NHS

Greater Manchester Mental Health

NHS Foundation Trust

Annual Report and Accounts 2017/2018

Greater Manchester Mental Health NHS Foundation Trust

Improving Lives

Greater Manchester Mental Health NHS Foundation Trust

Annual Report and Accounts 2017/2018

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

Annual Report and Accounts 2017/2018

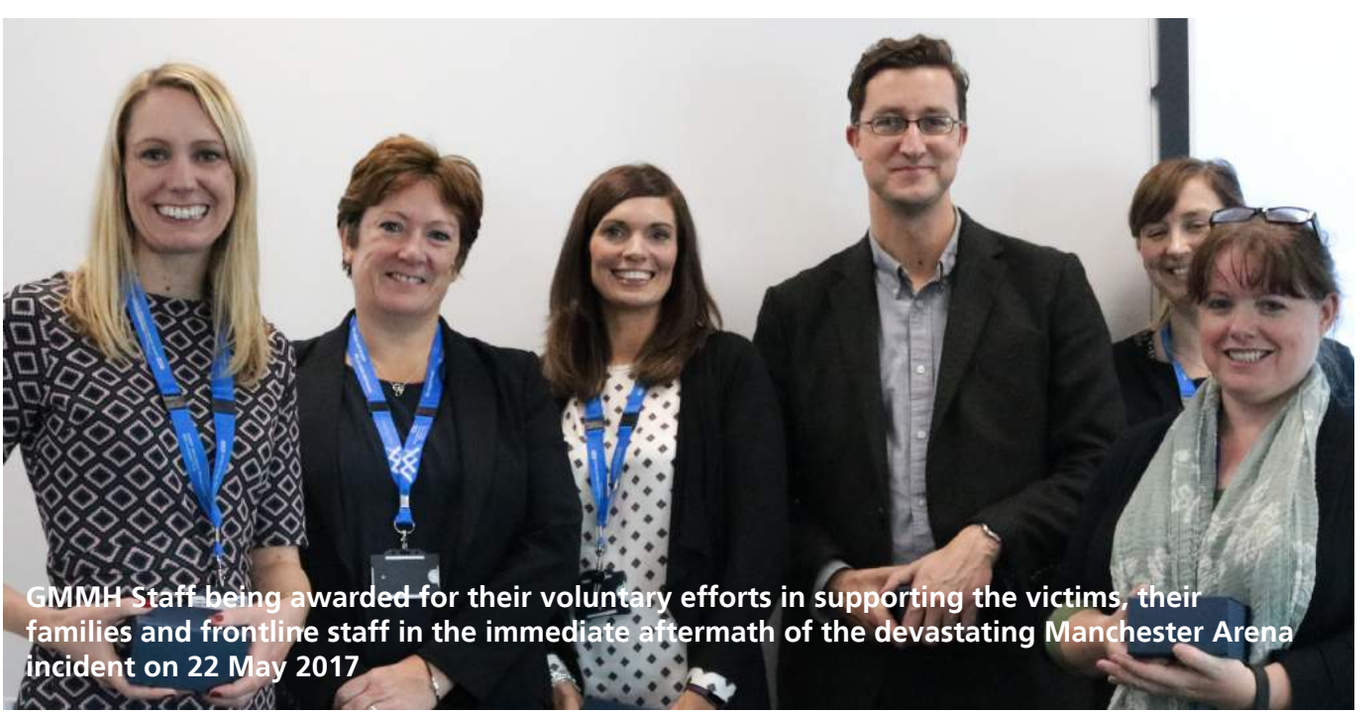
Greater Manchester Mental Health NHS Foundation Trust

I am delighted to present our Annual Report for Greater Manchester Mental Health NHS Foundation Trust for the year ended 31 March 2018 - our first full year as an enlarged Trust incorporating the former Manchester Mental Health and Social Care NHS Trust.

This report, and the Quality Account that accompanies it, highlights some of our many achievements over the course of the year. Not least the efforts of staff across the organisation in ensuring that our service users have continued to be well-supported and receive excellent care during this period of transition and change.

When we successfully completed the acquisition of Manchester Mental Health and Social Care NHS Trust (MMHSCT) in December 2017, it felt like the end of a monumental task. In reality, it was just the start. MMHSCT was a Trust under significant pressure, identified by the Trust Development Authority (TDA) as unsustainable in its current form and by the Care Quality Commission (CQC) as 'Requires Improvement'. Greater Manchester West Mental Health NHS Foundation Trust (GMW), on the other hand, was a high performing Trust, in recent receipt of an overall 'Good' rating from the CQC but with ambitions to increase the organisation's influence, and that of the mental health sector, across the devolved Greater Manchester region. Uniting the two organisations took courage, collaboration and a clear plan. The hard work involved in laying the foundations and beginning to deliver on our plan during 2017/18 cannot be underestimated.

As I reported in last year's Annual Report, by early 2017/18 there were encouraging signs that the two organisations were really beginning to come together. This position has continued during the year, enabled in part by the agreement of a shared set of values that have united staff in a common purpose. We have also restructured our corporate and senior clinical management functions to better meet the needs of the enlarged organisation and facilitate the delivery of our transformation plans, and have taken time to unpick and understand the challenges in Manchester. A number of these challenges – in particular, the increasing demand for adult acute and PICU (Psychiatric Intensive Care Unit) beds and the reliance on agency staffing – cut across the whole organisation and indeed the sector. As we now move forward with implementing sustainable solutions for the future, it is clear that this has been time well-spent.
Our efforts were validated with the award of an overall 'Good' rating and an 'Outstanding' rating



GMMH Staff being awarded for their voluntary efforts in supporting the victims, their families and frontline staff in the immediate aftermath of the devastating Manchester Arena incident on 22 May 2017

for well-led (leadership) from the CQC in February 2018. This followed a core service with well-led inspection undertaken in line with the CQC's new regime. It would be remiss of me not to highlight within this the achievement of an 'Outstanding' rating by our substance misuse services in their first CQC inspection. Achieving these ratings during such a period of change is testament to the professionalism and commitment of our staff. Well done and thank you to all involved.

At a Greater Manchester level, we have continued to press hard to ensure that the voice of mental health is heard. We have negotiated investment from the regional transformation fund and from our local commissioners to support delivery of the Five Year Forward View for Mental Health and the Greater Manchester Mental Health Strategy. This includes investment in co-ordinated programmes of work focussed on perinatal mental health and in local developments in relation to IAPT (Improving Access to Psychological Therapies), early intervention in psychosis, all age RAID (Rapid Assessment, Interface and Discharge) and 'Core 24' standard liaison psychiatry services.

I would also like to make special mention of the voluntary efforts of our staff in supporting the victims, their families and frontline staff in the immediate aftermath of the devastating Manchester Arena incident on 22 May 2017. We have since continued to work in partnership with the other providers in Greater Manchester, as part of the Manchester Resilience Hub, to make medium and longer-term packages of mental health support available to those affected.

We have been well-supported over the last 12 months by our newly formed Council of Governors. We have welcomed, in particular, the enthusiasm and energy our new governors have shown in delivering the requirements of this role. The attendance of governors at a range of meetings has proved invaluable, as has their insight and individual contributions. We have had a number of governor retirements during the period and I would like to take this opportunity to formally thank those who have stepped down.

Looking ahead, the challenges facing this organisation and the wider NHS will only increase as demand for services grows against a climate of ever tightening budgets and shortfalls in workforce supply. Our plans for 2018/19 to 2019/20 are structured to enable us to grasp the opportunities available to build our organisation in this context. They are focussed on improving quality of care and maintaining financial stability, whilst working in partnership to strengthen the sustainability of services for the future. Achieving our plans will be not be easy, but I know that everyone here at GMMH will rise to these challenges in the interests of our service users and carers.

And finally, I would like to thank our former Chief Executive, Bev Humphrey, who retired at the end of March 2018 following 12 outstanding years at the Trust's helm and 35 years in the NHS overall. Bev's contribution to the Trust, and the wider NHS, is incomparable. We will certainly miss her tenacity and humour. Neil Thwaite was appointed as Bev's successor in April 2018. Neil has been a key executive member of the Trust's Board of Directors since 2006 and has operated as Deputy Chief Executive in recent years. Neil brings a background of successful transformational leadership, partnership working, performance improvement and strategic focus amongst other things – all skills which are critical to this role. With the support of our skilled and dedicated Executive Management Team and the wider workforce, I am confident that Neil will lead this organisation on to even greater success.

Rupert Nichols, Chair
21 May 2018

For any further information on the information contained in this report, or to keep in touch with our developments, please contact us on communications@gmmh.nhs.uk, follow us on Twitter @GMMH_NHS or like us on Facebook (www.facebook.com/GMMentalHealth).

Performance Report

Statement from the Chief Executive

I am pleased to introduce this review of the performance of Greater Manchester Mental Health NHS Foundation Trust (GMMH) for the period ended 31 March 2018. My first report as Chief Executive of this fantastic organisation.

Whilst our CQC inspection outcome is a highlight, there are many other things that we can be proud of. Our achievements from a quality perspective are covered in detail in our Quality Account, which we take pride in presenting separately to this Annual Report as a document in its own right. We have also seen a number of other key developments, including:

The launch of Be Well, our new social prescribing service in North Manchester in December 2017. 'Be Well' has been designed to provide more community-based support for healthy lifestyles, including supporting social, emotional and practical needs and promoting community resilience. The service operates a strengths-based model and connects people with existing activities and networks as well as creating new ones.

The launch of Achieve, our new integrated drug and alcohol recovery treatment service in Bolton, Salford and Trafford in January 2018. Achieve is delivered in partnership with a range of providers – namely, The Big Life Group, THOMAS, Great Places Housing Group, Early Break and Salford Royal – who bring different experience and expertise to the model. The service is focussed on prevention and early intervention, providing easy access and a wide range of support and interventions to build on individuals' recovery capital and reduce reliance on more specialist services. In building closer relationships with local communities, 'Achieve' also aims to have a sustainable impact on the health and wellbeing of individuals and, through them, on children, young people and families.

Award of a contract to deliver community-based Children and Young People's Mental Health Services

Neil Thwaite
Chief Executive

(CAMHS) in Bolton, working in partnership with North West Boroughs Mental Health NHS Foundation Trust. This service commenced in April 2018 and uses a 'Thrive' model of care to organise services and help individuals to access the most effective interventions.

Working in partnership with Alternative Futures Group (AFG) to deliver rehabilitation and recovery services for women with complex and specialist needs in Bolton. With the support of Bolton Clinical Commissioning Group (CCG), we have recently refurbished and extended Hawthorn House on the Royal Bolton Hospital site to provide a fit for purpose service for 14 women. 'Honeysuckle Lodge', as it now known, offers continuity of care for women leaving inpatient services in a supportive and welcoming environment.

Commencement of work to build a new Section 136 suite at Park House in North Manchester, which will meet all required Department of Health standards. By providing an improved physical environment for those detained under Section 136 of the Mental Health Act, we are aiming to improve patient and carer experience, deliver more effective care pathways and further strengthen our

relationship with Greater Manchester Police (GMP).

These developments demonstrate our commitment to partnership working, recognising the benefits this can bring to service users and carers, all organisations involved and the wider health and social care economy. We have a strong track record of collaborating effectively with a range of partners - including commissioners, other statutory providers, the private sector and voluntary sector organisations – and have continued this approach in 2017/18. Our partnerships enable the delivery of more innovative and integrated services and take a variety of forms including prime provider models, sub-contracts, alliance agreements and more information arrangements.

We have also been able to draw on best practice and innovation across the enlarged Trust to maintain and begin to enhance performance over the reporting period. Later in this Performance Report you will find more detail on our performance against our key statutory and locally-agreed performance targets. I would like to highlight, in particular, the challenges we have faced with regard to achieving our IAPT (Improving Access to Psychological Therapies) access and recovery targets in Manchester and Salford and, as a consequence, at a Trust-wide level. Performance in Salford has dipped due to increased demand and we are working with commissioners to address this gap. In Manchester, we have been focussed on agreeing and implementing a new clinical model and resolving a number of accommodation issues. We expect to see this work come to fruition in 2018/19.

I would also like to note some of the progress made in starting to deliver our transformation plans for Manchester. Community engagement has been a critical strand of this and we have taken steps to ensure that user and carers are represented on all of our Transformation Working Groups (TWGs). We have also launched our Manchester Wellbeing Fund, which aims to invest in and build on local assets across the city. We have worked hard to monitor and manage the significant increases in demand for inpatient admissions during the reporting period and the associated use of Out of Area Placements (OAPs). In the short-term, we have made additional capacity available for Manchester service users at our MacColl and Griffin Wards, which opened during 2017/18. We are now looking to implement our new Enhanced Community Mental Health Model for Manchester, which will provide a more effective alternative to inpatient care. We are also working with providers across Greater Manchester to deliver an OAPs trajectory based on a recently agreed OAPs definition for the region. This will remain one of our biggest challenges in 2018/19.

In this report, you will also find a detailed breakdown of the Trust's financial performance during the period. At year-end, we are reporting a normal operating surplus of £4.009 million. Our financial position underpins our ability to deliver our transformation plans. It is therefore critical that we continue to deliver a strong financial performance going forward. As identified above, the toughest challenges we face are in relation to out of area (OAPs) expenditure and also our ability to control our reliance on agency staffing. Both are a common issue for mental health Trusts due to increasing demand for beds and a national shortage of skilled professionals, which has led to heightened competition to fill vacancies. In implementing our own new Workforce Strategy and collaborating with partners on a Greater Manchester strategy, we will work to strengthen our position as an employer of choice. We certainly have much that we can 'sell' about this organisation, particularly following the acquisition, and about Greater Manchester in general. We recognise that this problem will not easily be solved, however, and will continue to use agency staff where required to maintain the safety and quality of our services.

None of these achievements would be possible without the continued work and support of our amazing staff. I would like to take this opportunity to thank all staff for their valued contribution to the work of our Trust. I am very much looking forward to working with you during my first year as Chief Executive.

Neil Thwaite, Chief Executive
21 May 2018

Overview

About us

Greater Manchester Mental Health NHS Foundation Trust (GMMH) is a statutory body established as a public benefit corporation under Section 35 of the National Health Service Act 2006 on 1 February 2008.

GMMH delivers a range of integrated mental health and social care services to a population of over 1.2 million people in Bolton, Salford, Trafford and the City of Manchester. We provide 875 inpatient beds in total. Within this our adult and later life inpatient bed numbers, which include psychiatric intensive care, stand at 451. These services are provided on the following hospital sites:

- Royal Bolton Hospital
- Salford Royal Hospital – Meadowbrook Unit
- Trafford General Hospital – Moorside Unit
- North Manchester General Hospital – Park House
- Wythenshawe Hospital – Laureate House

Inpatient rehabilitation and recovery services are provided at Bramley Street, Copeland Ward and Braeburn House in Salford, at Anson Road and Acacia Ward in Manchester and at Honeysuckle Lodge in Bolton (106 beds in total).

Our community services are wide-ranging and focussed on supporting people to maintain their mental health and stay out of hospital. They include crisis care, home-based treatment, early intervention in psychosis services, IAPT (Improving Access to Psychological Therapies) services, community rehabilitation services, memory clinics and health and wellbeing services.

We also provide a range of more specialist or tertiary services across Greater Manchester, the North West of England and beyond. These include substance misuse services (inpatient and community-based), forensic mental health services for adults and adolescents, child and adolescent mental health services, mental health and deafness services, health and justice services (in 11 prisons and two secure children's homes), community psychological therapies and perinatal ('mother and baby') mental health services. The latter are provided from a specialist ten bedded unit at Laureate House in Wythenshawe.

We employ over 4,850 (headcount) members of staff and deliver services from over 140 locations. In a 12-month period we expect to meet the needs of around 53,000 services users.

Our main commissioners are:

- Bolton Clinical Commissioning Group
- Salford Clinical Commissioning Group
- Salford Royal NHS Foundation Trust via a sub-contract arrangement
- Trafford Clinical Commissioning Group
- Manchester Clinical Commissioning Group
- NHS England
- Local authorities in Cumbria, Central Lancashire, Salford, Trafford and Manchester

We ensure that all commissioners are kept up to date about the performance of our services through a range of performance reports, contract monitoring meetings and other strategic meetings.

Our Strategic Framework

We remain focussed on delivering 'Improved Lives and Optimistic Futures for People Affected by Mental Health and Substance Misuse Problems'.

Our vision is supported by our new values:

- We are caring and compassionate
- We inspire hope
- We are open and honest
- We work together
- We value and respect

These values were developed collaboratively with staff, people who use our services and other key stakeholders and agreed in July 2017. Our values, and the behaviours linked with each, are underpinned by a new strapline – 'Improving Lives' – which reflects our over-arching vision.

Each year we follow an established process for developing plans to support the achievement of our vision and objectives. Our plans are developed in consultation with our staff and other key stakeholders including our partners and the Council of Governors. Examples of key achievements against our 2017/18 plans are provided throughout this Report and in our Quality Account. Further information on our forward plans for 2018/19 to 2019/20 can be found in our Operational Plan, which is published on the NHS Improvement website.

