation on its 10th Birthday of being a Foundation Trust.

CPFT continue to be a pivotal role in supporting the development of our Primary Care Networks and future ways of working within Cambridgeshire and Peterborough. The CCG look forward to supporting and actively participating in the 15-step challenge across inpatient areas and working with CPFT internal Quality Assurance programme and priorities.

In conclusion Cambridgeshire and Peterborough CCG are pleased to report progress against the 2018/19 priorities both locally agreed and those nationally mandated and support the priorities identified for 2019/20.

Cambridgeshire and Peterborough NHS Foundation Trust

STATEMENT BY THE GOVERNORS
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST
22 May 2019

The Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) welcomes the opportunity to comment on the Trust's Quality Account for the year ending 2018-19. The report is well prepared and presented. The issues are highlighted and explained, and the actions to address these are linked.

We are happy to report that the governors have an open, transparent and collaborative relationship with the Trust. We have regular opportunities to hold the Non-Executive Directors to account, to inform service developments and the overall strategy of the organisation, and to contribute to the wider work of the Trust.

The report represents a huge exercise, presenting a significant amount of information setting out the performance of the Trust on key areas of its service, and shows CPFT performing well against various standards. We congratulate the Trust on its many achievements during the year.

We are pleased to note the progress on the quality priorities for 2018-19, most notably the reduction in patient falls, increase in memory assessments undertaken and improvements in patient survey scores around having a formal meeting to discuss care. We are particularly happy to see the significant increase in carer records, having been fully involved in agreeing the changes in the recording framework earlier in the year. We support the continued focus on carer records and the fresh focus on young carers in the coming year.

We also commend the Trust on the improvements in key performance indicators such as the Early Intervention in Psychosis (EIP), Improving Access to Psychological Therapies (IAPT) and Inappropriate Out of Area Placements, among other things.

On the other hand, we are concerned that the children's services were not able to meet its target of 95% risk assessment for young people on the waiting list. Mental health prominently tends to start in young people, and appropriate interventions including risk assessments are of the highest importance. However, we note the steady progress since the introduction of the revised processes and the 90% achievement as of March 2019. Staff wellbeing is also an area of concern, particularly staff sickness levels. We also feel it is unsatisfactory for staff to feel undervalued, not supported and the lack of communication from senior managers. We are confident that the Trust and the Chief Executive are taking this seriously and are working with staff to develop meaningful actions for improvement.

Overall, we are content with the report and will continue to work with the Trust to improve the health outcomes for the people in Cambridgeshire and Peterborough.

STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL
HEALTH COMMITTEE
17 May 2019

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 12th July 2018 and further followed up with CPFT at a meeting on 17th January 2019 to specially discuss the findings of the Ombudsman report into Eating Disorders and scrutinise CPFTs response to the report. Minutes of the discussions are available from the links below:

https://cambridgeshire.cmis.uk.com/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/876/Committee/6/Default.aspx

https://cambridgeshire.cmis.uk.com/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/882/Committee/6/Default.aspx

Representatives from CPFT, as a provider of the First Response Service (for patients experiencing a mental health crises) along with commissioners were also invited on 17th January 2019 to discuss the access arrangements to this service for patients living in Wisbech. The committee were reassured by commitments from both organisations that the arrangements for accessing out of hours services did work (Minutes of this meeting available from the link below):

https://cambridgeshire.cmis.uk.com/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/876/Committee/6/Default.aspx

In reviewing the Quality Account the Health Committee notes that pressure on services continues to increase, with a 10.09% rise in referrals between 2017/18 and 2018/19. The Trust has coped with this well and the CQC inspection in June 2018 gave an overall verdict of 'Good' for its services. There were some notable areas of progress in 2018-19, for example in falls reduction, with a 5% overall reduction mainly related to community services, and this remains a priority for 2019-20. This is well related to the STP work programme priorities.

In other areas there is evidence that the Trust has not reached some of its quality priority targets set for 2018/19, which means that its overall priorities for improvement - best care, innovation, best value and good staff experience of working in the trust – are still acknowledged as work in progress.

The priority areas selected for 2018-19 focused on reducing avoidable harm, improving health outcomes and improving experience of care. Most targets were achieved but some targets relating to training, data capture and recording were missed. This may link to the data recorded locally and through the NHS England staff survey about sickness absence, feelings of stress and motivation at work and, in the CYPF directorate about the quality of relationships between senior managers and staff (pages 13-18). Effective support and

training are key components of staff wellbeing and positivity about their workplace. Page 35-37 notes that there is ‘much to do to improve the health and wellbeing of our staff’.

The Health Committee has taken a particular interest in workforce development, recruitment and retention issues across the whole health care sector and continues to scrutinise this under the Sustainable Transformation programme (expecting an update report in July 2019). The Committee were encouraged to see that CPFT has focused on enhancing workforce quality and skills during 2018-19 and part of this has been working to embed a safety culture through a focus on it in staff appraisals, with acknowledged progress (pages 22 and 35). It is recognised that this work is ongoing and clarification on where this sits in the 2019-20 priorities has been requested. The ongoing work of training the trainers on the ‘Understanding Quality Service and Redesign’ programme is noted and Duty of Candour, Structured Judgements Reviews and Speaking Up all highlight work in progress by the Trust to drive ‘a definite change in attitudes and behaviour’ (pages 58-69).

The Health Committee were pleased to note that CPFT received a “Good” rating following their CQC inspection in March 2018. The ‘well led’ part of the CQC review highlighted some areas for management improvement including actions related to promoting equal opportunities, transparency and objectivity in recruitment and supporting diversity (page 56). The Committee would like to see further incorporation of this into the 2019-20 priorities for developing and supporting staff. Improving experience of care for patients and the experience of carers is reported, with progress during 2018-19 on two-thirds of the priorities set. The Committee was pleased to note a fairly low and reducing level of complaints was recorded for 2018-19; interestingly, this sits alongside a 15% decrease in compliments. A priority in this area for 2019-20 is to bring in the NHS complaints satisfaction survey and focus on shared learning, improving response times and reviewing the quality of action plans (page 98-100).

At present, the Trust sits in the average group of trusts of its type across England. However, it has commendable ambitions to improve on this during 2019-20. Health Committee members look forward to discussing these improvement plans with senior representatives from the Trust at their quarterly liaison meetings. The Health Committee members have maintained an open dialogue with senior leadership at the Trust through these valuable liaison meetings which are seen as an essential part of the health scrutiny function.

STATEMENT BY PETERBOROUGH HEALTH SCRUTINY COMMITTEE
15 May 2019

The Health Scrutiny Committee has welcomed the opportunity to comment on the Quality Account 2018/2019 for the Cambridgeshire and Peterborough NHS Foundation Trust.
The Committee found the Quality Account 2018/2019 for most part a very positive report with high levels of patient satisfaction in most areas and good overall outcomes. The document was easy to read and well-presented albeit quite lengthy and at times repetitious. The clear contents page allowed easy navigation throughout the document with abbreviations and acronyms explained as well as a glossary was welcomed by the Committee.