At our first Annual Members Meeting as GMMH in October 2017, we presented awards to individuals and teams from across the Trust who were felt to have best represented our new values during the year. The winners and highly commended in each category were as follows:

We inspire hope	
Winner	Donna Bostock, Support, Time and Recovery Worker for Salford Community Engagement and Recovery Team
Highly Commended	Denise McArthur, Team Leader of the Early Intervention Team, Trafford

We work together	
Winner	Salford Early Intervention Team
Highly Commended	Hayeswater Ward, Edenfield Centre

We are open and honest	
Winner	Carine Linganzi, Administrator for the Community Inclusion Service in Hulme, Manchester
Highly Commended	Zena Bouharif, Ward Manager at Maple House, Bolton

We value and respect	
Winner	Kenny Moth, Chris Oldland and Philip Stott, Members of the Catering Team
Highly Commended	Sue Bright, Recovery Occupational Therapist at Unity, Cumbria

We are caring and compassionate	
Winner	Trish Dwyer, Acute Services Manager, Later Life Services in Manchester
Highly Commended	Keats Ward, Meadowbrook Unit, Salford

We were honoured to welcome Andy Burnham, Mayor of Greater Manchester, as our Keynote Speaker at our Annual Members Meeting. In his speech, the Mayor echoed our commitment to taking a person-centred, whole system approach to our delivery of care. The Mayor also took the opportunity to present awards to the following four members of staff, in acknowledgement of the efforts of their respective professional group/service in the aftermath of the Manchester Arena attack:

Dr Shermin Imran
Children and Young People's Services

Stephanie Kennedy
Psychological Therapies

Debra Woodcock
Nursing

Reverend Jeremy Law
Chaplaincy and Spiritual Care

Our Business Model

All NHS Foundation Trusts are required to have a Board of Directors, a Council of Governors and a membership scheme that is open to members of the public, staff and, as we have chosen, service users and carers. Members vote to elect governors and can also stand for election themselves. The Directors Report on pages 32 to 60 outlines the steps taken to ensure that the Board of Directors and Council of Governors fulfil the requirements of their respective roles.

During 2017/18, we have completed a comprehensive restructure of our corporate and senior clinical management functions to better meet the needs of the enlarged organisation. Our clinical services are now structured along three divisional lines:

- Salford, Bolton and Greater Manchester-wide
- Trafford, Manchester and Manchester city-wide
- Specialist services

Our corporate services are structured to align with executive director reporting lines as follows:

- Nursing and Governance (including clinical governance and quality)
- Finance and Information Management and Technology (IM&T)
- HR and Corporate Affairs (including facilities, Estates and Capital)
- Strategic Development (including Performance and Contracting)
- Medical (including Pharmacy and Research and Development)

Our corporate services work closely with our clinical divisions, for example, through dedicated posts and joint projects and meetings

Our Staff

We rely on a committed and motivated workforce to deliver the high standards we set for all of our services. The staff report ('Our Staff') on pages 70 to 81of this Annual Report provides information on the make-up and views of our diverse workforce, including the most recent staff survey results, changes to our policies and procedures and our future workforce plans. At the end of 2017/18, we employed 5,094 whole time equivalent staff.

Our Key Risks and Uncertainties

Our Board of Directors has overall responsibility for ensuring that the Trust's risk management system is sufficiently robust to mitigate any significant risks that may threaten achievement of the Trust's agreed strategic objectives. Assurance on the effectiveness of this system is gained primarily through the work of Board committees and the Executive Management Team, through the use of audit and other independent inspection or accreditation, and through the systematic collection and scrutiny of performance data.

Our Board Assurance Framework sets out the current key risks to achievement of the Trust's strategic objectives and identifies any gaps in controls and assurances on which the Board relies. The Board of Directors is responsible for reviewing the Board Assurance Framework on a quarterly basis, to ensure that there is an appropriate spread of strategic objectives and that the main risks have been identified.

During the last twelve months, we have reviewed and updated the structure of our Board Assurance Framework to better align the risks identified with the focus of Board attention, to clarify ownership of risks and to enable increased transparency and assurance.

The most significant risks and uncertainties currently faced, based on their likelihood and impact, are related to:

- Future workforce supply – recruitment and retention of high quality staff
- Out of Area Placements (OAPs) – usage and expenditure
- Learning from deaths – implementation of robust mortality governance processes
- Cultural alignment – aligning the cultures of the two former organisations
- Agency – usage and expenditure
- Acquisition of MMHSCT – delivery of our agreed Post-Transaction Implementation Plan

We continuously test the effectiveness of the controls in place to mitigate these risks through our internal and external assurance mechanisms and take action to implement additional controls as required.

Our Performance

We are a high performing organisation with a strong track record of delivering all required financial, operational and quality targets set by our commissioners, regulators and the government. Following the acquisition of MMHSCT, we have focussed on extending our robust approach to performance reporting and governance across the combined entity.

Our performance management framework defines our principles of performance management and sets out how these should be put into practice across the organisation. This framework has recently been updated to take account of the changes to the organisation following the acquisition.

We have established a strong performance culture. Responsibility for delivering care to the standards required by regulators and commissioners is apportioned appropriately from Board level through to individual members of staff. Our performance management framework is operationalised through our governance structure with standing agenda items on performance at our monthly Board of Directors and Operational Leadership Committee meetings. This ensures a clear Trust-wide and divisional performance position for all key targets, which is owned at a senior level. Performance issues feed through from these meetings into divisional senior leadership meetings, individual appraisals and supervision sessions enabling shared ownership across the organisation of key performance indicators (KPIs) and other mandatory targets. A monthly Trust-wide Performance Measures and Data Quality meeting scrutinises the detail around achievement of KPIs, agreeing actions to improve performance, sharing best practice across the Trust and escalating risk as appropriate. Delivery of CQUIN (Commissioning for Quality and Innovation) targets is also reviewed by exception on a monthly basis. Quarterly CQUIN meetings are held in specialist and district services to monitor and support achievement against CQUIN targets. Terms of reference for these meetings have been updated to reflect the acquisition. The Quality Governance Committee also plays a key role in the performance management framework by supporting triangulation of performance and quality information to improve delivery of care for our service users and carers.

Our Business Intelligence Team enables the organisation to reach and maintain required performance levels by operating processes and protocols for data collection and analysing and reporting performance against our key performance requirements and contractual commitments. Board scrutiny of performance follows a process of data validation and review at local service and divisional level. Where necessary, remedial action is agreed to improve any areas of under-performance and this is monitored in subsequent meetings of the Board of Directors. This ensures that the performance against KPIs is clearly visible at all levels with any potential risks highlighted and appropriate actions put in place. This avoids any uncertainty around levels of performance either contractual or regulatory.

Achievement of our Key Performance Targets

In October 2016, NHS Improvement introduced a new approach to overseeing providers and supporting improvement - the 'Single Oversight Framework' – which has been further updated in November 2017. Our key performance indicators and reports reflect the updated requirements as appropriate.

The following table summarises our performance against our key performance indicators during 2017/18. KPIs have been mapped against the Care Quality Commission's five domains to enable triangulation of results. A 'Green' rating indicates that performance has achieved the required standard. Our 'Quality Account' for 2017/18 provides more detailed information on our CQUIN schemes and performance against the key mental health targets in 2017/18.

CQC Domain	Source	Indicator	Rating
Effectiveness	Single Oversight Framework	MHSDS (Mental Health Services Dataset) Identifiers – data completeness	G
		MHSDS Priorities – data completeness	R
		Operational Performance – overall performance against operational performance indicators	G
		Quality Indicators	G
	National CQUIN	Frequent A&E Attenders' Support	G
Safety	Single Oversight Framework	Gatekeeping – patients requiring acute care received a gatekeeping assessment by a crisis resolution and home treatment team	G
	CQC	Registration	G
	National CQUIN	NHS Staff Health and Wellbeing	G
		Healthy Food - for staff, visitors and patients	G
		Flu Vaccinations - for front line clinical staff	G
		Communication with GPs – improving physical health of those with an SMI (severe mental illness)	G
		Improving transition from CAMHS	G
	CCG CQUIN	Suicide Prevention	G
	NHSE CQUIN	Discharge and Resettlement - for all specialist mental health inpatient services	G
		Transition from inpatient CAMHS	G
	HR	Staffing Levels	G
Responsiveness	Single Oversight Framework	Early Intervention - treatment start within two weeks	G
		Cardio-Metabolic Assessment – cardio-metabolic assessment and treatment for people with psychosis is delivered routinely	A
		IAPT - treated within six weeks	R
		IAPT - treated within 18 weeks	R
	National CQUIN	Risky Behaviours - preventing ill health from risky behaviours	A
Caring	Single Oversight Framework	IAPT Recovery – achievement of 50% recovery target	R

CQC Domain	Source	Indicator	Rating
Caring	NHS England CQUIN	Development of Recovery Colleges – for medium and low secure patients	G
	Single Oversight Framework	Quality of Care – overall position against indicators	G
Well-led	Locally-set	Sickness Rolling 12 Months	R
		Sickness In-Month	G
		Staff Friends and Family Test	G
		Finance and Use of Resources	G
	Single Oversight Framework	Strategic Change – including contribution to developing, agreeing and delivering Sustainability and Transformation Plans (STPs)	G
		Leadership and improvement capability – demonstration of effective Board and governance, continuous improvement capability and an effective use of data	G

We work hard to ensure our key performance metrics are achieved. Where there are areas rated as 'Amber' or 'Red' we put comprehensive action plans in place.

At Quarter 4 2017/18, Trust-wide performance against the IAPT access and recovery targets was rated as 'Red'. This rating reflects the impact of Salford and Manchester services' performance on the overall position and has been compounded by difficulties in recruiting skilled IAPT workers. Plans to improve IAPT services in Manchester were developed prior to the acquisition and implementation has commenced during the year. This has included the development of trajectories to clear historical waiting lists and more effective and timely management of new referrals. We are now beginning to see improvements in performance as a result of these actions. We have also agreed additional investment in IAPT with commissioners in Manchester and Salford to address capacity issues and enable achievement of future CCG targets. To note, in Salford, we only provide Step 3 IAPT services and this, in itself, impacts on our recovery rates which are linked to the delivery of the whole stepped-care IAPT pathway.

With regard to the complete and valid submission of MHSDS (Mental Health Services Data Set) priority metrics relating to employment and accommodation status, our ability to achieve the 85% target has been impacted in 2017/18 by the capabilities of the current clinical information system in Manchester. We are progressing plans to improve our performance in the interim, whilst we implement a new clinical information system in Manchester which aligns with that used across the wider Trust.

Staff sickness absence has also continued to be a challenge during 2017/18, with sickness levels consistently recorded above our locally set target of 5.75%. The actions we are taking to address this are summarised in the 'Our Staff' section of this report and include approaches to promote employee health and wellbeing and improve sickness absence management.

Our Financial Performance

As demonstrated in our Annual Accounts, we delivered a positive financial position at the end of 2017/18. We maintained low levels of financial risk throughout the year, whilst also achieving the cost efficiencies required for future sustainability and making significant capital investment.

Our financial performance can be summarised as follows:

- Our overall income and expenditure position shows delivery of a net retained surplus of £8.2 million. Our normal operating surplus for the year is £4.009 million. This difference in performance is due to the impact of asset revaluation and additional income for meeting the control total of £2.355 million.
- Our overall Finance and Use of Resources Rating as at 31 March 2018 is 3 (see pages 86 to 87 for further detail).
- Our total Comprehensive income, after movements direct to reserves, is £23.07 million.
- A desk top revaluation of our property, plant and equipment was undertaken by the District Valuer in February 2018. Due to the significant impact of desk top movement the resultant revaluation has been reflected in the financial outturn as reported at 31 March 2018.

Income and Expenditure Position

We received a total of £293.3 million income for 2017/18, which represented an increase on our planned income. The majority of this income related to patient care (£258.0 million).

	For the Year to 31 March 2018		
	Plan	Actual	Variance
	£000's	£000's	£000's
Clinical Income	256,827	258,000	1,173
Other Income	32,643	35,292	2,649
Total Income	**289,470**	**293,292**	**3,822**
Operating Expenditure	(275,893)	(277,684)	(1,791)
EBITDA	**13,577**	**15,608**	**2,031**
Depreciation	(6,360)	(6,789)	429
Interest Receivable	186	149	(37)
Interest Expense	(394)	(195)	199
Public Dividend Capital	(4,654)	(4,981)	(327)
Profit/(Loss) on disposal of assets		3	3
Surplus/(Deficit) before Other Non-Operating Expenses	**2,355**	**3,795**	**1,440**
Other Non-Operating Income/Expenses			
Impairment Losses (Reversals) net (on non PFI assets)	(500)	4,387	4,887
Net Surplus/(Deficit)	**1,855**	**8,182**	**6,327**
Elements of Comprehensive Income	(15)	14,888	14,903
Comprehensive Income	**1,840**	**23,070**	**21,230**

The table below confirms our normalised operating performance:

Financial Performance for the year	£'000
Surplus/(deficit) for the year from continuing operations	8,182
Reversal of Impairments following revaluation of PPE	(4,387)
Reversal of non-cash SOFP pension	214
Operating Surplus for the year	**4,009**

The majority of our £293.3 million income received related to patient care (£258.0 million). This can be broken down by commissioner as follows:

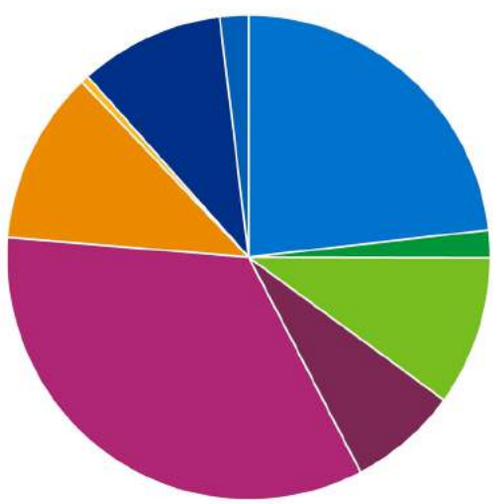
	Income (£'000s)
NHS England	60,333
NHS Salford CCG	4,777
NHS Bolton CCG	25,926
NHS Trafford CCG	18,987
NHS MCR	88,335
SRFT*	30,109
Other CCGs	1,333
Local Authorities	25,211
Other	4,966
Total	**258,000**

To note:

- SRFT (Salford Royal NHS Foundation Trust) - mental health services for Salford, previously commissioned by NHS Salford CCG, were transferred to the Salford Integrated Care Organisation which is part of Salford Royal NHS Foundation Trust, from 1 July 2017

Patient Care Income by Commissioner April 2017 - March 2018

NHS England	**23%**
NHS Salford CCG	**1%**
NHS Bolton CCG	**10%**
NHS Trafford CCG	**7%**
NHS MCR	**32%**
SRFT	**12%**
Other CCGs	**2%**
Local Authorities	**10%**
Other	**3%**



We received £35.3 million other income for non-patient care services, with the majority (£13.6 million) coming from Health Education England (HEE) to support education and training. In addition, we received income of £4.6 million to support research and development, £3.4 million Sustainability and Transformation funding, and £5.95 million to support the acquisition of Manchester mental health services.

Our Expenditure in 2017/18 totalled £280.1 million and can be analysed as follows:

Operating Expenses	Expenditure (£'000s)
Staff Costs	205,647
Premises and Transport	11,467
Supplies and Services - Clinical and General	8,073
Purchase of Healthcare from NHS Bodies	10,864
Purchase of Healthcare from Non NHS Bodies	15,122
Other	4,384
Drug Costs	4,668
Establishment	3,270
Research and Development Costs	4,384
Redundancy	728
Rentals under Operating leases	5,765
Training, Courses and Conferences	3,312
Total Operating Expenditure	**277,684**
Depreciation	6,789
Impairments of Property, Plant and Equipment	(4,387)
Loss on disposal of land and buildings	0
Grand Total	**280,086**

The largest item of expenditure relates to staff costs at £205.6 million or 73.4% of operating expenses. A desk top revaluation of our estate was carried out as at 31 March 2018. This valuation resulted in the reversal of previous impairments due to upward revaluation of £4,387k.

Capital Investment

We have continued to invest in the development and improvement of our estate (patient and non-patient facilities) in 2017/18. We invested a total of £8.9 million across the year. Key capital developments have included the commencement of work to develop a new purpose-built pharmacy on our Prestwich site and the refurbishment and extension of Hawthorn House on the Royal Bolton Hospital site to provide a new locked rehabilitation service for females with complex and specialist needs ('Honeysuckle Lodge'). We have also invested capital in our new patient administration system, backlog maintenance, statutory works, work to reduce ligature risks and energy performance improvements.

The following table provides an overview of our capital expenditure during the reporting period:

Capital Expenditure	Expenditure to 31 March 2018 (£'000's)
Hawthorn House development of Bolton rehabilitation and recovery service	1,687
Pharmacy at Prestwich site	1,683
Software Licences – Manchester Infrastructure and PaRIS	1,664
Computers/IT equipment	1,062
Backlog Maintenance Schemes	940
Harrop House	924
Pharmacy at Woodlands	229
Ligature Audit Schemes	125
Other Schemes	123
Manchester services – S136 suite	114
Tottington Lane Landslip	111
Statutory Schemes	78
Energy Improvement Scheme	68
Minor Schemes	65
Vehicle replacements	24
Total	**8,897**

Liquidity and Short Term Investments

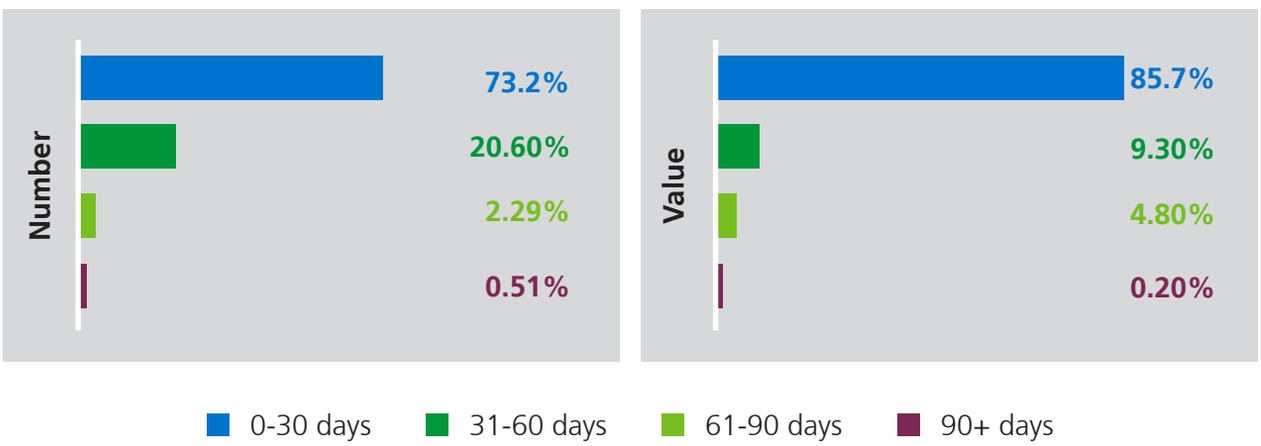
As at 31 March 2018, our cash balance stood at £38.7 million, with interest receivable of £0.1 million being reinvested in the delivery of services.

Better Payment Practice Code – Measure of Compliance

The Better Payment Practice Code (BPPC) requires the Trust to pay all NHS, and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. Where this involves a non-public sector organisation, the Trust takes action to ensure that payments are made as quickly as possible.

Our performance against the BPPC as at 31 March 2018 is 73.2% in terms of number of invoices paid within 30 days and 85.7% by value of invoice.

Percentage of Invoices Paid within 30 days



Cost Allocation

We have complied with all cost allocation and charging requirements set out in the HM Treasury Guidelines in 2017/18.

Preparation of our Accounts

We have prepared our annual accounts for 2017/18 in accordance with paragraphs 24 and 25 to Schedule 7 to the National Health Service Act 2006, guidance issued by NHS Improvement, the independent regulator of NHS Foundation Trusts, and International Financial Reporting Standards (IFRS). Our accounting policies for use in preparing our accounts are reviewed annually to reflect any changing circumstances involving accounts regulation and guidance and are approved by our Board of Directors.

Accounting policies for pensions and other retirement benefits are set out in Note 8 to the accounts. Details of senior employees' remuneration can be found in our Remuneration Report on page 61 onwards.

Going Concern Disclosure

Following a review by the Board of Directors in March 2018, the Directors have a reasonable expectation that the Trust has adequate resources to continue to adopt the going concern basis in preparing the accounts for 2017/18.

Future Financial Strategy

The financial year 2017/18 has seen a major change in the Trust's configuration and associated finances. The acquisition of MMHSCT in January 2017 increased the size and complexity of the organisation. The following years will prove to be a significant challenge as we work to deliver improvements to mental health services in Manchester, alongside the continued development of services for all service users.

The NHS continues to face an unprecedented financial dilemma where the supply of funding is struggling to match the growing demand for healthcare. The need to deliver year on year efficiency savings of 2% compounds this pressure. For the Trust this equates to an estimated recurrent savings requirement of £5m. We have an excellent track record of making all required efficiencies and have agreed plans to address this agenda without compromising service quality in 2018/19.

In this context, our future financial strategy is focussed on:

- Maintaining a Use of Resources (UoR) of 2 and meeting our Control Total for 2018/19
- Maintaining cash balances to support future working capital requirements
- Delivering CIPs in line with national requirement
- Having revenue available for investment in the service model and capital infrastructure

We will achieve this by:

- Using a combination of internal funds and external funding from Commissioners and the Department of Health to support the integration, service change and the transition process
- Undertaking regular reviews of the Trust's financial performance, including any variations against plan
- Holding a contingency to manage risk

Taking this approach will allow us to remain financially secure, to continue to invest in our services and to improve our buildings and ward environments.

Key challenges to be managed through this strategy over the coming years include the implementation of the Five Year Forward View for Mental Health, the ongoing transformation of Manchester services, the continuing impact of the devolution of health and social care in Greater Manchester, and the ongoing tendering activity in substance misuse services and other specialist services.

Delivering Social Value

We take our corporate social responsibilities seriously and are committed to contributing positively to the health and sustainability of all of the communities we work with and provide services to.

Co-Producing and Co-Delivering our Services with People with Lived Experience

Service users and carers have continued to provide valuable support to our key corporate functions during the reporting period, including through participation in audit activity, PLACE inspections, Care Quality Commission focus groups and our programme of 'Quality Matters' walk-around visits.

Our service users and carers have had opportunity to be involved in redefining our Trust values. We held a number of focus groups with staff, service users and carers across our new organisational footprint to seek their views on what good care looked and felt like. From the feedback received, we drew out a list of key themes and then asked staff, service users and carers to vote on the values which mattered the most to them. Our new values are set out on page 11 of this report.

Service users and carers from across Manchester have also been involved in our Manchester transformation work-streams. Service users and carers are represented in each Transformation Working Group (TWG) and have been supported via a monthly meeting where they can share their experiences and agree key points to report to the over-arching Transformation Steering Group. Most representatives also attend the monthly Manchester Service User and Carer Forum where transformation is a standing agenda item. This Forum is well-attended and enables a link with the Trust's Council of Governors through our elected City of Manchester governors.

During Quarter 3 of 2017/18, we consulted with staff, service users and carers in Manchester on updates to our Trust-wide 'Service User Engagement Strategy'. Our original Strategy was developed pre-acquisition with staff, service users and carers from Bolton, Salford, Trafford and our Specialist Services. The priorities they identified remain central to the new Strategy, but those areas identified as important to people in Manchester have also now been added to strengthen our commitment to engagement across the Trust. These include improving service user and carer involvement in care planning and connecting service user and carer engagement forums to our CAREhub. With the support of a number of independent service user groups, we have also better reflected national guidance in our refreshed Strategy, including in terms of different levels of participation. There was recognition throughout the consultation exercise that, as a Trust, we have done a lot of work in terms of consulting with service users and carers and engaging them in service delivery. There is more, however, that can be done to enable co-production particularly in relation to business planning and service developments.

Our Recovery Academy continues to be recognised as a model of good practice in relation to co-production and we launched our tenth prospectus on 1 October 2017. We now offer 62 courses across our footprint - including in North, South and Central Manchester - and have over 5,500 students registered with the Recovery Academy. Of our students, nearly 50% are service users and carers. Our courses are delivered by a bank of tutors, including over 20 tutors with lived experience of mental health and/or substance misuse problems.

In last year's Annual Report, we referenced the investment received from Health Education England (HEE) to further develop Peer Mentorship across our district mental health services in 2017/18. As this funding comes to a close, we are pleased to report that eleven out of the sixteen Peer Mentors recruited completed their training and are now in situ within our Early Intervention Teams. In total, we have 29 Peer Mentors in operation across the Trust - including within our Substance Misuse Services - and we are now

working to integrate the role into our rehabilitation and inpatient services.

In addition to Peer Mentors, we also have over 92 volunteers working across our services in a range of roles. These roles have been developed based on feedback received from our patient experience surveys. They include Activity Coordinators (to alleviate boredom on our inpatient wards) and Group Facilitators (to bring the benefits of shared lived experience to our therapeutic group work programmes).

Due to our commitment to volunteering, we have seen a significant increase in applications for volunteering opportunities with a further 60 received during the financial year. We have now recruited a specialist Volunteer Recruitment Administrator who will support services going forward to recruit, induct and support volunteers. The process of becoming an Investors in Volunteering organisation is also underway.

Service users and carers from across the Trust have taken part in digital story workshops. These workshops have resulted in the creation of a series of digital stories from across different GMMH districts and services. The stories highlight a wide range of issues including community resilience, the urgent care system, the role of the GP and emergency services, medications, follow up post discharge, and the experience within low and medium secure services. The stories also describe what high quality care feels like and the impact that this can have both when care is good and when the care experience is less positive. We are planning to feed these stories into our Quality Matters improvement programme and also share them with staff to support reflective practice.

Equality

We are committed to ensuring equality and diversity is an integral part of service delivery. We have a duty to provide equal access and opportunities to all of our service users, relatives, carers and staff. During 2017/18, our equality and diversity governance structure has been reviewed and strengthened to better meet the needs of the combined entity. This has included expanding the membership of the Trust-wide Equality and Diversity meeting and establishing new networks across Greater Manchester.

During 2017/18, we have celebrated a number of achievements related to equality and diversity. These include:

- Adapting the service information available on our website to include British Sign Language (BSL)
- Launching a new dining club for people living with early onset dementia
- Developing transgender guidance for clinical services
- Engaging with staff with protected characteristics, for example, through the establishment of a BAME (black, asian and minority ethnic) forum
- Enhancing the spiritual health care team across the organisation
- Piloting a Trust EDS2 (Equality Delivery System 2) workshop using a new method of public grading. This will be implemented across our localities in 2018/19
- Strengthening our Workforce Race Equality Standard (WRES) action plan, with a key focus on developing a BAME mentoring scheme and leadership programme
- Committed GMMH representation at LGBT (lesbian, gay, bisexual, transgender) Pride
- Introducing new Learning Disability training for clinicians
- Acquiring investment in the provision of a Greater Manchester-wide perinatal mental health service

Our Annual Equality Report breaks down and analyses our staff and service user equality data. It also showcases our achievements and provides a narrative update on actions agreed in the previous year. During 2017/18, we met all of our local equality and diversity objectives. There remain, however, a number of Trust-

wide issues, such as the recording of disabilities, which require further organisational focus.

In early 2018/19, we will develop and launch a new overarching Equality and Diversity Strategy, which will set out our priorities and ambitions for the next three years. These will include:

- Ensuring that we continue to strengthen the data collection of our service users' protected characteristics
- Holding local equality engagement events with staff, service users and other stakeholders to obtain feedback on our equality performance and to help us to identify equality objectives
- Identifying priorities for service development through analysis of protected characteristics data and other intelligence
- Incorporating equality objectives into our business plans
- Undertaking equality impact assessments on business cases and plans to ensure that they meet the needs of, and do not disadvantage, service users of any protected characteristics

Pathways into Employment and Apprenticeships

2017/18 has seen significant progress made with regard to pathways into employment and apprenticeships. As a registered apprenticeship delivery centre, with the ability to draw down funding directly from the Apprenticeship Levy, we have seen an increase in the number of our staff taking up apprenticeship opportunities. We have also seen an increase in services recruiting into roles specifically developed to support someone into an apprenticeship opportunity. As at February 2018, 2.61% of our workforce were engaged in an apprenticeship programme, which is in excess of the Public Sector statutory target of 2.3%.

During the summer of 2017, we introduced a new Workforce Community Engagement Officer role with the specific remit of working with our local communities to support the long-term unemployed back into employment. Since October 2017, we have been working with Manchester College to provide Pre-Employment Placements for seven people and with Hopwood Hall College to provide Traineeships for three people. We have also supported 15 school and college students to undertake formal work experience placements in our Forensic Mental Health Services, John Denmark Unit, Chapman Barker Unit and Woodlands Unit.

Our internally-delivered apprenticeship portfolio has grown during 2017/18. We have continued to provide apprenticeships in Health and Social Care, Business Administration and Customer Service and have also introduced apprenticeships in Leadership and Management, ranging from entry level qualifications for our first line leaders to an ILM (Institute of Leadership and Management) accredited Level 5 Higher Apprenticeship for our senior managers and aspiring leaders. Our dedicated Functional Skills Tutor has also supported all learners in the achievement of Maths, English and ICT qualifications.

We were delighted to have our Matrix Accreditation renewed in 2017/18. The Matrix standard is a quality framework that measures the career information, advice and guidance made available to learners engaged in our apprenticeship programmes. We also hosted a positive compliance visit from the Education and Skills Funding Agency (ESFA), which demonstrated strong financial management of our Apprenticeship Levy and have taken steps to strengthen our partnerships with other local training providers. This has enabled a number of our staff to access more specialist programmes such as Pharmacy Technician and Nursery Nursing.

Finally, during March 2018, we celebrated National Apprenticeship Week and for the second year running are proud to be the employer of another college-nominated Apprentice of the Year. Joining

Andrew Dunne from our Catering Services, who was last year's Apprentice of the Year for Bury College, is Stacey Staton. Stacey is training to be a Pharmacy Technician and won Trafford College's Apprentice of the Year award. We could not be prouder of everything that Andrew and Stacey have achieved.

Modern Slavery

We are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. In early 2017/18, we completed our annual assessment of the Trust's risk exposure to modern slavery and reviewed our 'Slavery and Human Trafficking Policy Statement'. This statement is published on our website and sets out the actions taken by the organisation to understand the potential risks and implement effective systems and controls. These include undertaking appropriate pre-employment checks on directly employed staff and requiring agencies to provide assurance that pre-employment clearance has been obtained for any agency staff employed by the organisation. We also require all of our suppliers to comply with the provisions of the UK Modern Slavery Act (2015) through agreement of our 'Supplier Code of Conduct', purchase orders and tender specifications.

Anti-Fraud, Bribery and Corruption

We do not tolerate fraud, bribery and corruption and aim to eliminate such activity as far as possible to ensure that public resources are freed up for better patient care. We encourage anyone with reasonable suspicions of fraud, bribery and corruption to report them and have a policy in place to support this. Our commitment to anti-bribery is clearly set out in our Anti-Bribery Statement, which is available via our website.

Sustainability

During 2017/18, we have endeavoured to find further ways of reducing the amount of carbon used within our services in accordance with NHS guidelines. A number of key initiatives are proving efficient. The continued work with 'Warp It', for example, has benefited the Trust, local community schemes, schools and charities. 'Warp It' helps to reduce waste disposal and purchasing costs by supporting the distribution, re-use and recycling of redundant resources such as furniture, equipment, fixtures and fittings. Examples of projects undertaken in the last 12 months include offering re-usable office furniture for use elsewhere in the Trust and/or by external bodies in the local area, such as schools and charities. Through 'Warp It' we have delivered the following savings over the period, which is an increase of approximately £10k on the savings realised in 2016/17:

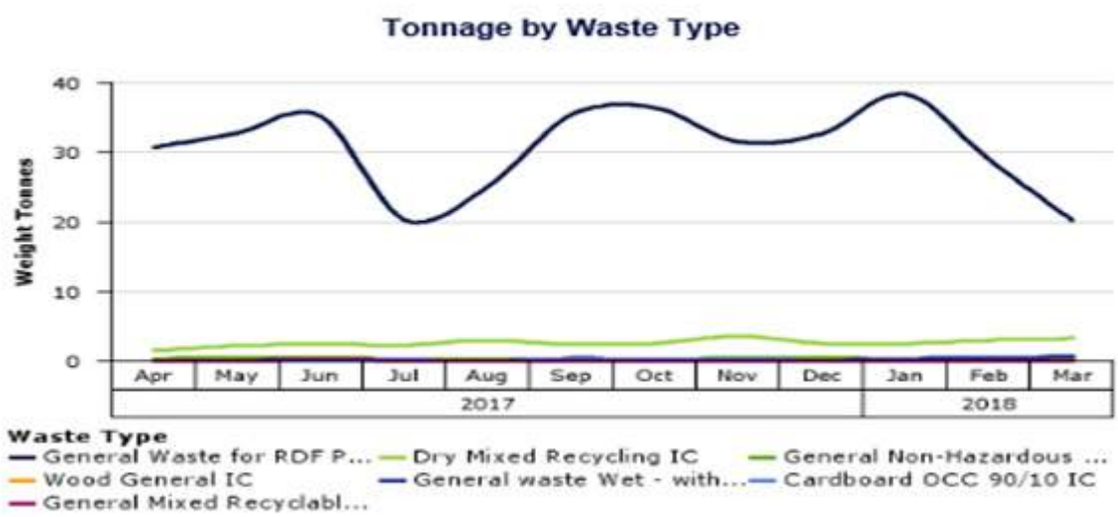
CO2 Saved (KG)	Cars off the Road	Waste Avoided (KG)	Trees Planted Equivalent	Total Savings
24,303	11	6,497	33	£62,507

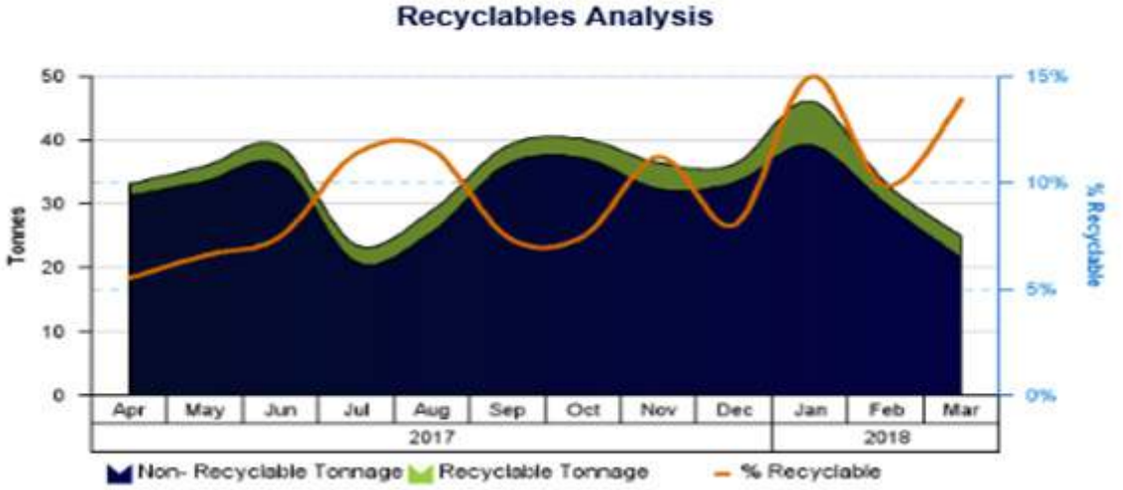
Following the recent publication of NICE guidance on road-traffic-related air pollution and its links to ill health, we have reviewed our approach to minimising pollution from vehicles. Current positive examples include the inclusion of a zero emission vehicle in our vehicle fleet and four vehicles with 'Stop-Start' technology, the provision of driver training and ensuring that all vehicles procured have 1.0L eco boost engines, which reduce emissions and enable improved fuel consumption. We also promote cycle to work schemes and provide changing rooms, showers and cycle racks/pods in a number of areas. We are working to increase staff awareness and uptake of these initiatives, to further reduce air pollution.