The Committee were pleased to see good honest reporting on Serious Incident and Structured Judgement Reviews with detailed learning outcomes in place and that CAMEO were continuing to build on its success with results above national targets.

Areas of concern for the Committee were:

- The workforce and staff issues but were pleased to see that one of the key priorities going forward was around supporting staff, strengthening staff engagement, reward and recognition of achievement, and maximising the value of the workforce whilst supporting and improving staff wellbeing.
- The Patient Survey regarding feedback on food which was showing as the lowest rating and would have liked to have seen examples of feedback from the Patient Survey.

The Committee feel that the Cambridgeshire and Peterborough NHS Foundation Trust on the whole are doing a great job under difficult circumstances.

The Chief Executive, Tracy Dowling attended a meeting of the Health Scrutiny Committee in March 2018 to assist in providing an update on key current local mental health work streams and Members were able to challenge and question the Chief Executive on mental health provision which had been a key theme of the Committees work programme for 2017/18. The Committee would welcome the Chief Executive at a future meeting of the Committee to receive a further update.

STATEMENT BY HEALTHWATCH CAMBRIDGESHIRE AND PETERBOROUGH
16 May 2019

Summary and comment on relationship
Healthwatch Cambridgeshire and Peterborough welcomes the opportunity to comment on the Trust's draft Quality Account.

There is a wealth of detail in the account, presented to enable the public to be very well informed about the teams and Trust services. It is clear that a huge amount of work goes on at all levels to both monitor and improve quality of care – often based on national requirements, but also including local initiatives such as the First Response Service and primary care mental health services.

Healthwatch enjoys good access to the Trust and information sharing is welcomed. In January we wrote a letter of concern about access to core mental health services 2019 summarising feedback from service seekers and their families over the year. This has helped to evidence some of your concerns too, and all parties including the CCG are finding ways to take these forwards. Noting the high figure for people referred to adult and specialist mental health services, we will particularly be interested in what proportion of these people taken on for a service, and how that affects their experience during 2019/20.

Highlighting improvements
Examples of good results or new developments are very encouraging to see:

- The high number of services which have or are working towards national accreditation
- The greater momentum now with regard to quality improvement, with a model adopted, 20 staff trained, and co-production as a core principle
- Continued good performance of the Psychological Well-being Service, with over 16,000 referrals, 99% satisfied patients and a 52% recovery rate
- Significant strides in improving engagement with carers across all three Directorates, good take up of the new e-learning module, and very good satisfaction rates reported by carers through your internal surveys.

However, some sections may be ambiguous to patients and service users:

- The Older People's and Community Directorate has set itself a target of reducing the number of missed insulin related incidents; the target is not achieved, but it is stated that "the Directorate views the increase in the number of incidents reported as a positive outcome". Perhaps this is to do with encouraging disclosure when mistakes are made?
- In discussing patients absconding, data is presented that these worrying patient safety events continue to increase year on year; however, the rate of increase is slowing down. Is it premature to say this is "a positive improvement"?

Challenges noted
We observe that Board reports have stated concerns about adherence to NICE guidelines. Here, the "significant improvements in implementing NICE guidelines in the year" describes improvement in processes and improving communications. It would be good to

see more clarity about services which at the end of the year more fully reflected NICE guidance compared to at the start, such as contained in national audit results but not summarised, and as described as an example for the guidance on decision making and mental capacity. This goes hand in hand with the challenges to implement routine outcome measures meaningful to patients, and to embed the use of new themes to better understand patient experience data.

The Account notes the high levels of complaints related to unmet needs in adult mental health. Whilst it is important to "proactively manage carer expectations," naturally we would urge the Trust to take steps to improve the ways in which legitimate needs can be met, as well as getting better at communicating the limitations to accessing care.

It is concerning that the rate of all types of absence from inpatient units continues to rise. Is this to do with more than impacts of the Smoke Free Policy?

It is hard to follow where the Trust's responsibilities now sit with regard to physical health checks for people with severe mental illness, compared to GPs - something patients and their families tell us. It appears that only 12% of those who should have had their physical health check completed during the year, did so. Now that the national CQUIN has been withdrawn we would urge that attention to this crucial area of patient safety is not lost. We note that complaints continue at over 100 per year in the Adult and Specialist Mental Health Directorate and note the priority to learn from complaints in all services. Board reports, but not this Account, show a failure against targets to resolve complaints within an average of 30 working days. Food satisfaction scores for patients are shown as having been below target for three years now. The Trust has outlined actions to improve this situation.

Looking to the future

We welcome the statement from the Trust that "our patients and their carers are truly at the heart of our strategy". Priorities to improve safety align to the most recent CQC rating. We share your concern about physical assaults on staff and acknowledge the hard work by everyone to provide the quality care represented in this Account.

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 2018-19* 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 2018 to 22 May 2019;
    - papers relating to quality reported to the Board over the period 1 April 2018 to 22 May 2019;
    - feedback from commissioners, Cambridgeshire and Peterborough Clinical Commissioning Group dated 17 May 2019;
    - feedback from the Council of Governors dated 22 May 2019
    - feedback from Healthwatch Cambridgeshire and Peterborough dated 16 May 2019;
    - feedback from Cambridgeshire Overview and Scrutiny Committee dated 17 May 2019
    - feedback from Peterborough Overview and Scrutiny Committee dated 15 May 2019
    - 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 2018-19"* dated 23 May 2019;
    - The national patient survey *'2018 National NHS Community Mental Health Service User Survey Management Report for Cambridgeshire and Peterborough NHS Foundation Trust'*;
    - The national staff survey "*2018 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 2019 dated 24 May 2019;
    - CQC Inspection Report dated 21June 2018.

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the Quality Report (available at https://improvement.nhs.uk/resources/nhs-foundation-trust-annual-reporting-manual/)

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

23 May 2019 Date.....Chairman

23 May 2019 Date.....Chief Executive

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 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

1. 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
2. Inappropriate out-of-area placements for adult mental health services

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 2018/19' 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 2018/19' 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 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2018 to 23 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 23 May 2019
- feedback from commissioners dated 16 May 2019;
- feedback from governors dated 22 May 2019;
- feedback from local Healthwatch organisations dated June 2018;
- feedback from the Overview and Scrutiny Committee dated 16 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 23 May 2019;
- the national patient survey dated 2018;

- the local patient survey dated June 2018;
- the national staff survey dated 2018;
- the local staff survey dated 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 8 May 2019;
- the Care Quality Commission's inspection report dated 21 June 2018

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 Council of Governors in reporting Cambridgeshire and Peterborough NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, 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 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques 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 2018/19' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Cambridgeshire and Peterborough NHS Foundation Trust. Our audit work on the financial statements of Cambridgeshire and Peterborough NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Cambridgeshire and Peterborough NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Cambridgeshire and Peterborough NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Cambridgeshire and Peterborough NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Cambridgeshire and Peterborough NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Cambridgeshire and Peterborough NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the 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 2019:

- 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 2018/19' 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 2018/19'; and
- the indicators in the 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 2018/19' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
110 Bishopsgate, London, EC2N 4AY