In February 2018, we commissioned an independent company to review our waste-streams and

identify opportunities to reduce the amount currently sent to landfill. A number of areas of good practice were identified, such as the use of clear waste bags as opposed to the black household ones still in use in many Trusts. The review also found that the majority of our waste is dry recyclable and, as such, very little is sent to landfill. Identified areas for improvement related to the provision of food waste receptacles, to enable food waste to be kept separate from other dry recyclable waste and thus increase our waste recycling. Working with a company called 'bio-bean', we have also started to segregate spent coffee grounds from our hot beverage machines for recycling into carbon-neutral advanced biofuels.

	Total 2017/18
Total Tonnage Collected	416.035
Non-Recyclable Tonnage	376.395
Recyclable Tonnage	39.640
% Recyclable	**9.53%**





Energy reduction also remains a key target for both the Trust and the NHS as a whole. Through careful energy management and the introduction of a number of energy reduction initiatives, we have been able to reduce our overall energy usage in year. This has led to a decrease in our CO2 emissions and the amount of carbon used.

Overall Trust Performance	2016/17	2017/18
Giga joules per 100m3 (Gj/100m3)	38.47	32.06
Tonnes of CO2 (Tonne/CO2)	6,231.53	5,348.32
Tonnes of Carbon	2,387.50	2,146.62

As demonstrated above, an overall reduction of 6.41 Gj /100m3 in energy usage has led to a reduction of 883.21 tonnes of CO2 and 240 tonnes of carbon in year.

Research and Innovation

Our Research and Innovation service has undergone a significant period of integration and change since the acquisition of MMHSCT We have strived to retain the best from both GMW and MMHSCT throughout this process and continue to be one of the country's most productive mental health research Trusts.

Our research portfolio has been strengthened during 2017/18, notably in relation to our dementia research where we have seen significant increases in participant recruitment. We have also achieved an excellent success rate in terms of NIHR (National Institute of Health Research) grants and fellowships. This includes funding for research focussed on improving access to psychological therapy on inpatient psychiatric wards and enhancing the quality of psychological interventions delivered by telephone. Our NHS-funded research ensures that our patients have access to the UK's leading interventions, which are improving the health of our population.

We have continued to grow our commercial research portfolio, demonstrating our commitment to working with industry to support the development of new interventions that seek to improve the lives of patients with mental health symptoms or dementia. Through additional Research Capability Funding (RCF) we have also been able to develop five new Research Units focussed on youth mental health, CAMHS digital, healthy brains, trauma and resilience, and patient safety. It is hoped that these new units will build on the success of our well-established, self-sustaining Psychosis Research Unit.

We have remained focussed on putting our research into practice. Examples of success in this area include EDIE and EDIE-2 trials leading to a NICE (National Institute for Health and Care Excellence) recommendation of CBT (cognitive behavioural therapy) for young people at risk of developing success. Our user-led research on recovery from psychosis and a subsequent NIHR programme grant has also led to the development of a questionnaire about process of recovery. This questionnaire is now mandated for use nationally as an outcome measure in the evaluation of early intervention services.

We have also developed a new Research and Innovation Strategy, which sets out our key aims taking into account our organisational values and the direction of travel set out in 'The Five Year Forward View for Mental Health'. Service user involvement is central to our Strategy and is also a critical deliverable for all of our Research Units. Progress against our strategic aims will be overseen by our Research and Innovation Committee going forward.

Our research and innovation service finished the year in a strong financial position. Further information on our Research and Innovation activities during 2017/18 is provided in our Quality Account, which accompanies this Annual Report.

Customer Care

Our Customer Care Team have continued to support and facilitate the management of complaints, concerns and compliments received during the period. When we receive a complaint, we aim to provide individuals with a timely response, including all the evidence available to show that we have dealt with their concerns in a clear and transparent way. All complaints received are recorded onto the Trust's DATIX system and reported to the Board of Directors on a monthly basis as part of the Board Performance Report. Complaints administration was considered by the CQC during their inspection in September – December 2017. The CQC found that we 'treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.'

Systems for recording, managing and reporting complaints, concerns and compliments have been standardised across GMMH following the acquisition of MMHSCT.

We received 589 complaints during the reporting period. The following table breaks these complaints down by service area and provides a comparison to the position in 2016/17 for all of the services that now make up GMMH.

	2016/17	2017/18
Bolton	69	87
Manchester	187	235
Salford	83	101
Specialist Services	138	103
Trafford	48	63
Totals	**525**	**589**

The upward trend in complaints received in 2017/18 compared to 2016/17 relates to our district services in Bolton, Salford, Trafford and Manchester. We have analysed this trend but no recurring themes have been identified.

302 improvement actions have been identified across the organisation as an outcome of the complaints received. Of these, 140 actions are complete and 162 are in progress at the time of writing.

Examples of services improvements undertaken during 2017/18 following complaints include:

- Better communication in Bolton – information packs have been reviewed to ensure that the information provided is accurate and up to date
- Greater levels of dignity within inpatient services in Salford – staff have reflected on and improved their approach to conducting searches of our inpatients
- Safer service delivery in Manchester – the training provided to staff on conducting home visits when service users are reluctant to allow workers into their homes has been strengthened
- Better communication in our Specialist Services – admission documentation has been amended to ensure that, for example, the introduction of a key worker is documented within the notes as standard
- Better appreciation of carers in Trafford – nursing staff have participated in reflective practice on the importance of the role of carers

Significant Events Post 1 April 2018

There have been no significant events since 1 April 2018, which have affected delivery of our strategy and key objectives.

Overseas Operations

We did not have any overseas operations during the year.

Neil Thwaite, Chief Executive
21 May 2018


joy
you!
Whole Person
spirit

Accountability Report

Directors' Report

The Board of Directors of GMMH present their annual overview of the arrangements in place to ensure that services have been well-led during the period 1 April 2017 to 31 March 2018. The Directors' Report should be read in conjunction with the Performance Report, Quality Account and Annual Governance Statement.

Following our most recent inspection by the Care Quality Commission (CQC), which took place during September to December 2017, the CQC awarded an 'Outstanding' rating for well-led (leadership). In awarding this rating, the CQC highlighted:

- The leadership team's effective oversight of the risks and challenges facing the Trust
- The maintenance of a strong clinical and financial performance during and subsequent to the acquisition
- The Trust's effective approach to partnership working
- The well-established and thorough systems for investigating serious incidents and learning lessons
- The involvement of service users and carers, including in Manchester's transformation plans, which demonstrated true co-production
- The approach to risk management

No material inconsistencies have been identified between the CQC report and our own evaluation of the organisation's performance and system of internal control as set out in this Annual Report.

Statement of Directors' Responsibilities

All Directors consider that the Annual Report and Accounts for 2017/18, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the performance, business model and strategy of the Trust. All Directors have confirmed that, so far as they are aware, there is no relevant audit information of which the Trust's auditor is not aware and that they have taken all the steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

The required disclosures regarding our performance against the Better Payment Practice Code, our compliance with cost allocation and charging guidance, our income and our approach to preparing our Accounts on a going concern basis are provided in 'Our Financial Performance' on page 17 onwards.

Neil Thwaite, Chief Executive (by order of the board)
21 May 2018

Our Governance Arrangements

We have worked hard since the acquisition of MMHSCT to ensure that our governance arrangements are sound and fit for purpose, both in the short-term and looking forward.

Our Board of Directors operates as a unitary Board, with decisions made collectively by executive and Non-Executive Directors and responsibilities and liabilities shared. Our Board offers a wide range of skills and experience, with a number of directors having a medical or nursing professional background and other members offering skills in finance, strategy, business development and the law. The Board believes that it is balanced in its composition and appropriate to the requirements of the organisation.

Our Board of Directors sets the overall strategic direction for the Trust and is collectively responsible for monitoring all aspects of performance, providing financial stewardship and ensuring the provision of high quality, safe and effective services. Executive directors manage the day to day operational running of the organisation, whilst our Non-Executive Directors are focussed on challenging the Executive Team on management and strategy. Our Non-Executive Directors do not hold any managerial responsibility, but are collectively accountable with the executive directors for the Trust's performance. The contribution of Non-Executive Directors and their relationships with executive directors and governors, is facilitated by the Chair.

All of our Non-Executive Directors are considered to be independent, as they have not been employed previously by the Trust, do not have any financial or other business interest in the organisation and do not have close family ties with any of the Trust's directors, senior employees or advisors. None of the current Non-Executive Directors have served on the Board for more than six years. Other significant commitments held by the Chair during the reporting period are summarised in the Board of Directors' Register of Interests on page 50. These commitments have not changed significantly during the year.

Our Council of Governors provide local accountability by representing the interests of members and partner organisations. The Board of Directors retains overall responsibility for decision-making, except where the Council of Governors has statutory responsibilities. Directors develop an understanding of the views of governors, and enable governors to fulfil their duties, through attendance at Council of Governors' meetings, meetings of the Council's committee and working groups, and attendance at the Annual Members' Meeting. The Board works closely with our Council of Governors to enable the governors to carry out their statutory duties. Governors' views have been sought on the Trust's forward plans during the period and Board members have also provided feedback on the Trust's undertakings and performance. See page 54 onwards for further detail on the activities of our Council of Governors during 2017/18.

Our Board of Directors

There have been no significant changes to the portfolios of Executive members of the Board of Directors since 1 April 2017. Changes reported in the Annual Report 2016/17 came into effect from 1 April 2017.

As previously noted, Bev Humphrey retired from her position as Chief Executive on 31 March 2018. Neil Thwaite acted as Interim Chief Executive from 1 April 2018 and took on the role substantively following Council of Governors' approval of the appointment on 9 April 2018.

The members of our Board of Directors during 2017/18 were:

Rupert Nichols
Chair (current term ends July 2019)

Rupert is a solicitor and Chartered Secretary with 40 years' commercial board-level experience in a wide range of organisations in the legal and accountancy, logistics, manufacturing and services sector. He has extensive experience in corporate governance, compliance, mergers and acquisitions and risk management.

Previously Chair of Calderstones Partnership NHS Foundation Trust and board member of the NHS Confederation Mental Health Network, Rupert brings valuable experience of mental health and learning disabilities leadership to GMMH.

Anthony Bell
Non-Executive Director (current terms ends July 2018)

Anthony joined GMMH in 2014 and is a qualified accountant. Anthony has over 20 years of experience at board level in the education and social housing sectors, and has also held senior roles in the private sector. He is a non-executive director at two local housing associations and deputy chair of a managed workspace complex company, which supports developing business. Anthony has also previously been a board member and treasurer of a training placement organisation for minority groups, and an education Trust which supported disadvantaged groups.

Anthony is Chair of GMMH's Charitable Funds Committee and a member of the Audit Committee.

Stephen Dalton
Non-Executive Director (current term ends December 2019)

Stephen has over forty years of experience in the NHS. He started his NHS career in 1976 as a general nurse on Merseyside, followed by a period working in mental health services in South Manchester and a series of clinical leadership roles including as a Director of Nursing. Stephen spent 17 years as a Trust Chief Executive, in Merseyside and Cumbria, responsible for delivering frontline clinical services and describes his career passion as mental health services.

Stephen is known nationally for his work as Chief Executive of the NHS Confederation and of the Mental Health Network, both roles demanded engagement at the highest level of government and the NHS.

Kathy Doran OBE

Non-Executive Director and Vice-Chair (current term ends July 2018)

Kathy joined GMMH in 2014 and has 38 year's public sector experience across central government and NHS providers and commissioners. For 11 years until 2013, Kathy worked in primary care and as cluster primary care Trust executive. She is also a former member of the National Institute of Health Research Advisory Board and has been an advisor to NHS Employers in relation to GP pay. Kathy is the Chair designate of Your Housing Group (a large North West housing association), Chair of The Reader Organisation (a Liverpool-based charity) and also Chair of the Local Governing Body of Birkenhead High School Academy.

Kathy is Chair of GMMH's Quality Governance Committee.

Julie Jarman

Non-Executive Director (current term ends July 2020)

Julie joined GMMH in 2014. Julie has over 17 years' experience of senior management in the voluntary sector both in the UK and in international development. She also works as a management coach and mentor. Julie currently works as a Principles Programmes lead for the Equality and Human Rights Commission. She is also a Trustee of two charities: MIND in Salford and HomeWorkers Worldwide.

Julie is a member of GMMH's Quality Governance Committee and Charitable Funds Committee.

Andrea Knott

Non-Executive Director (current term ends December 2019)

Andrea is a chartered accountant with over 20 years business and financial experience in the private sector and is currently a Transformation Leader for a major pharmaceutical company (AstraZeneca). Andrea brings a wealth of experience in strategic and operational planning, performance management, merger & acquisition integration and change management.

Andrea is Chair of GMMH's Audit Committee.

Pauleen Lane

Non-Executive Director and Senior Independent Director (current term ends December 2019)

Pauleen is currently Group Manager for National Infrastructure at the Planning Inspectorate and also a visiting lecturer at Manchester University. She has a PhD in numerical modelling and geotechnical engineering. Her early career was in local governments - in officer and councillor positions at Trafford Council - and as a commissioner with the Audit Commission.

She has experience in a range of public sector non-executive roles including at Liverpool Women's Hospital, the Sports Ground Safety Authority, the North West Development Agency, English Partnerships, Tenant Services Authority and the Coal Authority.

Pauleen is GMMH's Senior Independent Director and a member of the Audit Committee.

Bev Humphrey

Chief Executive until 31 March 2018

Bev was Chief Executive of the Trust from October 2006 to 31 March 2018. She was previously Chief Executive for The Walton Centre for Neurosciences NHS Trust in 2004. Other NHS experience includes being Director of Performance for Cumbria and Lancashire Strategic Health Authority in 2002 and Director of Specialist Services Commissioning for Lancashire and South Cumbria in 2000. Prior to this, Bev held various managerial posts in both acute and community services in Merseyside, Essex and Lancashire, having started her career in the NHS in 1983.

Outside of GMMH, Bev chaired the North West Mental Health Chief Executives Group and was also Chair of the National Mental Health Network of the NHS Confederation. Bev has been included in a Health Service Journal list as one of the Top 50 NHS Chief Executives.

Neil Thwaite

Interim Chief Executive from 1 April 2018 and Substantive Chief Executive from 9 April 2018

Neil started his career in the NHS in 1993 and has worked across many NHS sectors including acute care, primary care, the Cancer Network and the Strategic Health Authority. Neil is formally qualified in business and project management, most recently successfully attaining a Master's in Business Administration at Manchester Business School.

Neil joined GMMH in 2006 and was the Executive lead for the successful Foundation Trust application. He has a great deal of experience and a strong interest in service development, business planning, contracting, performance improvement and strategy.