24 May 2019

SECTION 4: Annual Accounts 2018-19

Cambridgeshire and Peterborough NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Foreword to the accounts

Cambridgeshire and Peterborough NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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 **23 May 2019**

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	198,784	192,107
Other operating income	4	25,461	32,854
Operating expenses	6, 8	(217,382)	(216,654)
Operating surplus from continuing operations		**6,863**	**8,307**
Finance income	11	987	36
Finance expenses	12	(1,744)	(1,686)
PDC dividends payable		(2,008)	(2,250)
Net finance costs		**(2,765)**	**(3,900)**
Other gains / (losses)	13	-	9,667
Surplus for the year from continuing operations		**4,098**	**14,074**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(8,137)
Revaluations	15	830	-
Other reserve movements		-	2
Total comprehensive income for the period		**4,928**	**5,939**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Property, plant and equipment	14	81,626	82,870
Total non-current assets		**81,626**	**82,870**
Current assets			
Inventories		82	94
Receivables	18	23,514	33,533
Other investments / financial assets	16	20,220	-
Non-current assets held for sale / assets in disposal groups	19	1,375	955
Cash and cash equivalents	20	28,886	32,005
Total current assets		**74,077**	**66,587**
Current liabilities			
Trade and other payables	21	(27,191)	(27,512)
Borrowings	23	(778)	(744)
Provisions	25	(401)	(121)
Other liabilities	22	(8,072)	(5,707)
Total current liabilities		**(36,442)**	**(34,084)**
Total assets less current liabilities		**119,261**	**115,373**
Non-current liabilities			
Borrowings	23	(24,119)	(24,867)
Provisions	25	(1,244)	(1,548)
Other liabilities	22	(192)	(192)
Total non-current liabilities		**(25,555)**	**(26,607)**
Total assets employed		**93,706**	**88,766**
Financed by			
Public dividend capital		8,380	8,368
Revaluation reserve		23,519	22,689
Other reserves		33,733	33,733
Income and expenditure reserve		28,074	23,976
Total taxpayers' equity		**93,706**	**88,766**

The notes on pages 8 to 50 form part of these accounts.

Name	**Tracy Dowling**
Position	**Chief Executive**
Date	23 May 2019

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**8,368**	**22,689**	**33,733**	**23,976**	**88,766**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	4,098	**4,098**
Revaluations	-	830	-	-	**830**
Public dividend capital received	12	-	-	-	**12**
Taxpayers' equity at 31 March 2019	**8,380**	**23,519**	**33,733**	**28,074**	**93,706**

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**
Prior period adjustment	-	-	-	-	-
Taxpayers' equity at 1 April 2017 - restated	**8,158**	**38,127**	**33,732**	**2,600**	**82,617**
Surplus/(deficit) for the year	-	-	-	14,074	**14,074**
Impairments	-	(8,137)	-	-	**(8,137)**
Transfer to retained earnings on disposal of assets	-	(7,301)	-	7,301	-
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**

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	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		6,863	8,307
Non-cash income and expense:			
Depreciation and amortisation	6.1	4,601	5,192
Net impairments	7	-	9,574
(Increase) / decrease in receivables and other assets		10,332	(18,300)
(Increase) / decrease in inventories		12	25
Increase / (decrease) in payables and other liabilties		2,273	2,120
Increase / (decrease) in provisions		(24)	(212)
Net cash generated from / (used in) operating activities		**24,057**	**6,706**
Cash flows from investing activities			
Interest received		650	36
Purchase and sale of financial assets / investments		(20,220)	-
Purchase of property, plant, equipment and investment property		(3,176)	(3,796)
Sales of property, plant, equipment and investment property		-	20,410
Net cash generated from / (used in) investing activities		**(22,746)**	**16,650**
Cash flows from financing activities			
Public dividend capital received		12	210
Capital element of finance lease rental payments		(18)	(43)
Capital element of PFI, LIFT and other service concession payments		(696)	(696)
Other interest		(5)	-
Interest paid on finance lease liabilities		(50)	(55)
Interest paid on PFI, LIFT and other service concession obligations		(1,689)	(1,631)
PDC dividend (paid) / refunded		(1,984)	(2,330)
Net cash generated from / (used in) financing activities		**(4,430)**	**(4,545)**
Increase / (decrease) in cash and cash equivalents		**(3,119)**	**18,811**
Cash and cash equivalents at 1 April - brought forward		**32,005**	**13,194**
Cash and cash equivalents at 31 March	20.1	**28,886**	**32,005**

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 2018/19 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 the 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

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of revision and future periods if the revision affects both current and future periods.

The following are the judgements, apart from those involving estimations (see Note 1.2.1) 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 3 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 1.2.1 Key Sources of estimation uncertainty

The following are the key assumptions about the future and other key sources of estimation uncertainty at the end of the reporting year, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property Valuations
Valuation assumptions for Property, Plant and Equipment with carrying assets of £81.6m are based on valuations provided by the the Trust's Valuation Advisors, Boshier and Company, Chartered Surveyors as at 31 March 2019 in line with note 1.7.

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 2019/20. The Trust has accounted for this joint venture under the equity method in the year. However, the joint venture has not traded during the year.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The majority of the Trust's healthcare contracts are on a block basis, where it is deemed that performance obligations are met on an equal monthly basis. To this end, commissioners pay the annual contract value in 12 equal instalments during the year. Each instalment is paid during the month to which it relates. Where a contract is on a cost and volume basis, invoices are raised as the performance obligation is discharged in line with the timeline mandated within the NHS Standard Contract.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner against which performance obligations and payments are agreed on a quarterly basis.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

Note 1.4.2 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 1.4.3 Other income

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.

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. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

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 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 at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. The quinquennial valuation of land and buildings was undertaken as at 31st March 2019. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 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' cease 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 De-recognition

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 abandoned 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 useful 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful 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 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 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 1.9 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 Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Note 1.10.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.10.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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.

Financial assets are classified as subsequently measured at amortised cost.
Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.10.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.11 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 1.11.1 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 charge 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 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 1.11.2 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 1.12 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 27.2 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 1.13 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, but are disclosed in note 28 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 28, 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 1.14 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 1.15 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 1.16 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 1.17 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 1.18 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 1.19 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 1.20 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 1.21 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

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.
IFRS 17 *Insurance Contracts*	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the *FReM*: early adoption is not therefore permitted.
IFRIC 23 *Uncertainty over Income Tax Treatments*	Application required for accounting periods beginning on or after 1 January 2019.