Dr Chris Daly
Medical Director

Chris worked as a Consultant Community Psychiatrist in Australia for two years from 1994. He joined the Trust in 1996 as a Consultant General Adult Psychiatrist, working in inpatient and community settings. His special interest is in substance misuse and he has led and developed a range of services for alcohol and drug dependent individuals including dual diagnosis services.

Chris has extensive experience in teaching and training junior doctors in psychiatry. He has also been actively involved in tender applications and in developing service models within Alcohol and Drugs services. Chris' recent achievements include being the clinical lead in developing the award-winning RADAR pathway at the Chapman Barker Unit.

Gill Green
Director of Nursing and Governance

Gill joined the Trust in August 2011. Gill has extensive experience in delivering nursing care in both acute and community settings and has worked for a number of different NHS organisations including Clatterbridge Hospital in Bebington, James Cook University Hospital in Middlesborough, Barnsley Care Services Direct and South West Yorkshire Partnership NHS Foundation Trust.

Gill also works closely with third sector providers, including experience of Trusteeships in this area. She is particularly involved in nursing workforce education and nursing leadership across the Greater Manchester area.

Ismail Hafeji
Director of Finance and IM&T

Ismail joined GMMH in 2011. Ismail offers a wealth of experience, having worked in NHS finance since 1983 at NHS Trusts, Health Authorities and PCTs around the North West. He has worked as a Finance Director for over ten years.

His previous role was as Director of Finance, IT and Information with NHS Bolton. Ismail also worked as Acting Director of Finance for the former West Lancashire and Chorley and South Ribble PCTs.

Andrew Maloney
Director of Human Resources and Corporate Affairs

Andrew has worked in senior HR positions across a broad range of NHS sectors. From 2000 to 2004 he worked as the Assistant Director of HR for Sefton Health Authority and Sefton Primary Care Trust working on HR change management projects that supported the establishment of PCTs across Sefton. In 2004, Andrew joined The Walton Centre NHS Trust as Director of HR and was part of the executive team that led the organisation to Foundation Trust status.

Andrew joined GMMH in 2009 as Director of HR and Governance and has more recently taken on wider responsibility for facilities and corporate governance. Andrew also undertakes two national roles as an NHS Employers representative on the Social Partnership Forum and the NHS Staff Council. He is also a member of the Executive Advisory Council for the Faculty of Business and Law at Manchester Metropolitan University.

Deborah Partington
Director of Operations

Deborah began her NHS career almost 30 years ago, when she started her nurse training in Salford. Since then she has held a variety of senior posts at the Trust, including Clinical Leader, Head of Operations, Network Director and Associate Director of Operations. She was seconded to the NHS Confederation – Mental Health Network for a year working with them to represent health organisations across England within national strategic developments.

As well as her nursing qualifications, Deborah also has a Masters in Health Services Management from the University of Manchester. A key focus of Deborah's current role is providing executive oversight and guidance to the Manchester transformation programme. Deborah's leadership has also been critical to the Trust's performance in its recent Care Quality Commission inspection.

Meetings of the Board of Directors

During 2017/18, the Board of Directors met formally on nine occasions. The first part of our Board meetings are held in public, with the papers for each meeting published on our website. Governors are provided with a copy of the agenda prior to each Board meeting and access to a copy of the minutes once they are approved at the following meeting.

A quorum of seven directors, including no less than two executive directors, of which one must be the Chief Executive or Deputy Chief Executive, and no less than two Non-Executive Directors, of which one must be the Chair or Vice-Chair, is required for a Board of Directors' meeting to take place.

The following table shows the attendance of individual directors at our 2017/18 Board meetings.

		No. of Meetings Attended	No. of Meetings the Director could have Attended
Non-Executive Directors	**Rupert Nichols** Chair	9	9
	Anthony Bell Non-Executive Director	9	9
	Stephen Dalton Non-Executive Director	6	9
	Kathy Doran Non-Executive Director	6	9
	Julie Jarman Non-Executive Director	9	9
	Andrea Knott Non-Executive Director	9	9
	Pauleen Lane Non-Executive Director	8	9
Executive Directors	**Bev Humphrey** Chief Executive	9	9
	Neil Thwaite Deputy Chief Executive/Director of Strategic Development	8	9
	Chris Daly Medical Director	9	9
	Gill Green Director of Nursing and Governance	9	9
	Ismail Hafeji Director of Finance and IM&T	8	9
	Andrew Maloney Director of HR and Corporate Affairs	9	9
	Deborah Partington Director of Operations	7	9

Evaluating Board Performance and Effectiveness

Performance evaluation of both executive and non-executive members of the Board of Directors is by individual appraisal and collective evaluation. The Chair conducts all non-executive appraisals and also appraises the Chief Executive. The Council of Governors agreed this year's Chair and Non-Executive Director appraisal process in February 2018, for operation in the first quarter of 2018/19. The process is broadly the same as the new process introduced in 2016/17, being competency-based, targeted towards the specific requirements of the role and including self- and peer-assessment. The Nominations Committee of the Council of Governors receive a report on appraisal outcomes and agree associated development plans and this is, in turn, considered at a full meeting of the Council of Governors. The Senior Independent Director conducts the Chair's appraisal. Executive director appraisals are held with the Chief Executive. The outcome of all appraisals is the agreement of objectives and personal development plans for the upcoming year.

Board development activity during the reporting period followed a formal schedule and commenced in June 2017. Development activities focussed on Board effectiveness, risk management and Board assurance, the Greater Manchester Mental Health Strategy, preparation for the CQC inspection and future strategy, including in relation to the workforce.

All individual Board members have been assessed against the requirements of the Fit and Proper Persons Regulations to determine that they are of good character, are physically and mentally fit, and offer the necessary skills, qualifications and experience. There were no issues identified in this regard.

Board members have continued to evaluate the effectiveness of Board meetings at the end of each meeting with feedback reviewed at the subsequent meeting and informing Board development activity. In December 2017, the Board of Directors met to review the feedback themes emerging over the course of the year and agreed a number of improvement actions, which are now being taken forward.

Board Committee Structures

During the reporting period, the Board of Directors has been supported by four formal sub-committees:

A. Audit Committee
B. Quality Governance Committee
C. Charitable Funds Committee
D. Remuneration and Terms of Service Committee

The work of each of these Committees is described below. A review of the Terms of Reference and membership of individual Committees has been undertaken during the period to ensure that they continue to be fit for purpose. The minutes of all Committee meetings have been reported to the Board of Directors. Committee Chair's report have also been presented to the next meeting of the Board of Directors immediately following a Committee meeting to enable more timely feedback and assurance.

A. Audit Committee

The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities, on behalf of the Board of Directors. The Audit Committee ensures that an effective internal audit function is in operation, which meets all required standards, and reviews and monitors the work and findings of the Trust's external auditors. The Committee is also responsible for ensuring that the Trust has adequate counter fraud arrangements in place.

The Audit Committee Terms of Reference were subject to an annual review in October 2017.

Committee Membership and Meetings

The Audit Committee has been chaired throughout the year by a non-executive director and the Committee's membership comprised two further Non-Executive Directors selected on the basis of their individual skills and experience. Membership of the Audit Committee as at 31 March 2018 was as follows:

- Andrea Knott, Chair
- Anthony Bell, Vice-Chair
- Pauleen Lane, Non-Executive Director

The Audit Committee has been assisted in its work through the routine attendance at meetings of our internal auditors, anti-fraud specialist and external auditors. The Director of Finance and IM&T, Director of HR and Corporate Affairs and Director of Nursing and Governance also attended meetings during the period, as a result of their lead roles on matters considered by the Committee.

The Audit Committee met six times in 2017/18 and the table below shows each member's attendance.

Name	No. of Meetings Attended	No. of Meetings the Director could have Attended
Anthony Bell Committee Member and Vice-Chair	6	6
Andrea Knott Committee Chair	6	6
Pauleen Lane Committee Member	6	6

Audit Committee members have had opportunity to meet privately with external and internal auditors during 2017/18. Right of access to the Chair for internal audit, external audit and counter-fraud has also been maintained throughout the year.

Audit Committee Effectiveness

In February 2018, MIAA facilitated a session with Audit Committee members to review the Committee's effectiveness. This session focussed on good practice, delivery of duties and compliance with the Terms of Reference. The session was informed by self-assessments completed by Committee members. The outcomes of the review were positive overall, with a number of actions for improvement identified. These included the need to agree objectives for the Committee's attention during the coming year.

Assurance - Internal Audit

Our internal audit function has continued to be provided by Mersey Internal Audit Agency (MIAA) during 2017/18. Our Team at MIAA consists of an Engagement Lead and Engagement Manager. MIAA also provided the internal audit function at the former MMHSCT. To support the transition and integration of the two organisations during the period, MIAA have provided insight into MMHSCT's internal audit coverage and outcomes and anti-fraud activity. MIAA have also reported progress on delivery of any remaining planned assurances for MMHSCT to GMMH's Audit Committee.

Improve the outcome

Our annual plan of internal audits is designed to support the Board of Directors and Audit Committee in discharging their governance responsibilities. The outcomes of internal

audits give assurance to the Board, via the Audit Committee, that risks are understood and being addressed or reduced to an acceptable level. Internal audit plans fully comply with national standards and guidance.

The Internal Audit Plan for 2017/18 was agreed by the Audit Committee in April 2017 and reflected the risk assessment, assurance requirements and strategic objectives of the enlarged organisation. The plan was delivered within the agreed reporting timescales. The Audit Committee received reports on 15 internal audits completed during the reporting period, of which 1 received a 'High Assurance' opinion, 12 received a 'Significant Assurance' opinion and 2 received a 'Limited Assurance' opinion. The 'Limited Assurance' opinions followed assessments of the effectiveness and efficiency of the Trust's systems for managing bank and agency staffing and of the systems and processes established in relation to meeting the physical health needs of patients with a severe mental illness (SMI). Recommendations from both audits are being taken forward to strengthen our controls in these areas.

The Committee has secured assurance on progress with outstanding audit recommendations via twice-yearly follow-up reports.

The Committee received the Director of Internal Audit's opinion on the overall adequacy and effectiveness of GMMH's risk management, control and governance processes, for the financial year 2017/18, in April 2018. The overall opinion was that 'Substantial Assurance' can be given that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

In 2017/18, we spent £125k on internal audit.

Assurance - External Audit

KPMG were appointed as our external auditors by the Council of Governors in July 2016, for a three-year period effective from 1 December 2016.

At Audit Committee meetings during 2017/18, KPMG have presented technical updates on accounting, business and regulatory matters that are relevant to our organisation and the wider healthcare sector. The effectiveness of KPMG's services have been judged on the basis of the quality of their audit findings, management's response and stakeholder feedback. In February 2018, KPMG made the case to the Audit Committee on their independence and compliance with applicable technical and ethical standards.

On 5 February 2018, the Audit Committee considered and approved the 'External Audit Plan for 2017/18', including the proposed materiality levels and financial risk assessment. In addition to the mandated risks, the External Audit Plan highlighted three significant audit opinion risks relating to the valuation of NHS income and deferred income, the valuation of land and building assets and the valuation of the Local Government Pension Scheme (LGPS) liability.

We incurred external audit fees of £78k in 2017/18 for statutory audit services. We also incurred nominal fees of £7k for the provision of non-audit services in relation to pensions advice.

Assurance - Anti-Fraud

Our anti-fraud services have also continued to be provided by Mersey Internal Audit during the period and operated by a dedicated Local Anti-Fraud Specialist. Our annual anti-fraud work plan was approved by the Audit Committee in April 2017 and informed by local risk assessment and national standards and best practice. The Audit Committee received regular reports on the progress and outcomes of anti-fraud work during the period.

All employees have been given an overview of our 'Anti-Fraud, Bribery and Corruption Policy' at induction with awareness sessions conducted on an ad hoc basis and the policy available to all staff thereafter.

We participated in an NHS Protect (now NHS Counter Fraud Authority) focussed assessment inspection in May 2017, following submission of our annual self-assessment against the NHS Protect Standards for Providers. This assessment reviewed our anti-fraud arrangements in relation to the 'Inform and Involve' and 'Hold to Account' standards. The Audit Committee undertook a thorough review of the inspection outcomes and associated recommendations, including the need to further embed a counter-fraud culture across the organisation and learning related to the use of the FIRST system for incident reporting. The Committee agreed actions to address these and a management response to NHS Protect.

The Audit Committee has been able to provide assurance to the Board, via the Committee Chair's Assurance Reports, on the adequacy of the arrangements in place to counter fraud, corruption and bribery.

In 2017/18, we spent £31k on anti-fraud services.

Financial Statements, Operations and Compliance

On 27 April 2018, the Audit Committee reviewed a summary of the Trust's performance based on the annual accounts for the period 1 April 2017 to 31 March 2018. The Committee noted any variations from performance in 2016/17, including the explanations provided for this. Management brought to the Committee's attention significant movements in the accounts over the period.

The Committee reviewed the Trust's financial statements, with a particular focus on:

- Compliance with financial reporting standards
- Areas requiring significant judgements in applying accounting policies
- Any changes to accounting policies during the year – no changes were reported
- Whether the accounts offer a fair reflection of the Trust's performance

The Committee considered the significant audit risks identified in relation to the financial statements, including the valuation of NHS income and deferred income, the valuation of land and building assets and the valuation of the Local Government Pension Scheme (LGPS) liability. The Committee also considered the areas where the Trust has applied judgement in the treatment of revenue and costs, to ensure that the annual accounts represented a true position of the Trust's finances.

Annual Governance Statement

At its meeting on 27 April 2018, the Audit Committee reviewed the draft Annual Governance Statement for 2017/18. The statement was judged consistent with the Audit Committee's view on the organisation's system of internal control.

B. Quality Governance Committee

The Quality Governance Committee develops and defines our quality framework and quality strategy on behalf of the Board of Directors, identifying the Trust's key quality priorities, safety issues, goals and standards. The Committee tracks performance against agreed quality priorities, including those set out in the Quality Account, and provides assurance to the Board that the required standards are achieved or that action is taken on sub-standard performance.

The Board of Director members of the Quality Governance Committee as at 31 March 2018 are listed below. The Committee's membership has also included expert representation from the Trust's clinical services, professional leads and the governance team during the year. The wider membership of the Committee has been reviewed in 2017/18 to ensure appropriate representation from across the Trust's services. Interim Terms of Reference for the Quality Governance Committee were in operation in early 2017/18, with final Terms of Reference agreed in July 2017.

The Quality Governance Committee met nine times during the financial year with Board members' attendance recorded as follows:

		No. of Meetings Attended	No. of Meetings the Director could have Attended
Non-Executive Directors	**Kathy Doran** Committee Chair	8	9
	Julie Jarman Committee Member	9	9
Executive Directors	**Chris Daly** Medical Director and Vice Chair	7	9
	Gill Green Director of Nursing and Governance	8	9
	Bev Humphrey Chief Executive	3	9
	Andrew Maloney Director of HR and Corporate Affairs	7	9
	Deborah Partington Director of Operations	4	9
	Neil Thwaite Deputy Chief Executive/Director Strategic Development	8	9

Key areas of focus for the Quality Governance Committee during 2017/18 are reported on in our Quality Account.

C. Charitable Funds Committee

The work of the Charitable Funds Committee is focussed on ensuring that the Trust properly discharges its responsibilities as Corporate Trustee of the Trust's Charitable Funds. During 2017/18, we have merged the two predecessor charities to create Greater Manchester Mental Health NHS Foundation Trust Charitable Fund. As part of this work, we have taken time to understand the history of the available funds to ensure that we continue to properly discharge our duties as Trustees of the Fund and meet donors' wishes. Our focus in 2018/19 will be on relaunching our Charitable Fund with a view to raising staff awareness and increasing expenditure of the available funds.

Committee membership during 2017/18 have been:

- Anthony Bell, Non-Executive Director and Committee Chair
- Gill Green, Director of Nursing and Governance
- Ismail Hafeji, Director of Finance and IM&T
- Julie Jarman, Non-Executive Director

The Terms of the Charitable Funds Committee were reviewed by the Committee in February and July 2017.

The Charitable Funds Committee met three times in 2017/18 with attendance recorded as follows:

		No. of Meetings Attended	No. of Meetings the Director could have Attended
Non-Executive Directors	**Anthony Bell** Committee Chair	8	9
	Julie Jarman Committee Member	9	9
Executive Directors	**Gill Green** Director of Nursing and Governance	7	9
	Ismail Hafeji Director of Finance and IM&T	8	9


The University of Manchester
POSTGRADUATE DIPLOMA
Kimberley McInerney
The University of Manchester
POSTGRADUATE DIPLOMA
Amanda Jane Roles
STAFF

D. Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is responsible for reviewing the Trust's leadership requirements and identifying and appointing candidates to fill executive director vacancies on the Board. The Committee also monitors and evaluates the performance of executive directors and makes recommendations to the Board of Directors on the remuneration and other conditions of services of those members of staff and other senior managers on locally-determined pay.
A key focus of the Remuneration and Terms of Service Committee in the latter part of 2017/18 has been the appointment of the Trust's new Chief Executive. The Committee agreed the role requirements, remuneration and appointment criteria, taking into account current and future needs. With the support of experienced recruitment specialists (Gatenby Sanderson), the Committee led a thorough recruitment process to generate an appropriate candidate pool and select a preferred candidate. The final stage of the selection process required candidates to participate in a structured discussion with a number of service users and carers, in addition to a meeting with Executive Directors and a formal interview with a selection panel. The selection panel comprised members of the Remuneration and Terms of Service Committee, plus an experienced NHS Chief Executive operating in the capacity of independent external assessor. In line with good practice, the Council of Governors were involved throughout the process, including through the attendance of Les Allen, Lead Governor as an observer at the final interviews. Margaret Willis, Service User and Carer Governor, was also a member of the Service User and Carer Discussion Group. At the end of the process, the Committee were unanimous in their decision to appoint Neil Thwaite as the Trust's new Chief Executive. This appointment was approved by the Council of Governors on 9 April 2018.

Further information on the work of the Remuneration and Terms of Service Committee in 2017/18, including Committee membership and attendance at meetings, is provided on page 61 of this report. The Remuneration and Terms of Service Committee most recently reviewed and agreed its Terms of Reference in February 2017.

Register of Interests

As set out in our constitution, all members of the Board of Directors have a responsibility to declare any relevant and material interests which may be at conflict with, or preferentially enhanced by, their relationship with the Trust. Declarations are entered into a Register of Interests and are available to the public on request via Kim Saville, Company Secretary (kim.saville@gmmh.nhs.uk). The Register is kept up to date by means of an annual review at the end of each financial year and updated within the year recording any changes to interests. Board members are also required to declare any conflicts of interest that arise in the course of conducting Trust business, specifically at the beginning of each Board of Directors' meeting. The declared interests of members of the Board of Directors at the end of March 2018 are shown in the table overleaf:

Register of Interests Declared by the Board of Directors – March 2018

Name	Position/Role	Term of Office	
Anthony Bell	Non-Executive Director	31.07.18	
Chris Daly	Medical Director	N/A	
Stephen Dalton	Non-Executive Director	31.12.19	
Kathy Doran	Non-Executive Director	31.07.18	
Gill Green	Director of Nursing and Governance	N/A	
Ismail Hafeji	Director of Finance and IM&T	N/A	
Bev Humphrey	Chief Executive	N/A	
Julie Jarman	Non-Executive Director	31.07.20	
Andrea Knott	Non-Executive Director	31.12.19	
Pauleen Lane	Non-Executive Director	31.12.19	
Andrew Maloney	Director of HR and Corporate Affairs	N/A	

	Interests Declared	Date of Entry onto Register or Amendment
	• Non-Executive Director – Cariocca Enterprises • Non-Executive Director – Inclusion Housing, York • Non-Executive Director – Equity Enterprises Ltd., Equity Housing Group Ltd., Cheadle Hulme, Cheshire	30.10.17
	• Nil	01.08.16
	• NHS England Programme Director, New Care Models Tertiary Mental Health – temporary role (12 months from April 2018) • Lead for Chief Executive Development Groups – sponsored by NHS Employers • Director – SJ Dalton Ltd.	26.03.18
	• Chair Designate - Your Housing Group • Chair - The Reader Organisation • Chair – Local Governing Body of Birkenhead High School Academy	20.03.18
	• Nil	30.04.12
	• Nil	26.03.18
	• Chair of NHS Confederation Mental Health Network • Trustee of NHS Confederation	04.04.16
	• Treasurer of MIND in Salford • Trustee – HomeWorkers Worldwide • Company Director of small mineral rights holding company (Blenkie Ltd.) • Principle Programmes – Equality and Human Rights Commission	14.02.18
	• Transformation Leader, AstraZeneca PLC	26.03.18
	• Group Manager National Infrastructure, The Planning Inspectorate • Visiting Lecturer, The University of Manchester • Governor, St. Hilda's Primary School, Firswood • Member of Central Manchester University Hospitals NHS Foundation Trust, University Hospital of South Manchester NHS Foundation Trust and Liverpool Women's NHS Foundation Trust • Partner (Martin Rathfelder) is a member of the Manchester Provider Programme Selection Board and administrator of the Socialist Health Association	30.01.17
	• Member of Executive Advisory Council, Manchester Metropolitan University, Faculty of Business and Law	22.04.16

Register of Interests Declared by the Board of Directors – March 2018 Continued

Name	Position/Role	Term of Office	
Rupert Nichols	Chair	31.06.19	
Deborah Partington	Director of Operations	N/A	
Neil Thwaite	Deputy CEO/Director of Strategic Development	N/A	

Appointment and Removal of Non-Executive Directors

The Council of Governors is responsible for the appointment and, where required, removal of Non-Executive Directors, including the Chair. The Council of Governors is supported in this consideration by recommendations from its Nominations Committee. There were no appointments or removals of Non-Executive Directors during 2017/18. In July 2017, the Council of Governors approved the re-appointment of Julie Jarman, Non-Executive Director, for a second three-year term (effective from 1 August 2017). This was on the basis of a recommendation received from the Nominations Committee following a review of Julie Jarman's performance.

	Interests Declared	Date of Entry onto Register or Amendment
	• Director - Eddie Stobart Logistics Ltd. • Director – NeedleSmart Limited • Chair – Rainford Academies Trust	26.03.18
	• Nil	01.08.16
	• Nil	30.04.12

Our Council of Governors

We welcomed a newly constituted Council of Governors in April 2018, the composition of which better reflects the expanded scope and geography of GMMH. The Council of Governors comprises elected and appointed governors who represent the interests of our members, the wider public and our partner organisations. Governors hold the Board of Directors to account for the performance of the Trust through Non-Executive Directors and also exercise their statutory duties as set out in legislation.

The Chair of the Board of Directors also chairs the meetings of our Council of Governors with the Chief Executive and other executive and Non-Executive Directors regularly in attendance. Attendance at meetings enables Board members to understand the views of governors and members. Due to the close working relationship between the Council of Governors and the Board of Directors, if any conflicts or disagreements arise these can be aired and resolved quickly. The Lead Governor and Senior Independent Director would also play a key role in dispute resolution as and when required.

Minutes and papers for our Council of Governors meetings are publicly available via our website.

Governor Activities

During 2017/18, key duties exercised by the Council of Governors have included:

- Appointing a new Lead Governor and agreeing the Terms of Reference and membership of the Council of Governors committees
- Receiving the outcomes of the chair and Non-Executive Director appraisal process
- Approving the re-appointment of one of the Trust's Non-Executive Directors (Julie Jarman) for a further three-year period
- Approving an uplift to chair and Non-Executive Director remuneration
- Giving views on the Trust's future strategic plans
- Advising on the Quality Account priorities for 2018/19 and selecting a local indicator for external assurance
- Service User and Carer Governor representation at the Trust's CARE Hub meeting

In line with good practice, the Council of Governors were also involved throughout the process to recruit a new Chief Executive for GMMH. In February 2018, the Council of Governors received a briefing paper outlining the recruitment process and including the role description and person specification. Les Allen, Lead Governor, was in attendance at the final interviews and Margaret Willis, Service User and Carer Governor, was a member of the Service User and Carer Discussion Group during the final stage of the Selection Process. The Council of Governors approved the appointment of Neil Thwaite as the Trust's new Chief Executive on 9 April 2018, following a recommendation from the Remuneration and Terms of Service Committee.

Committees and Working Groups

The Council of Governors has one formal committee - the Nominations Committee - and one Working Group focused on implementation of the Membership Strategy. In 2017/18, both groups agreed clear Terms of Reference and reported back on progress to the full Council of Governors.

Attendance at Meetings

The full Council of Governors met on five occasions in 2017/18. The following table shows governor attendance at meetings during the period.

Constituency	Governor	Term of Office	No. of Meetings Attended	No. of Meetings Governor could have Attended
Elected Governors				
Public: Bolton	Les Allen	31.03.2019	4	5
	Albert Phipps	31.03.2020	3	5
Public: Salford	Bryan Blears	31.03.2019	2	5
	David Sutton	31.03.2020	5	5
Public: Trafford	Margaret Kerr	31.03.2019	2	5
	Iris Nickson	31.03.2020	4	5
Public: City of Manchester	Philip Benson-Hannam	Retired in March 2018	3	5
	Nayla Cookson	31.03.2019	4	5
	Lynn Howe	31.03.2020	5	5
Public: Other England and Wales	Rob Beresford	31.03.2020	4	5
	Phil Saxton	31.03.2019	3	5
Service User and Carer	Michael Crouch	31.03.2020	2	5
	John Hogan	Retired in July 2017	2	2
	Margaret Riley	31.03.2019	2	5
	Dan Stears	31.03.2020	5	5
	Margaret Willis	31.03.2019	3	3
Staff: Medical	Victoria Sullivan	31.03.2020	2	5
Staff: Nursing	Stuart Edmondson	31.08.2019	4	5
	Chris Vogl	Retired in April 2018	4	5
Staff: Psychological Therapies	Nasur Iqbal	31.08.2019	1	1
	Katie Pownell	Retired in June 2017	3	4
Staff: Allied Health Professionals	Frances Wilkinson	Retired in Oct 2017	2	3
Staff: Non-Clinical Staff	Julie Turner	Retired in March 2018	5	5
Staff: Social Care	Rick Wright	31.03.2020	4	5

Constituency	Governor	Term of Office	No. of Meetings Attended	No. of Meetings Governor could have Attended
Appointed Governors				
University of Salford	Margaret Rowe, Dean of School of Nursing, Midwifery, Social Work and Social Sciences at University of Salford	31.03.2020	4	5
Greater Manchester Police (GMP)	Chief Inspector Andrew Sidebotham	Retired in December 2017	1	1
	Detective Chief Inspector Sara Wallwork	31.03.2020	1	1
Greater Manchester Association of Clinical Commissioning Groups (CCGs)	Trish Anderson, Mental Health Lead for Greater Manchester CCGs and Chief Officer of Wigan Clinical Commissioning Group	31.03.2020	2	3

The table below shows attendance by Directors at meetings of the Council of Governors in 2017/18

		No. of Meetings Attended	No. of Meetings the Director could have Attended
Non-Executive Directors	**Rupert Nichols** Chair	5	5
	Anthony Bell Non-Executive Director	4	5
	Stephen Dalton Non-Executive Director	3	5
	Kathy Doran Non-Executive Director	4	5
	Julie Jarman Non-Executive Director	4	5
	Andrea Knott Non-Executive Director	1	5
	Pauleen Lane Non-Executive Director	2	5

		No. of Meetings Attended	No. of Meetings the Director could have Attended
Executive Directors	**Bev Humphrey** Chief Executive	4	5
	Chris Daly Medical Director	4	5
	Gill Green Director of Nursing and Governance	3	5
	Ismail Hafeji Director of Finance and IM&T	5	5
	Andrew Maloney Director of HR and Corporate Affairs	3	5
	Deborah Partington Director of Operations	2	5
	Neil Thwaite Deputy Chief Executive/ Director of Strategic Development	4	5

Elections

The following individuals stepped down from their seat on the Council of Governors during the reporting period:

- John Hogan, Service User and Carer Governor
- Katie Pownell, Staff Governor (Psychological Therapies)
- Frances Wilkinson, Staff Governor (Allied Health Professionals)
- Julie Turner, Staff Governor (Non-Clinical)
- Philip Benson-Hannam, Public Governor (City of Manchester)
- Chris Vogl, Staff Governor (Nursing)
- Chief Inspector Andrew Sidebotham, Appointed Governor representing Greater Manchester Police

In accordance with the terms of our constitution, where the most recent election was held less than twelve months previously, we invited the next highest polling candidate to fill the seat for the unexpired period of the term of office. On this basis, Margaret Willis re-joined the Council of Governors as a Service User and Carer Governor in September 2017 and we also welcomed Nasur Iqbal (Staff Governor: Psychological Therapies) and Anita Arrigonie (Staff Governor: Non-Clinical with effect from April 2018) to the Council of Governors. We held a by-election to fill the Staff: Allied Health Professionals seat on the Council of Governors, following Frances Wilkinson's resignation. Jane Lee was elected to this seat in April 2018.

Detective Chief Inspector Sara Wallwork joined the Council of Governors as Appointed Governor representing Greater Manchester Police in February 2018. This followed the resignation of Chief Inspector Andrew Sidebotham from the Council due to a promotion within GMP. Sara Wallwork is GMP's Strategic Lead for Mental Health.

Council of Governors Effectiveness Review

In October 2017, all governors were invited to share their views on the performance of the Council of Governors by completing a short survey. Members of the Board of Directors were also invited to comment on the difference made by the Council of Governors over the last 12 months and the opportunities for the future.

Governors reviewed the outcomes of the survey at their meeting in December 2017 and agreed that the Membership Strategy Working Group would take forward work to act on the identified areas for improvement, including in relation to membership engagement.

Governor Development

During 2017/18, we have continued to support governors to deliver their role. Key development activities undertaken in 2017/18 included:

- Induction training for new governors facilitated by UK Engage – covering the structure and business of the NHS, the role of governors and their key duties, public accountability and local ownership, mechanisms for holding the Trust Board to account, and confidence in making challenges
- A series of governor development sessions facilitated by executive directors focussed on finance, performance, service and business development, future strategy and workforce strategy
- A series of governor development sessions facilitated by Non-Executive Directors focussed on the role of the Audit Committee, Quality Governance Committee and Charitable Funds Committee and the role of the designated non-executive director (Julie Jarman) in relation to Associate Hospital Managers
- Regular Chief Executive, Executive Director and Associate Director briefings to governors – for example on performance, the management of serious untoward incidents and lessons learned, the role of the Freedom to Speak Up Guardian, the Trust's Care Quality Commission inspection outcomes, progress with the Manchester transformation programme, and the draft Operational Plan 2018/19 to 2019/20
- Briefings from external partners – for example on the Greater Manchester Mental Health Strategy and associated investment plan
- Continued access to external training and networking opportunities for governors, including those facilitated by NHS Providers – GovernWell

Register of Interests – Council of Governors

All governors have a responsibility to declare any material or relevant interests. Declarations are reported publicly and recorded in a Register of Interests, which is maintained by the Company Secretary. The Register is available to the public on request via Kim Saville, Company Secretary (kim.saville@gmmh.nhs.uk).

Our Members

Our membership community is made up of public, service user and carer, and staff members. From these members, governors are elected to sit on our Council of Governors to represent members' interests in how our services are delivered and developed and how the organisation is run. Our constitution, which is publicly available, sets out the eligibility criteria for joining our different membership constituencies and the boundaries for public constituency areas. Eligible staff are automatically 'opted in' as members, but have the option to 'opt out' if they prefer.

In line with the terms of our Constitution, members of the Trust have the following rights and benefits to:

- Be able to elect Governors
- Be able to stand as a Governor
- Receive regular information about our activities, such as newsletters
- Provide opinions and be kept informed of plans for future developments
- Be involved and consulted on issues such as changes and improvements to services
- Act as an ambassador for their community or interest group
- Attend member events

Our Current Membership

The following table provides a breakdown of our membership as at the end of March 2018.

Constituency		No. as at Quarter 4 2018
Public	Bolton	743
	Salford	624
	Trafford	588
	City of Manchester	2,268
	Other England and Wales	927
Service Users and Carers		1,387
Sub-total		**6,537**
Staff		4,071
Total membership		**10,608**

We monitor the numbers and profile of our membership, including through routine reporting to the Board of Directors and NHS Improvement.

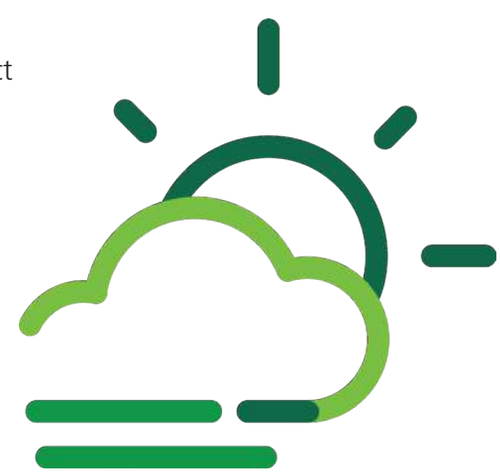
Membership Engagement Strategy

During the reporting period, the Membership Strategy Working Group of the Council of Governors, which is chaired by our Lead Governor, has reviewed and refreshed the Trust's Membership Engagement Strategy and mapped existing governor networks within constituencies in order to facilitate improved engagement. We have also started to pilot two new approaches to member engagement. One, focussed on engaging with public constituents in Bolton and the second focussed on engaging with service users and carers in Manchester through, for example, the Manchester Service User and Carer Forum. If successful, these pilots will be rolled out more widely across all of our membership constituencies.

Interested in Becoming a Member?

Membership is free and you can choose your level of engagement as a member from very active to as little as receiving newsletters and updates. If you are interested in becoming a member of Greater Manchester Mental Health NHS Foundation Trust, and are eligible to do so, please contact Steph Neville, Head of Corporate Affairs via steph.neville@gmmh.nhs.uk or on 0161 358 1601.

If you are an existing member and would like to contact your governor representative, or a Director of the Trust, please also contact Steph Neville or visit our website at www.gmmh.nhs.uk/contact-us.