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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
A & E income	1,397	1,393
Mental health services		
Cost and volume contract income	8,587	10,341
Block contract income	94,102	87,430
Clinical partnerships providing mandatory services (including S75 agreements)	13,666	13,976
Community services		
Community services income from CCGs and NHS England	70,343	67,841
Income from other sources (e.g. local authorities)	6,469	4,492
All services		
Private patient income	127	149
Agenda for Change pay award central funding	2,321	-
Other clinical income	1,772	6,485
Total income from activities	**198,784**	**192,107**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	11,673	12,529
Clinical commissioning groups	154,773	151,795
Department of Health and Social Care	2,321	-
Other NHS providers	10,179	7,068
NHS other	-	46
Local authorities	16,778	17,389
Non-NHS: private patients	127	149
Non NHS: other	2,933	3,131
Total income from activities	**198,784**	**192,107**
Of which:		
Related to continuing operations	198,784	192,107

Note 4 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	4,371	4,358
Education and training (excluding notional apprenticeship levy income)	8,858	9,246
Non-patient care services to other bodies	3,199	2,108
Provider sustainability / sustainability and transformation fund income (PSF / STF)	3,728	12,778
Other contract income	5,228	4,353
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	77	11
Total other operating income	**25,461**	**32,854**
Of which:		
Related to continuing operations	25,461	32,854

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	386
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	339

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2019
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000
within one year	6,584
after one year, not later than five years	1,488
after five years	-
Total revenue allocated to remainig performance obligations	**8,072**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 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:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	168,920	166,735
Income from services not designated as commissioner requested services	29,864	25,372
Total	**198,784**	**192,107**

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	1,917	1,833
Staff and executive directors costs	157,511	149,062
Remuneration of non-executive directors	151	144
Supplies and services - clinical (excluding drugs costs)	2,458	2,567
Supplies and services - general	10,146	9,536
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,181	1,221
Consultancy costs	149	132
Establishment	2,711	3,831
Premises	11,626	11,237
Transport (including patient travel)	3,372	1,799
Depreciation on property, plant and equipment	4,601	5,192
Net impairments	-	9,574
Movement in credit loss allowance: contract receivables / contract assets	(55)	
Movement in credit loss allowance: all other receivables and investments	171	55
Audit fees payable to the external auditor		
audit services- statutory audit	41	46
other auditor remuneration (external auditor only)	5	6
Internal audit costs	79	109
Clinical negligence	851	715
Legal fees	411	395
Insurance	55	50
Research and development	4,513	4,516
Education and training	5,711	5,015
Rentals under operating leases	3,595	3,749
Redundancy	114	194
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	2,181	2,167
Car parking & security	200	117
Hospitality	59	50
Losses, ex gratia & special payments	1	1
Other	3,627	3,341
Total	**217,382**	**216,654**
Of which:		
Related to continuing operations	217,382	216,654

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 7 Impairment of assets

	2018/19 £000	2017/18 £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**

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	131,105	121,625
Social security costs	11,533	10,691
Apprenticeship levy	612	567
Employer's contributions to NHS pensions	15,703	14,698
Termination benefits	114	194
Temporary staff (including agency)	6,880	9,558
Total gross staff costs	**165,947**	**157,333**
Recoveries in respect of seconded staff	-	-
Total staff costs	**165,947**	**157,333**
Of which		
Costs capitalised as part of assets	384	453

Note 8.1 Retirements due to ill-health

During 2018/19 there were 4 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £478k (£566k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases

Note 10.1 Cambridgeshire and Peterborough NHS Foundation Trust as a lessor

Nil for 2018/19 and 2017/18.

Note 10.2 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.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	3,595	3,749
Total	**3,595**	**3,749**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	3,055	3,392
- later than one year and not later than five years;	1,264	3,824
- later than five years.	-	-
Total	**4,319**	**7,216**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	145	36
Other finance income	842	-
Total finance income	**987**	**36**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19	2017/18
	£000	£000
Interest expense:		
Finance leases	50	55
Interest on late payment of commercial debt	5	-
Main finance costs on PFI and LIFT schemes obligations	1,139	1,139
Contingent finance costs on PFI and LIFT scheme obligations	550	492
Total interest expense	**1,744**	**1,686**
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	**1,744**	**1,686**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	5	-

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	-	9,671
Losses on disposal of assets	-	(4)
Total gains / (losses) on disposal of assets	**-**	**9,667**
Total other gains / (losses)	**-**	**9,667**

Note 14.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**9,635**	**72,372**	**1,243**	**1,614**	**13,408**	**1,283**	**99,555**
Additions	-	778	1,223	229	611	106	**2,947**
Revaluations	100	(2,454)	-	-	-	-	**(2,354)**
Reclassifications	-	248	(1,152)	182	722	-	**-**
Transfers to / from assets held for sale	(185)	(250)	-	-	-	-	**(435)**
Disposals / derecognition	-	-	-	-	(329)	-	**(329)**
Valuation/gross cost at 31 March 2019	**9,550**	**70,694**	**1,314**	**2,025**	**14,412**	**1,389**	**99,384**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**5,488**	**-**	**1,031**	**9,140**	**1,026**	**16,685**
Provided during the year	-	2,544	-	113	1,834	110	**4,601**
Revaluations	-	(3,184)	-	-	-	-	**(3,184)**
Transfers to / from assets held for sale	-	(15)	-	-	-	-	**(15)**
Disposals / derecognition	-	-	-	-	(329)	-	**(329)**
Accumulated depreciation at 31 March 2019	**-**	**4,833**	**-**	**1,144**	**10,645**	**1,136**	**17,758**
Net book value at 31 March 2019	**9,550**	**65,861**	**1,314**	**881**	**3,767**	**253**	**81,626**
Net book value at 1 April 2018	**9,635**	**66,884**	**1,243**	**583**	**4,268**	**257**	**82,870**

Note 14.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**20,825**	**87,506**	**3,226**	**1,465**	**11,940**	**1,233**	**126,195**
Valuation / gross cost at 1 April 2017 - restated	**20,825**	**87,506**	**3,226**	**1,465**	**11,940**	**1,233**	**126,195**
Additions	-	1,354	1,201	207	963	50	**3,775**
Impairments	-	(17,122)	(1,549)	-	-	-	**(18,671)**
Reclassifications	-	1,094	(1,635)	36	505	-	**-**
Transfers to / from assets held for sale	(11,190)	(460)	-	-	-	-	**(11,650)**
Disposals / derecognition	-	-	-	(94)	-	-	**(94)**
Valuation/gross cost at 31 March 2018	**9,635**	**72,372**	**1,243**	**1,614**	**13,408**	**1,283**	**99,555**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**3,348**	**-**	**952**	**7,276**	**924**	**12,500**
Accumulated depreciation at 1 April 2017 - restated	**-**	**3,348**	**-**	**952**	**7,276**	**924**	**12,500**
Provided during the year	-	3,115	-	111	1,864	102	**5,192**
Impairments	-	(960)	-	-	-	-	**(960)**
Transfers to / from assets held for sale	-	(15)	-	-	-	-	**(15)**
Disposals / derecognition	-	-	-	(32)	-	-	**(32)**
Accumulated depreciation at 31 March 2018	**-**	**5,488**	**-**	**1,031**	**9,140**	**1,026**	**16,685**
Net book value at 31 March 2018	**9,635**	**66,884**	**1,243**	**583**	**4,268**	**257**	**82,870**
Net book value at 1 April 2017	**20,825**	**84,158**	**3,226**	**513**	**4,664**	**309**	**113,695**