Remuneration Report

I am pleased to present our Remuneration Report for 2017/18. This report outlines our approach to setting the remuneration of our senior managers and the decisions and payments made during the reporting period. For the purposes of this report, senior managers are defined as the executive and non-executive members of our Board of Directors. The remuneration, allowances and other terms of service of our Chief Executive, other Executive Directors and other senior managers on locally-determined pay is determined by the Remuneration and Terms of Service Committee of our Board of Directors. The remuneration of the Chair and other Non-Executive Directors is agreed by our Council of Governors, following recommendations from the Nominations Committee.

Annual Statement on Remuneration

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee of the Board of Directors was chaired by Rupert Nichols, Chair, during the reporting period. All Non-Executive Directors are members of the Committee.

During 2017/18, the Remuneration and Terms of Service Committee met on four occasions (in May and July 2017 and in January and March 2018). The latter two meetings were convened as part of the Chief Executive recruitment process. Attendance at each meeting was as follows:

		No. of Meetings Attended	No. of Meetings the Director could have Attended
Non-Executive Directors	**Rupert Nichols** Chair	4	4
	Anthony Bell Non-Executive Director	4	4
	Stephen Dalton Non-Executive Director	2	4
	Kathy Doran Non-Executive Director	2	4
	Julie Jarman Non-Executive Director	3	4
	Andrea Knott Non-Executive Director	4	4
	Pauleen Lane Non-Executive Director	2	4

On the occasions where Non-Executive Directors were unable to attend meetings of the Remuneration and Terms of Service Committee, the Chair sought their opinion/views in advance of the meeting.

The Company Secretary was in attendance at three of the four meetings for the purposes of minute taking. Andrew Maloney, Director of HR and Corporate Affairs, attended the January and March 2018 meetings in an advisory capacity. Bev Humphrey, Chief Executive, attended the July 2017 meeting also in an advisory capacity.

In May 2017, the Committee approved an uplift to the Chief Executive's salary with effect from 1 March 2017. This followed a review of both Chief Executive and Executive Director salaries in February 2017. (The full-year effect of the agreed uplift to executive director salaries, effective from 1 March 2017, is reported in the following Annual Report on Remuneration). The review of the Chief Executive's salary took into account the threshold for disclosure used in the Civil Service and subsequent correspondence with NHS Improvement. (To note, at the point of the salary review, the threshold was set at £142,500. This has subsequently increased to £150,000 from January 2018). In approving the Chief Executive's salary uplift, the Committee rewarded the leadership provided throughout the acquisition process and recognised the significant changes in the organisation's size and scope post-acquisition.

In July 2017, the Committee undertook its annual review of Associate Director pay. The Committee took the decision to reflect the national pay deal for 2017/18 and award a 1% consolidated uplift.

In January 2018, the Committee approved an indicative salary level for the new Chief Executive, subject to the outcomes of the recruitment process. This approval took into account benchmarking data and advice received from NHS Improvement, including in relation to the salary exceeding the threshold for disclosure used in the Civil Service and the regulator's guidance on pay for Very Senior Managers (VSM). Committee members considered the agreed salary to be appropriate to the role and necessary in terms of attracting suitable candidates. At their meeting in March 2018, where the Committee approved the appointment of Neil Thwaite as Chief Executive, the Committee formally approved the new Chief Executive's salary.

Nominations Committee

The Nominations Committee of the Council of Governors met on one occasion during the reporting period. The Committee was chaired by the Chair of the Trust and attendance of Committee members at the meeting was as follows:

	No. of Meetings Attended	No. of Meetings the Director could have Attended
Rupert Nichols Chair	1	1
Les Allen Lead Governor	1	1
Lynn Howe Public Governor (City of Manchester)	0	1
Margaret Riley Service User and Carer Governor	0	1
Dan Stears Service User and Carer Governor	1	1
Julie Turner Staff Governor (Non-Clinical)	1	1

In June 2017, the Nominations Committee reviewed chair and non-executive director pay rates. This review took into account benchmarking data. The Committee agreed to recommend the award of a 1% consolidated uplift for the Chair and all other Non-Executive Directors, in line with the national pay deal for 2017/18. This recommendation was approved by the Council of Governors in July 2017 and made effective from 1 April 2017.

Rupert Nichols, Chair
21 May 2018

Senior Managers' Remuneration Policy

Our senior managers' remuneration policy helps attract and retain high-performing and talented individuals. We take account of the financial challenges facing the wider-NHS when implementing this policy.

Our remuneration policy for directors is based on a spot rate informed by external benchmarking data. Remuneration is subject to periodic review, as indicated in our 'Annual Statement on Remuneration'. Increases in pay are informed by recommendations from the National Pay Review bodies for Very Senior Managers. It is our policy to not pay any annual or long-term performance-related bonuses. Performance against agreed strategic objectives is monitored via the annual appraisal process.

The only non-cash elements of executive director remuneration are pension-related benefits, accrued under the NHS pension scheme, and car leases. Pension contributions are made by both the employer and employee in accordance with the rules of the national scheme.

All contracts for executive directors are substantive NHS contracts and are subject to the giving of three months' notice by either party. Our normal disciplinary and performance management policies apply to senior managers. Our redundancy policy is consistent with the NHS redundancy terms for all staff.

Annual Report on Remuneration

Remuneration of Board Members

The following table details the salary paid to each member of our Board of Directors during 2017/18, in comparison to 2016/17, including taxable 'benefits in kind'. As per our Remuneration Policy, benefits in kind relate to the provision of lease cars. The dates of directors' service contracts, including the unexpired terms of Non-Executive Director contracts, are provided in 'Our Board of Directors' on page 34 onwards of this report. Details of off-payroll engagements and exit packages in 2017/18 are provided in our staff report ('Our Staff') on pages 79 to 81. As was the case in 2016/17, there were no annual or long-term performance-related bonuses paid to Board members during 2017/18. The value of all pension-related benefits in 2017/18 is shown within the total remuneration figure for that period.

Name and Title	2017/18 Salary and Fees	Taxable Benefits	2017/18 All Pension Related Benefits *	
	(Bands of £5,000) £'000	(To nearest £100) £	(Bands of £2,500) £'000	
R Nichols Chair	45-50			
A Knott Non-Executive Director	15-20			
P Lane Non-Executive Director	10-15			
S Dalton Non-Executive Director	10-15			
M Cowen Non-Executive Director	N/A			
T McDonnell Non-Executive Director	N/A			
A Bell Non-Executive Director	10-15			
K Doran Non-Executive Director	15-20			
J Jarman Non-Executive Director	10-15			
B Humphrey Chief Executive	185-190	5,200	225-227.5	
G Green Director of Nursing and Governance	130-135			
I Hafeji Director of Finance and IM&T	130-135	5,200	105-107.5	
A Maloney Director of HR and Corporate Affairs	130-135	5,500	80-82.5	
S Colgan Medical Director	N/A			
N Thwaite Deputy Chief Executive / Director of Strategic Development	130-135	5,500	90-92.5	
D Partington Director of Operations	130-135	7,078	217.5-220	
C Daly Medical Director	115-120		50-52.5	
M Campbell Acting Medical Director	N/A			

	2017/18 Total Remuneration	2016/17 Salary and Fees	Taxable Benefits	2016/17 Total Salary
	(Bands of £5,000) £'000	(Bands of £5,000) £'000	(To nearest £100) £	(Bands of £5,000) £'000
	45-50	35-40		35-40
	15-20	1-5		1-5
	10-15	1-5		1-5
	10-15	1-5		1-5
	N/A	15-20		15-20
	N/A	10-15		10-15
	10-15	10-15		10-15
	15-20	10-15		10-15
	10-15	10-15		10-15
	415-420	160-165	3,700	165-170
	130-135	120-125		120-125
	245-250	120-125	4,200	125-130
	220-225	120-125	4,700	125-130
	N/A	30-35		30-35
	230-235	120-125	4,500	125-130
	355-360	95-100		95-100
	165-170	120-125		120-125
	N/A	65-70		65-70

* To Note: All Pension Related Benefits 2017/18 – this is not a cash payment made to the director in year but is the annual increase in pension entitlement attributable to the director's membership of the NHS pension scheme during the financial year 2017/18.

Pension Benefit Disclosures

The pension benefit disclosures of executive directors are detailed in the table below. Non-executive director remuneration is non-pensionable.

Notes to the pension benefits disclosures:

- 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 and the other pension figures, 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.

- A 'Real Increase in CETV' 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.

Name and Title	Real Increase in Pension at Pension Age	Real Increase in Lump Sum at Pension Age	Total Accrued Pension at Pension Age at 31 March 2018	
	(Bands of £2,500) £'000	(To nearest £100) £	(Bands of £2,500) £'000	
Bev Humphrey Chief Executive	10-12.5	32.5-35	80-85	
N Thwaite Deputy Chief Executive/Director of Strategic Development	5-7.5	7.5-10	40-45	
I Hafeji Director of Finance and IM&T	5-7.5	15-17.5	55-60	
A Maloney Director of HR and Corporate Affairs	2.5-5	5-7.5	35-40	
D Partington Director of Operations	10-12.5	30-32.5	65-70	
C Daly Medical Director	2.5-5	10-12.5	85-90	

To note: Gill Green, Director of Nursing and Governance, is not a member of the NHS Pension Scheme and is therefore ex

Reporting bodies are required to disclose the relationship between the remuneration of their highest paid senior manager and the median remuneration of the organisation's workforce. The banded remuneration of our highest-paid director (the Chief Executive) in 2017/18 was £185,000 - £190,000 (excluding taxable and pension-related benefits). As shown in the following table this was 7.64 times the median remuneration of the entire workforce, calculated on the basis of full-time staff as at 31 March 2018 with amounts annualised according to whole time equivalents and hours paid. The 2017/18 ratio is higher than the ratio reported for 2016/17 and reflects the agreed uplift to the Chief Executive's salary.

	2017/18	2016/17
Band of Highest Paid Directors Total	185 – 190 (£000s)	160-165 (£000s)
Mid-point of Highest Paid Director	187.5	162.5
Staff Median Total Remuneration	£24,547	£26,302
Ratio	7.64 times	6.18 times

	Total Accrued Lump Sum at Pension Age at 31 March 2018 (Bands of £5,000) £'000	**Cash Equivalent Transfer Value at 31 March 2018** £'000	**Cash Equivalent Transfer Value at 31 March 2017** £'000	**Real increase in Cash Equivalent Transfer Value** £'000	**Employer's Contribution to Stakeholder Pension**
	240-245	1,715	1,387	312	27
	110-115	673	539	84	19
	170-175	1255	1,068	175	19
	95-100	562	465	91	19
	195-200	1215	951	253	19
	255-260	1773	1,786	0	8

re excluded from the above table.

Governor and Director Expenses

We reimburse expenses necessarily incurred by our directors and governors in the course of their business for the Trust. Expenses paid include mileage re-imbursement, parking expenses and other transport costs such as rail fares. We paid expenses to the value of the following to governors and members of the Board of Directors during the financial year.

	2017/18		2016/17	
	Governors	Directors	Governors	Directors
Band of Highest Paid Directors Total	24	14	27	16
Number Receiving Expenses	2	12	4	13
Aggregate Expenses Sum Paid (to the nearest £'00)	48	9,984	430	7,100

Neil Thwaite, Chief Executive
21 May 2018

Our Staff

Our staff are our greatest asset. We rely on a highly motivated and skilled workforce to deliver services that meet our high quality standards. The significant challenges embraced by this organisation during 2017/18 have demonstrated the strength and flexibility of our workforce and their commitment to achieving the best for our service users. We will continue to support our staff in the coming months and years, as we take forward our transformation plans.

Staff Costs

Our total staff costs incurred in 2017/18 equated to £209.6 million.

	Staff Group		2017/18	2016/17
	Permanent (£'000)	Other (£'000)	Total Costs (£'000)	Total Costs (£'000)
Salaries and wages	140,797	17,367	158,164	116,156
Social security costs	13,080	677	13,757	9,935
Apprenticeship levy	725	7	732	-
Employer's contributions to NHS pensions	18,811	-	18,811	13,644
Pension cost - other	-	412	412	95
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	728	-	728	469
Temporary staff	-	18,409	18,409	9,801
Total Gross Staff Costs	**174,141**	**36,872**	**211,013**	**150,100**
Recoveries in respect of seconded staff	(1,409)	-	(1,409)	(1,150)
Total Staff Costs	**172,732**	**36,872**	**209,604**	**148,950**
Of which:				
Costs capitalised as part of assets	167	50	217	216

Workforce Demographics

We employ a diverse workforce including doctors, nurses, therapists, specialist practitioners and administrators who work in a variety of settings within local communities and hospitals.

During 2017/18, we employed 5,094 whole time equivalent (WTE) staff. This number includes bank and agency staff and is broken down as follows:

	Permanently Employed (No.)	Other Employment Arrangement (No.)	Total Number 2017/18 (WTE)	Total Number 2016/17 (WTE)
Medical and dental	264	53	317	231
Ambulance staff	-	-	-	-
Administration and estates	502	49	551	964
Healthcare assistants and other support staff	582	148	730	155
Nursing, midwifery and health visiting staff	2,120	265	2,358	2,568
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	691	41	732	739
Healthcare science staff	-	-	-	-
Social care staff	105	111	216	243
Other	163	-	163	127
Total	**4,427**	**667**	**5,094**	**5,027**
Oh which:				
Number of employees engaged on capital projects	3	-	3	3

Our number of male and female staff (calculated on a headcount basis and including bank staff) as at the end of March 2018 was:

	Male	Female	Total
Directors	7	7	14
Workforce (excluding Directors)	1,299	3,541	4,840
Total	1,306	3,548	4,854

Gender Pay Gap

In accordance with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), we reported publicly on the difference in average pay between all men and women in our workforce (the gender pay gap) in March 2018.

As at 31 March 2018, our mean average gender pay gap demonstrates that our female staff are paid 12.64% less than our male staff.

	Mean Average Hourly Rate
Male	£17.11
Female	£14.95

The median average gender pay gap shows that our female staff are paid 5.04% less than our male staff.

	Mean Average Hourly Rate
Male	£14.02
Female	£13.31

The mean average gender pay gap for the whole of the public sector economy according to the October 2017 Office for National Statistics (ONS) annual survey of hours and earning figures is 17.7%. At 12.64%, our mean gender pay gap is below that of the wider public sector.

With regard to bonus pay, our mean bonus pay gap indicates that female staff are paid 25.04% less bonus than our male staff (a difference of £3,465 per annum). Our median bonus pay gap shows that female staff are paid 64% less bonus than our male staff (a difference of £7,074 per annum). This information relates to bonus payments received by medical staff in the form of Clinical Excellence Awards and demonstrates a significant difference in the median pay gap between our female and male doctors.

Our gender profile of staff within each quartile pay band was as follows at 31 March 2018:

Quartile Pay Band	Female %	Male %
Lower (Band 1 to Mid-Point Band 3)	75.64	24.36
Lower Middle (Mid-Point Band 3 to Mid-Point Band 5)	70.08	29.92
Upper Middle (Mid-Point Band 5 to Mid-Point Band 7)	73.80	26.20
Upper (Mid-Point Band 7 to Doctors/Consultants/ Very Senior Managers)	65.15	34.85

This data shows that there is a lower proportion of female staff in the upper quartile pay bands compared to female staff in the other quartiles.

We are committed to ensuring that our workforce is paid equitably and are continuing to work towards achieving gender pay parity. To start to address the identified gender pay gap, we are progressing the following actions:

- Promoting mental health career opportunities to schools and colleges with a particular emphasis on attracting males into the workforce
- Targeting leadership opportunities with a focus on gender and further developing our talent management strategy
- Aiming to maintain equal gender representation at Board level
- Promoting diversity and encouraging applications for Clinical Excellence Awards from all groups
- Promoting flexible working opportunities and raising awareness of parental leave entitlements

Staff Health and Wellbeing and Sickness Absence

Our overall sickness absence rate for 2017/18 was 5.94%, which represents an increase on last year's rate of 5.45% and is above our own target of 5.75%. The in-month sickness figure for March 2018 was below target at 5.19%. Long-term sickness absence continues to make up the majority of time lost to sickness and has increased over the year.

Our average number of sick days per full time equivalent (FTE) for the period January 2017 to December 2017 was 13.0 days. This compares to 13.2 days in the previous 12 months.

Staff Sickness Absence	2017	2016
Average FTE	4,345	4,345
Adjusted FTE Days Lost – As Per Cabinet Office Definitions	56,382	38,823
Average Sick Days per FTE	13.0	13.2

The above figures are provided by the Department of Health and Social Care (DHSC) and reflect the impact of the acquisition of MMHSCT from 1 January 2017.

We are reviewing how we support out staff with maintaining their health and wellbeing as part of the development of our new Workforce Strategy. In the meantime, with proactive support from our HR team, service managers are continuing to work hard to effectively manage sickness absence. Our services meet regularly with their identified HR representative to review cases of sickness absence and to develop strategies and actions as appropriate to the case. All cases of long-term sickness absence are reviewed by HR on a monthly basis to identify trends and 'blocks' to return to work and agree actions to minimise these.