Note 14.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019							
Owned - purchased	9,550	31,435	1,314	881	3,767	253	**47,200**
Finance leased	-	3,311	-	-	-	-	**3,311**
On-SoFP PFI contracts and other service concession arrangements	-	31,084	-	-	-	-	**31,084**
Owned - donated	-	31	-	-	-	-	**31**
NBV total at 31 March 2019	**9,550**	**65,861**	**1,314**	**881**	**3,767**	**253**	**81,626**

Note 14.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018							
Owned - purchased	9,635	33,503	1,243	583	4,268	257	**49,489**
Finance leased	-	1,922	-	-	-	-	**1,922**
On-SoFP PFI contracts and other service concession arrangements	-	31,426	-	-	-	-	**31,426**
Owned - donated	-	33	-	-	-	-	**33**
NBV total at 31 March 2018	**9,635**	**66,884**	**1,243**	**583**	**4,268**	**257**	**82,870**

Note 15 Revaluations of property, plant and equipment

All the freehold properties owned by the Foundation Trust were valued by Boshier & Company Chartered Surveyors in the 2018/19 financial year. This valuation represents the Trust's Quinquennial valuation. The properties were valued as at 31st March 2019. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of financial position date. In practice the Trust will ensure that there is a full quinquennial valuation and an interim valuation in the third year of each quinquennial cycle. In any intervening year the Trust will carry out a review of movements in appropriate land and building indices and where material fluctuations occur, will engage the services of a professional valuer to determine appropriate adjustments to the valuations of assets to ensure that book values reflect current values. Current values are determined as follows:

- Land and non specialised buildings – market value for existing use/modern equivalent asset
- Specialised building - Depreciated Replacement Cost

The valuations were in accordance with the requirements of the RICS valuation standards sixth edition and the international valuation standards. The valuation of each property was on the basis of market value, subject to the following assumptions:-

i) For owner occupied property: that the property would be sold as part of the continuing enterprise in occupation;
ii) For investment property: that the property would be sold subject to any existing leases;
iii) For surplus property and property held for development: that the property would be sold with vacant possession in its existing condition;

The Valuer's opinion of market value was primarily derived using:
i) Comparable recent market transactions on arm's length terms;
ii) The depreciated replacement cost method of valuation as the specialised nature of the asset means that there is no market transactions of this type of asset except as part of the enterprise in occupation and is subject to the prospect and viability of the continued occupation and use.

Plant and equipment that have not been revalued are shown at their depreciated value.

Note 16 Other investments / financial assets (current)

	31 March 2019 £000	31 March 2018 £000
Loans receivable within 12 months transferred from non-current financial assets	-	-
Deposits with the National Loans Fund	-	-
Other current financial assets	20,220	-
Total current investments / financial assets	**20,220**	**-**

Other current financial assets relates to a cash loan provided to the Department of Health and Social Care. This loan was transacted on 1st June 2018 and will remain in place until the Trust notifies the Department of Health and Social Care of the intention to terminate the agreement.

The loan yields 5% interest per annum.

Note 17 Disclosure of interests in other entities

UnitingCare Partnership LLP

UnitingCare Partnership LLP was a partnership set up between the Trust and Cambridge University Hospitals NHS Foundation Trust to bid for the Adults and Older People's services put out to tender by the Cambridgeshire and Peterborough Clinical Commissioning Group. The LLP was successful in securing this contract and as such took responsibility for the provision of these services from 1st April 2015. The LLP ceased trading on 3rd December 2015 .

There have been no payments since 2016/17, and the LLP will be formally wound up in 2019/20.

Cambridge University Health Partnership

Cambridge University Health Partners (CUHP) was designated an Academic Health Science Centre by the Department of Health in March 2009. The entity became fully established as a company limited by guarantee on 11th September 2009, with CPFT (as one of the four partners) underwriting 25% of the guarantee costs. The objectives of CUHP are to drive forward the partnership between the National Health Service (NHS) and the University of Cambridge.

The Trust has accepted as part of the members agreement a recurrent funding requirement of £103,300 (2017/18: £103,300), however the agreement requires unanimous confirmation of partners for any additional funding.

In view of the arrangements set out in the members agreement with CUHP, the Trust considers CUHP to be an Associate. However it has not been accounted for under the equity method as it is the Trust's view that the investment is not material.

Note 18.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	21,809	
Trade receivables*		16,195
Accrued income*		15,824
Allowance for impaired contract receivables / assets*	(264)	
Allowance for other impaired receivables	(409)	(806)
Prepayments (non-PFI)	1,362	1,420
Interest receivable	337	-
PDC dividend receivable	235	259
VAT receivable	194	393
Other receivables	250	248
Total current trade and other receivables	**23,514**	**33,533**
Of which receivables from NHS and DHSC group bodies:		
Current	19,867	29,630
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 18.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**806**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	450	(450)
New allowances arising	18	171
Changes in existing allowances	(73)	-
Utilisation of allowances (write offs)	(131)	(118)
Allowances as at 31 Mar 2019	**264**	**409**

Note 18.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**814**
Prior period adjustments	
Allowances as at 1 Apr 2017 - restated	**814**
Transfers by absorption	
Increase in provision	55
Amounts utilised	(63)
Unused amounts reversed	
Allowances as at 31 Mar 2018	**806**

Note 18.4 Exposure to credit risk

The main receivables of the Trust are accounts receivable and loans receivable related to the loan to the Department of Health and Social Care (DHSC). The former have a low degree of credit risk (risk concerning non-payment of an agreement by the counterparty). In accordance with good practice, the Trust strives to promptly identify and reduce concerns about collection by regularly monitoring the Trust's aged debt and providing an update to the Board and other Committees as to actions being taken to address outstanding payment. Collection risk is minimal as the majority of income sources are DHSC bodies. The Trust has no significant concentrations of credit risk with any counterparty.

Measuring the expected credit loss for accounts receivable:

Days Past Due:	Current	1 to 30 days	30 to 60 Days	60 - 90 Days	Over 90 Days	Over a year old	Specific	Total
Expected Credit Loss	1.50%	3%	5%	10%	25%	80%	100%	-
Accounts Receivable	2,041,451	2,073,408	256,993	15,442	831,016	354,483	75,033	5,647,826
Lifetime Expected Credit Losses	30,622	62,202	12,850	1,544	207,754	283,587	75,033	673,592

Note 19 Non-current assets held for sale and assets in disposal groups

	2018/19 £000	2017/18 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**955**	**-**
Prior period adjustment		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**955**	**-**
Transfers by absorption	-	-
Assets classified as available for sale in the year	420	11,635
Assets sold in year	-	(10,680)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**1,375**	**955**

The Trust has previously classified Vinery Road Site (Cambridge) as held for sale. It carries a net book value as at 31st March 2019 of £510,000 relating to land and £445,000 buildings. It is expected to be sold on the open market during 2019/20. The asset is currently vacant and surplus to Trust requirements.

During 2018/19, following Board approval, the Trust classified the following assets as held for sale:

- Drybread Road, Whittlesey
- Victoria Road, Wisbech

Drybread Road carries a net book value as at 31st March 2019 of £95,000 relating to land and £132,000 buildings, and Victoria Road carries a net book value of £90,000 relating to land and £103,000 buildings. Both properties are expected to be marketed and sold on the open market during 2019/20. Drybread Road is currently occupied, and Victoria Road is currently vacant.

Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**32,005**	**13,194**
Prior period adjustments	-	-
At 1 April (restated)	**32,005**	**13,194**
Net change in year	(3,119)	18,811
At 31 March	**28,886**	**32,005**
Broken down into:		
Cash at commercial banks and in hand	385	382
Cash with the Government Banking Service	28,501	31,623
Total cash and cash equivalents as in SoFP	**28,886**	**32,005**
Total cash and cash equivalents as in SoCF	**28,886**	**32,005**

Note 20.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019	31 March 2018
	£000	£000
Bank balances	95	93
Total third party assets	**95**	**93**

Note 21.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	6,819	3,836
Capital payables	221	450
Accruals	14,111	17,326
Other taxes payable	2,436	2,975
Other payables	3,604	2,925
Total current trade and other payables	**27,191**	**27,512**
Of which payables from NHS and DHSC group bodies:		
Current	2,543	1,852
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 22 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	8,072	5,707
Total other current liabilities	**8,072**	**5,707**
Non-current		
Net pension scheme liability	192	192
Total other non-current liabilities	**192**	**192**

The movement in deferred income includes funding from the Hamadi Medical Corporation in Qatar for future services to be provided of £1.5m

Note 23 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Obligations under finance leases	20	17
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	758	727
Total current borrowings	**778**	**744**
Non-current		
Obligations under finance leases	178	199
Obligations under PFI, LIFT or other service concession contracts	23,941	24,668
Total non-current borrowings	**24,119**	**24,867**

Note 23.1 Reconciliation of liabilities arising from financing activities

	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2018	**216**	**25,395**	**25,611**
Cash movements:			
Financing cash flows - payments and receipts of principal	(18)	(696)	**(714)**
Financing cash flows - payments of interest	(50)	(1,139)	**(1,189)**
Non-cash movements:			
Application of effective interest rate	50	1,139	**1,189**
Carrying value at 31 March 2019	**198**	**24,699**	**24,897**

Note 24 Finance leases

Note 24.1 Cambridgeshire and Peterborough NHS Foundation Trust as a lessee

Obligations under finance leases where Cambridgeshire and Peterborough NHS Foundation Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**480**	**551**
of which liabilities are due:		
- not later than one year;	67	67
- later than one year and not later than five years;	220	242
- later than five years.	193	242
Finance charges allocated to future periods	(282)	(335)
Net lease liabilities	**198**	**216**
of which payable:		
- not later than one year;	20	17
- later than one year and not later than five years;	66	75
- later than five years.	112	124

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**201**	**1,179**	**159**	**130**	**1,669**
Transfers by absorption	-	-	-	-	-
Change in the discount rate	-	-	-	-	-
Arising during the year	83	38	-	-	**121**
Utilised during the year	(69)	(64)	(12)	-	**(145)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-
Reversed unused	-	-	-	-	-
Unwinding of discount	-	-	-	-	-
At 31 March 2019	**215**	**1,153**	**147**	**130**	**1,645**
Expected timing of cash flows:					
- not later than one year;	70	54	147	130	**401**
- later than one year and not later than five years;	144	213	-	-	**357**
- later than five years.	1	886	-	-	**887**
Total	**215**	**1,153**	**147**	**130**	**1,645**

Pension: Early Departure Costs - This reflects the liabilities arising from early retirements.

Pension: Injury Benefits - This reflects the liabilities arising from injury benefits.

Legal claims - This reflects potential claims against the NHSLA scheme and provision for employer tribunal costs.

Other - reflects provisions arising from dilapidations for Trust properties.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions

Note 25.2 Clinical negligence liabilities

At 31 March 2019, £12,658k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Cambridgeshire and Peterborough NHS Foundation Trust (31 March 2018: £13,032k).

Note 26 Defined benefit pension schemes

The Trust employs a small number of staff that transferred from Cambridgeshire Community Services NHS Trust on 1 April 2015 as members of the Local Government Pension Scheme (LGPS). These staff formerly worked for Cambridgeshire County Council but transferred into the NHS in April 2004 as part of the Cambridgeshire wide section 75 agreement for the provision of Health and Social Care for Older People. The LGPS is a defined benefit statutory scheme administered in accordance with the Local Government Pension Scheme Regulations. The Trust became an admitted body to the scheme effective on 1 April 2015.

The balances and transactions in relation to the LGPS are immaterial to the financial statements.

Note 26.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2018/19	2017/18
	£000	£000
Present value of the defined benefit obligation at 1 April	(2,055)	(2,055)
Present value of the defined benefit obligation at 1 April - restated	(2,055)	(2,055)
Present value of the defined benefit obligation at 31 March	(2,055)	(2,055)
Plan assets at fair value at 1 April	1,863	1,863
Plan assets at fair value at 1 April -restated	1,863	1,863
Plan assets at fair value at 31 March	1,863	1,863
Plan surplus/(deficit) at 31 March	(192)	(192)

Note 26.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2019	31 March 2018
	£000	£000
Present value of the defined benefit obligation	(2,055)	(2,055)
Plan assets at fair value	1,863	1,863
Net defined benefit (obligation) / asset recognised in the SoFP	(192)	(192)
Fair value of any reimbursement right	-	-
Net (liability) / asset recognised in the SoFP	(192)	(192)

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

Note 27.1 Imputed finance lease obligations

Cambridgeshire and Peterborough NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**39,744**	**41,549**
Of which liabilities are due		
- not later than one year;	1,835	1,835
- later than one year and not later than five years;	7,196	7,249
- later than five years.	30,713	32,465
Finance charges allocated to future periods	(15,045)	(16,154)
Net PFI, LIFT or other service concession arrangement obligation	**24,699**	**25,395**
- not later than one year;	758	727
- later than one year and not later than five years;	3,235	3,148
- later than five years.	20,706	21,520

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**142,528**	**146,926**
Of which liabilities are due:		
- not later than one year;	4,508	4,398
- later than one year and not later than five years;	19,189	18,721
- later than five years.	118,831	123,807

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**4,566**	**4,680**
Consisting of:		
- Interest charge	1,139	1,139
- Repayment of finance lease liability	696	696
- Service element and other charges to operating expenditure	2,181	2,167
- Capital lifecycle maintenance	-	186
- Contingent rent	550	492
Total amount paid to service concession operator	**4,566**	**4,680**

The Trust is committed to make payments in relation to service charges on its PFI scheme. The charges are subject to an index linked inflation adjustment each year.

On 19th June 2007 the Trust concluded contracts under the Private Finance Initiative (PFI) with Peterborough (Progress Health) PLC for the construction of a new 102 bed hospital and the provision of hospital related services.

The PFI scheme was approved by the NHS Executive and HM Treasury as being better value for money than the public sector comparator. Under IFRIC 12, the PFI scheme is deemed to be on statement of Financial Position, meaning that the hospital is treated as an asset of the Trust, being acquired through a finance lease. The payments to Progress Health in respect of the facility (Cavell Centre) have therefore been analysed into finance lease charges and service charges. The accounting treatment of the PFI scheme is detailed in the accounting policies note.

The service element of the contract was £2,181,000 (2017/18: £2,167,000). The Cavell Centre was handed over to the Trust in two phases in November 2008 and May 2009. Payments under the scheme commenced in November 2008. The agreement is due to end in November 2042.

The estimated value of the scheme at inception was £25,700,000.

Note 28 Financial instruments

Note 28.1 Financial risk management

Financial risk management
Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with clinical commissioning groups and the way those clinical commissioning groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Market Risk
Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. A significant proportion of the Trust's transactions are undertaken in sterling and so its exposure to foreign exchange risk is minimal. It holds no significant investments other than short-term bank deposits. Other than cash balances, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cashflows are substantially independent of changes in market interest rates.

Interest Rate Risk
The Trust exposure to interest rate risk is primarily in relation to the PFI, details which are set out in Note 27.

Credit Risk
Because the majority of the Trust revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk
The Trust operating costs are incurred under contracts with healthcare commissioners which are financed from resources voted annually by Parliament . The Trust is not, therefore, exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	21,723	-	-	**21,723**
Other investments / financial assets	20,220	-	-	**20,220**
Cash and cash equivalents at bank and in hand	28,886	-	-	**28,886**
Total at 31 March 2019	**70,829**	**-**	**-**	**70,829**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	£000	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	31,854	-	-	-	**31,854**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	32,005	-	-	-	**32,005**
Total at 31 March 2018	**63,859**	**-**	**-**	**-**	**63,859**

Note 28.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	198	-	**198**
Obligations under PFI, LIFT and other service concession contracts	24,699	-	**24,699**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	22,592	-	**22,592**
Other financial liabilities	-	-	**-**
Provisions under contract	1,645	-	**1,645**
Total at 31 March 2019	**49,134**	**-**	**49,134**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	216	-	**216**
Obligations under PFI, LIFT and other service concession contracts	25,395	-	**25,395**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	27,512	-	**27,512**
Other financial liabilities	-	-	**-**
Provisions under contract	1,669	-	**1,669**
Total at 31 March 2018	**54,792**	**-**	**54,792**

Note 28.4 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	23,771	28,377
In more than one year but not more than two years	899	924
In more than two years but not more than five years	2,842	2,770
In more than five years	21,622	22,721
Total	**49,134**	**54,792**

Note 29 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Special payments				
Ex-gratia payments	6	1	4	1
Total special payments	**6**	**1**	**4**	**1**
Total losses and special payments	**6**	**1**	**4**	**1**
Compensation payments received		-		-

Note 30.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Note 30.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Application of the standard has had no significant impact for the Trust.

Note 31 Related parties

All bodies within the scope of the Whole Government Accounts (WGA) are treated as related parties of an NHS Foundation Trust including the Department of Health as the Trust's parent organisation. The main entities within the public sector that the Trust has dealings with are:-

Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire Community Services
Cambridgeshire County Council
Care Quality Commission
Head to Toe Charity
H M Revenue and Customs
Health Education England
Hertfordshire County Council
HMP Whitemoor
Homes England
NHS Bedfordshire CCG
NHS Cambs & Peterborough CCG
NHS England East of England Specialised Commissioning Team
NHS North Norgolk CCG
NHS Morwich CCG
NHS Pensions Agency
NHS Property Services
NHS Resolution
NHS South Lincolnshire CCG
NHS South Norfolk CCG
NHS Supply Chain
NHS West Norfolk CCG
NHS West Suffolk CCG
North West Anglia NHS Foundation Trust
Northamptonshire County Council
Peterborough City Council
Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust
South Staffs & Shropshire NHS Trust
St Helens and Knowsley Hospital Services NHS Trust

	2018-19			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Cambridgeshire County Council	542	9,540	0	2,401
Head to Toe Charity	0	120	0	0
Hertfordshire County Council	0	796	0	39
Homes England	8	0	0	0
HMRC	12,145	0	2,436	194
HMP Whitemoor	0	1,752	0	422
Northamptonshire County Council	0	992	0	248
Peterborough City Council	890	5,206	0	591

	2017-18			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Cambridgeshire County Council	200	10,949	453	1,521
Head to Toe Charity	0	0	0	0
Hertfordshire County Council		749		97
Homes England	0	20,218	0	0
HMRC	11,258	393	2,975	0
HMP Whitemoor	0	1,598	0	295
Northamptonshire County Council		854		116
Peterborough City Council	718	5,493		342

Note 32 Events after the reporting date

There are no events after the reporting date that materially impact the financial statements.

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 Cambridge and Peterborough NHS Foundation Trust (the 'Trust') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; 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.

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.

Grant Thornton

Overview of our audit approach

Financial statements audit

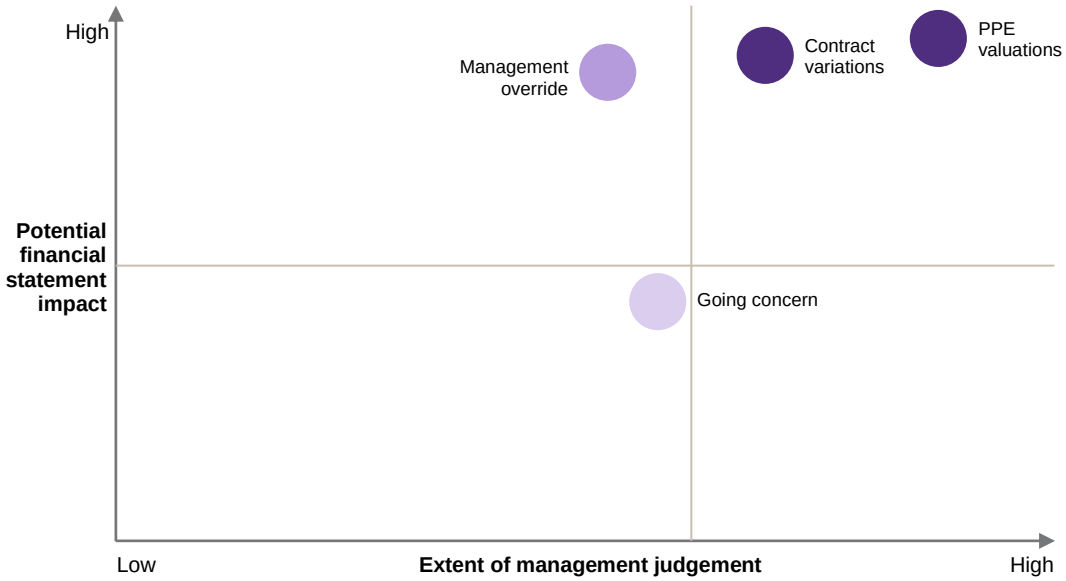
- Overall materiality: £4,347,000, which represents 2% of the Trust's gross operating expenses;
- Key audit matters were identified as:
  - Contract variations
  - Valuations of Property, Plant and Equipment

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified 1 significant risk in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (see Report on other legal and regulatory requirements section).

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
Risk 1 Contract Variations Approximately 85% of the Trust's income is from patient care activities through contracts with NHS commissioners and other partners. The Trust recognises income from patient care activities during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in block contracts with commissioners are subject to verification and agreement by contract partners. As such, there is a risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. Due to the nature of block contracts we have not identified a significant risk of material misstatement in relation to block contracts.	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; • 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. **Key observations** We obtained sufficient audit evidence to conclude that: - the Trust's accounting policy for recognition of operating income, which covers contract variations, is shown in note 3 complies with the Department of Health and Social Care

Key Audit Matter	How the matter was addressed in the audit
We therefore identified occurrence and accuracy of contract variations as a significant risk which was one of the most significant assessed risks of material misstatement.	(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.
Risk 2 Valuations of Property, Plant and Equipment The Trust re-values its land and buildings on a five-yearly basis to ensure the carrying value in the financial statements is not materially different from current value in existing use at the financial statements date. In intervening years, such as 2018/19, the Trust requests a desktop valuation from its valuation expert. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. We therefore identified valuation of land and buildings 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: • Evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts and the scope of their work; • Evaluating the competence, capabilities and objectivity of the valuation expert; • Obtaining an understanding from the valuer of the basis on which the valuations were carried out; and • Challenging the information and assumptions used by the valuer to assess completeness and consistency with our understanding. **Key observations** The Trust's accounting policy on the valuation of Property, Plant and Equipment, is shown in note 15 to the financial statements. We have obtained sufficient, appropriate audit evidence to conclude that: - the basis of the valuation was appropriate and the assumptions and processes used by management in determining the estimate were reasonable; and - the valuation of land and buildings disclosed in the financial statements is reasonable.

Our application of materiality

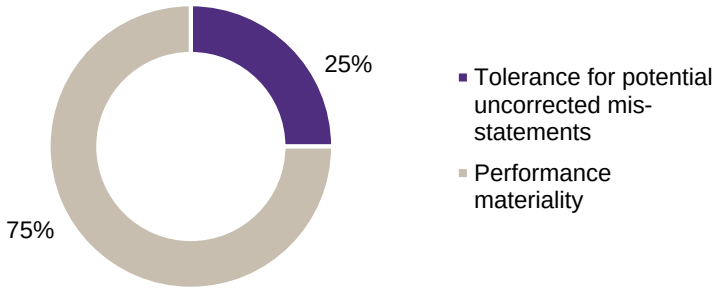
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£4,347,000 which is 2% 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 the Trust has expended its revenue and other funding. Materiality for the current year is the same percentage level of gross operating expenses as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Communication of misstatements to the Audit Committee	£217,000 and 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.

Overall materiality – Trust



An overview of the scope of our audit

Our audit approach was based on a thorough understanding of the Trust's business, was risk-based and included and evaluation of the Trust's internal control environment including its IT systems and controls over key financial systems.

The scope of the audit included:

- 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 income such that the untested balance is less than performance materiality;
- Testing, on a sample basis such that the untested balance of expenditure is less than performance materiality; and
- Testing, on a sample basis, the valuation of property plant and equipment such that the untested balance is less than performance materiality.

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 82**,** 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 obtained in the audit 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 the 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; in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance - the statement given by the directors on page 3 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.

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[1] does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2018/19 or is misleading or inconsistent with the information of which we are

aware from our audit. 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 2018/19 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 issue a report 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 refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take 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 the Chief Executive's responsibilities as the accounting officer, 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 2018/19, 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 Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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 2019**.**

We have nothing to report in respect of the above matter.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks	How the matter was addressed in the audit
Risk 1 Financial Sustainability The Trust's financial target for 2018/19 was to deliver a surplus of £2.162 million before receipt of Provider Sustainability Fund (PSF) income. This was based on the identification and delivery of £9.49 million of Cost Improvement Plans (CIPs). By January 2019 the Trust was forecasting to not meet its control total or its Cost Improvement Plans (CIPs), additionally uncertainty due to potential Brexit increased the macroeconomic pressures faced by the Trust. The risk is whether the Trust has adequate arrangements in place to ensure it meets its financial targets and therefore retains its entitlement to PSF income. Given the restricted nature of potential funding and statutory duty to provide a baseline level of services we consider financial sustainability to be a key challenge of the Trust.	Our audit work included, but was not restricted to: • Monitoring the Trust's performance against its financial target for 2018/19; • Understanding the Trust's delivery of it's 2018/19 CIPs target for the year; • Assessing the Trust's plans to set and deliver its 2019/20 budget; • Consideration of the Trust's cash position in 2018/19 and planned cash position in 2019/20; • Developing and understanding the Trust's capital plans for 2019/20 including consideration of how capital expenditure will be funded in the year; and • Analysing the Trusts reporting of its financial performance to the Board. **Key findings** • The Trust met its control total target for 2018.19 of £2.162m surplus before PSF funding, having achieved a year end position of £2.414m (subject to audit completion). • The Trust has under achieved against its CIPs target, aiming for £9.490m and achieving £6.663m. Only 21% of the savings made in 2018-19 were recurrent; • The Trust's CIP target for 2019-20 is £4.3m (2% of gross revenue expenditure); • The Trust is yet to finalise it's control total position with NHSI for 2019/20, however indications show this will likely be a small deficit (<£1m). • The Trust has yet to finalise service contracts for 2019/20 with its main commissioner (Cambridgeshire and Peterborough CCG), the terms of the proposed agreement are in

Significant risks	How the matter was addressed in the audit
	line with current service delivery plans. In 2018-19 the contract was also not agreed at this stage of the year and so this is not an indication of unusual practise, but reflects the challenging financial position in the local health economy (the local acute Trusts are running significant recurring deficits) • At the start of 2018/19 the Trust loaned the Department of Health and Social Care a recallable £20m, earning interest each year at 5%. Despite this large cash transfer the Trust still maintains a healthy and sustainable cash balance. • The Trust intends to continue to finance its Capital Expenditure plans from internally generated funds in 2019-20 as in 2018-19. This will be through a combination of funding available based on forecast Depreciation levels, capital receipts from land sales in year and utilisation of cash balances. The planned expenditure has been set at a level of £7.2m in 2019-20. The outline Capital Plan includes a range of schemes aimed at improving the Trust's Estate and Infrastructure and will see a further roll out of the Strategy. • The Trust also is not reliant on large new projects, but instead a rationalisation and improvement upon the existing site. • The Trust has underspent in its' capital plans in 2018-20. • The Trust has been appropriately sighted on the above developments through board reports during the year.

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 2006 to 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 2019, 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 Cambridge 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.

Use of our report

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.

Ciaran McLaughlin

Ciaran McLaughlin; Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

110 Bishopsgate
London
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24 May 2019