During 2017/18, we have taken a number of positive actions to support staff health and wellbeing and reduce sickness absence. These are summarised on page 77 of this report. People Asset Management (PAM) have also continued to provide our Occupational Health and Staff Support Services. Feedback from managers regarding the responsiveness of the service has continued to be positive. People Asset Management provide an enhanced service, which includes access to early interventions linked to physiotherapy and mental wellbeing to support staff who are experiencing difficulties in these areas.

NHS Staff Survey

The 2017 NHS Staff Survey was carried out between October 2017 and December 2017. This was the first full Staff Survey for GMMH and, as such, no comparative data is available for 2016.

We surveyed all employees, rather than a random sample, and achieved a response rate of 34%, which equates to 1,507 members of staff. In comparison to the national average for Mental Health Trusts of 52%, this is a disappointing return. We are planning to move to an electronic survey in 2018, as opposed to a paper-based approach, to give staff more flexibility and space to receive and complete the questionnaire.

The overall score for staff engagement within the organisation was 3.78, which is slightly below the national average of 3.79 for mental health Trusts. To enable a continual flow of feedback from staff, our Human Resources Directorate have started to run regular 'Weather Watch' sessions across teams. These sessions provide staff with the opportunity to discuss areas of concern and celebrate successes. They have also allowed facilitated feedback to be provided to the Divisional Senior Leadership Teams. The continuation of staff forums, held in partnership with staff side colleagues, has also proved a successful and positive way to engage staff in many areas of the Trust during 2017/18.

Our 2017 NHS Staff Survey results highlighted the following:

Top 5 Ranking Scores		
Question	2017	
	Trust	Average
% of staff / colleagues reporting most recent experience of harassment, bullying or abuse	66	61
% of staff agreeing that their role makes a difference to patients / service users	89	88
% of staff working extra hours	70	72
% of staff believing that the organisation provides equal opportunities for career progression or promotion	87	85
% of staff experiencing harassment, bullying or abuse from staff in last 12 months	21	21

Bottom 5 Ranking Scores		
Question	2017	
	Trust	Average
% of staff / colleagues reporting most recent experience of violence	90	93
% of staff witnessing potentially harmful errors, near misses or incidents in last month	30	27
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	36	32
Quality of appraisals	3.06	3.22
% of experiencing physical violence from staff in the last 12 months	4	3

Based on the outcomes of this survey, the focus corporately will be on improving the quality of staff appraisals and non-mandatory training, learning and development. We are looking to develop a more streamlined and fair CPD (continuing professional development) request process and introduce a more

flexible and accessible approach to appraisals that staff and managers can engage with in a meaningful way.

In addition to this, whilst we are pleased that staff feel able to report incidents of violence and aggression, we will continue to address the increase in the number of staff experiencing harassment or abuse from patients and the public over the last 12 months. During late 2017, we recruited substantively to a Lead Nurse for Safewards who will continue to review and embed positive practices on our ward environments.

With regard to more local improvements, we will be holding a number of focus groups across services to support the development of local improvement plans.

Staff Engagement

We take the views of our staff into account when making decisions that are likely to affect their interests. Members of our Board of Directors meet with staff-side (Trade Union) representatives on a monthly basis through our Joint Consultation and Negotiating Committee. This Committee discusses all policies, organisation change programmes and service developments. This approach is replicated for medical staff via the Local Negotiating Committee (LNC), which meets every two months.

Our managers also run regular Staff Forums in partnership with staff-side. These forums enable staff to raise concerns, including about issues that impact on wellbeing, and facilitate early resolution.

Outside of the NHS Staff Survey, we have continued to engage with consistently high numbers of staff through our staff 'Friends and Family Test'. In our most recent test (Quarter 4 2017/18), 1,109 members of staff took the time to respond. 72% of respondents said they would recommend the Trust to friends and family as a place to receive care or treatment and 64% said they would recommend the Trust as a place to work. This represents an improvement on the Quarter 3 position.

We have also taken steps to further promote the role of our Freedom to Speak up Guardian and other linked roles during 2017/18. This is with a view to supporting individuals across the enlarged organisation to come forward if they have a concern to raise.

Reporting Facilities Time

Under the Trade Union (Facility Time Publication Requirements) Regulations 2017, which came into force on 1 April 2018, public sector employers are now required to publish information on employees who are trade union officials and the facility time taken by them during the preceding 12 month period.

The following tables confirm:

- The total number of our employees who were union officials during the period 1 April 2017 to 31 March 2018
- The percentage of each of the above employee's working time spent on trade union duties (facility time)
- The percentage of our total pay bill spent on facility time
- The hours spent by employees who were union officials on paid trade union activities, as a percentage of total paid facility time hours

Relevant Union Officials:

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
13	5.35

Percentage of Time Spent on Facility Time:

Percentage of time	Number of employees
0%	0
1-50%	8
51-99%	3
100%	2

Percentage of Pay Bill Spent on Facility Time:

Total cost of facility time	£131,396
Total pay bill	£209,604,000
Percentage of the total pay bill spent on facility time, calculated as:	0.06

Paid Trade Union Activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated	100%

Policies and Actions

All policies, which affect staff, are developed in partnership with our staff-side representatives. During 2017/18, we have worked with staff-side to review and align our Human Resources policies following the acquisition of MMHSCT. Equality Impact Assessments are completed for each policy to ensure consideration is given to the impact the policy may have on different groups of staff. We also take into account best and our organisational values when operationalising all policy documents.

Supporting Staff with Disabilities

In respect of staff who have or develop a disability, we are committed to providing equality of access to jobs, promotions and development. To this end, we have continued to be signed up to the 'Disability Confident' scheme during 2017/18. Disability Confident Employers are recognised as going the extra mile to make sure disabled people get a fair chance. Our membership of this scheme demonstrates our commitment to:

- Getting the right people for our business
- Keeping and developing our people

We have recently started to pilot the Disability Passport across our services. This document provides a flexible framework for staff and managers to discuss the nature and impact of an individual's disability and agree any adjustments to support them in the workplace. The Passport also informs equality impact assessments and risk assessments during times of organisational change, to enable any enhanced support requirements to be identified and met.

In partnership with Access to Work and Remploy, we are also in the process of developing a suite of resources - including training materials, policies and guidelines – to support staff with disabilities. These resources will include a focus on mental health, workplace adjustments and MSK.

Health and Wellbeing

We have continued to progress our commitment to improving staff health and wellbeing during 2017/18 through the implementation of our Trust-wide Health and Wellbeing action plan. Examples of this include:

- Workplace Challenge – working in partnership with 'I Will If You Will' (IWIYW) and 'GARMIN', we launched a workplace challenge initiative, which offered staff the opportunity to purchase discounted fitness devices. Staff who took part were then able to monitor activity levels, get regular updates on progress and take part in Trust-wide initiatives. Staff engagement was high with all discounted devices allocated. We are now working with GARMIN to develop more bespoke workplace challenges.
- Run Leaders Programme - work continues to promote and widen access across the whole organisation to running groups. Several groups are now well-established, including groups for complete beginners, which have enabled staff to complete 0-5K programmes, maintain a 5K level, and move up from 5k to 10K. All running group leaders are accredited by England Athletics and have access to support and resources.
- Active Travel – we have continued our work with Transport for Greater Manchester (Active Travel) to develop and promote a range of alternative travel options for employees travelling to and from work. This includes bike hire and establishing and supporting local walks. We are now working to implement a new starter pack, which identifies travel options (other than car) as part of our recruitment process.
- Influenza vaccines – we administered 3,060 seasonal flu vaccinations to front-line staff during the period 1 September 2017 to 28 February 2018. This equates to a 74.2% uptake, which is higher than the national average and the required CQUIN target of 70%. All divisions achieved

a 70% uptake, with uptake in one area being as high as 83%. Our Manchester services increased their uptake from 56% in 2016/17 to 70% in 2017/18. We also administered 171 vaccines to service users identified as being most at risk. Work is underway to prepare for the successful delivery of our 2018/19 vaccination campaign, which will be focussed on achieving a Trust-wide uptake of 75%.

- Small Bids Fund – our Health and Wellbeing Steering Group has approved the funding of a number of bids to support health and wellbeing activities at a local level. These include initiatives focussed on physical activities, healthy eating and improving the physical environment (for example, providingfurniture, plants and lighting to create rest areas and encourage staff to take appropriate breaks).
- Mindfulness – staff across the Trust have access to mindfulness sessions at local sites and at times that suit working patterns
- Health and Wellbeing champions - work is ongoing to recruit new champions to ensure coverage across the whole Trust and also evaluate and improve the support, communication and engagement our champions have within their local service

Individual directorates have also continued to implement their own local health and wellbeing action plan. Taking a local approach means that we are able to deliver bespoke, proactive support which is reflective of different staff needs, local support available and service demands. These plans are derived from and feed up into the over-arching Trust-wide action plan. Progress is routinely monitored at a local level and via our Health and Wellbeing Steering Group.

In addition to our internal health and wellbeing activities, we also participated in a benchmarking assessment commissioned by the Health and Wellbeing Board during 2017/18. This assessment was focussed on understanding approaches to wellbeing across organisations in Manchester with a view to identifying areas of best practice, opportunities for partnership working and efficiencies, and areas for improvement. We scored highly in relation to a number of key strategic objectives and are currently exploring options to further improve the support we offer to staff with disabilities, as outlined above, and to enable staff to remain in work.

Expenditure on Consultancy

We have not incurred any expenditure on external consultancy services during 2017/18.

Off-Payroll Engagements

It is our policy that all Executive Directors and other senior managers and clinicians are paid via our payroll. We only appoint individuals off-payroll in exceptional circumstances, for example, contractors undertaking temporary project work. Where off-payroll engagements are used, we undertake risk-based assessments as to whether assurance is required that the individual is paying the right amount of tax.

The following tables detail our use of existing and new off-payroll engagements in 2017/18, including lengths of engagement at the time of reporting. We can confirm that we had no off-payroll engagements, costing more than £245 per day and lasting longer than six months, as of year-end.

Table 1	
For all off-payroll engagements as of 31 March 2018, costing more than £245 per day and lasting longer than six months	2017/18
No. of existing engagements as of 31 March 2018	0
Of which:	
No. that have existed for less than one year at time of reporting	-
No. that have existed for between one and two years at time of reporting	-
No. that have existed for between two and three years at time of reporting	-
No. that have existed for between three and four years at time of reporting	-
No. that have existed for four or more years at time of reporting	-

We had no new off-payroll engagements, or any that reached six months in duration, that cost more than £245 per day and lasted longer than six months during 2017/18.

Table 2	
For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2017 and 31 March 2018, costing more than £245 per day and lasting longer than six months	2017/18
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	
No. assessed as within the scope of IR35 (the 'off-payroll rules')	-
No. assessed as not within the scope of IR35	-
No. engaged directly (via PSC (personal service company) contracted to Trust) and are on the Trust's payroll	-
No. of engagements reassessed for consistency/assurance purposes during the year	-
No. of engagements that saw a change to IR35 status following the consistency review	-

We have not appointed any Board members or senior officials with significant financial responsibility, or individuals deemed as such, via off-payroll engagements in 2017/18.

Table 3	
For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018	2017/18
No. of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year	0
No. 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	0

Exit Packages

The following tables disclose the number of compulsory and other (non-compulsory) departures which attracted an exit package during 2017/18. The value and type of associated payment is also detailed. The total cost of exit packages in 2017/18 was £2.913million, compared to £691k in 2016/17. We funded 11 exit packages in excess of £100k in 2017/18, of which two were in excess of £150k.

Exit Packages Cost Band (incl. any special payment element)	No. of Compulsory Redundancies		No. of Other Departures		Total Number of Exit Packages	
	2017/18	2016/17	2017/18	2016/17	2017/18	2016/17
<£10,000	-	-	6	-	6	-
£10,001 - £25,000	-	2	9	1	9	3
£25,001 - £50,000	-	2	12	-	12	2
£50,001 - £100,000	-	2	12	-	12	2
£100,001 - £150,000	-	2	9	-	9	2
£150,001 - £200,000	-	1	2	-	2	1
>£200,000	-	-	-	-	-	-
Total Number of Exit Packages by Type	**-**	**9**	**50**	**1**	**50**	**10**
Total Resource Cost (£)	**£0**	**£668,000**	**£2,913,000**	**£23,000**	**£2,913,000**	**£691,000**

As demonstrated in the following table, the non-compulsory departure payments incurred in 2017/18 related to voluntary redundancies and were an outcome of the corporate and senior clinical management restructure undertaken following the acquisition of MMHSCT. No payments required Treasury approval.

	2017/18		2016/17	
	Payments Agreed (No.)	Total Value of Agreements (£'000)	Payments Agreed (No.)	Total Value of Agreements (£'000)
Voluntary redundancies including early retirement contractual costs	50	2,913	1	23
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring Treasury approval	-	-	-	-
Total	**50**	**2,913**	**1**	**23**
Of which				
Non-contractual payments requiring Treasury approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Compliance with 'The NHS Foundation Trust Code of Governance'

In preparing this report, we have applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The NHS Foundation Trust Code of Governance aims to enable foundation Trusts to build governance structures and processes that reflect best practice, whilst also being flexible to local needs. As the author of the Code of Governance, Monitor (now NHS Improvement) accepts that departure from the provisions of the Code may be justifiable in certain circumstances. In these circumstances, reasons for non-compliance should be explained i.e. 'comply or explain'. Other provisions of the Code require mandatory disclosures, even where we are fully compliant with the provision.

Mandatory Disclosures

Code Ref	Summary of Requirement	Disclosure on page(s)
A.1.1	The Schedule of Matters reserved for the Board of Directors should include clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	33 54
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by Directors.	34 - 49, 61
A.5.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The Annual Report should also identify the nominated lead governor.	54 - 56
B.1.1	The Board of Directors should identify in the Annual Report each Non-Executive director it considers to be independent, with reasons where necessary.	33
B.1.4	The Board of Directors should include in it's annual report a description of each Director's skills, expertise and experience. Alongside this, in the Annual Report, the board should make a clear statement about its own balance, completeness and appropriateness of the NHS foundation Trust.	33 - 38
B.2.10	A separate selection of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to Board appointments.	62 - 63

Code Ref	Summary of Requirement	Disclosure on page(s)
B.3.1	A Chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report.	50 - 52
B.5.6	Governors should canvass the opinion of the Trust's members and the public and, for Appointed Governors the body they represent, on the NHS foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	54
B.6.1	The Board of Directors should state in the annual report how performance evaluation of the Board, its committees, and its Directors, including the Chairperson, has been conducted.	41
B.6.2	Where there has been external evaluation of the board, and/or governance of the Trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust.	32
C.1.1	The Directors should explain in the annual report their responsibility for preparing the Annual Report and Accounts, and state that they consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation Trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	32 88 - 95
C.2.1	The Annual Report should contain a statement that the Board has conducted a review of the effectiveness of its systems of internal controls.	94
C.2.2	A Trust should disclose in the Annual Report: (a) If it has an internal audit function, how the function is structured and what role it performs; or (b) If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes	42 - 43
C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	N/A

Code Ref	Summary of Requirement	Disclosure on page(s)
C.3.9	A separate section of the Annual Report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: • The significant issues that the Committee considered in relation to financial settlements, operation and compliance, and how these issues were addressed; • An explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	41 - 46
D.1.3	Where an NHS foundation Trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the Annual Report should include a statement of whether or not the Director will retain such earnings.	N/A
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation Trust's website and in the Annual Report.	60
E.1.5	The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about the NHS foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations	54, 56 - 57
E.1.6	The Board of Directors should monitor how representative the NHS foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	59 - 60

The 'NHS Foundation Trust Annual Reporting Manual 2016/17' (FT ARM) also contains a number of additional mandatory disclosures, as follows:

FT ARM Summary of Requirement	Disclosure on page(s)
The Annual Report should include a statement about the number of meetings of the Council of Governors and individual attendance by Governors and Directors.	54 - 57
The Annual Report should include a brief description of the length of appointments of the Non-Executive Directors, and how they may be terminated.	34 – 36, 52
The disclosure in the Annual Report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a Chair or Non-Executive Director.	N/A

FT ARM Summary of Requirement	Disclosure on page(s)
If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.	N/A
The Annual Report should include: • A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • Information on the number of members and the number of members in each constituency; and • A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	59 - 60
The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation Trust. As each NHS foundation Trust must have registers or governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	50 – 52, 58

Comply or Explain Disclosures

As at 31 March 2018, the Trust was compliant with all of the Code's provisions except for the following:

- B.1.2 – at least half the Board, excluding the Chairperson, should comprise Non-Executive Directors determined by the Board to be independent

- D.1.1 – Any performance-related elements of the remuneration of Executive Directors should be designed to align their interests with those of patients, service users and taxpayers and to give those directors keen incentives to perform at the highest levels

With regard to the first provision (B.1.2), our constitution provides for parity between executive and Non-Executive Directors (including the Chair) with the Chair having a casting vote. Provision D.1.1 is not applicable, as our remuneration policy for Executive Directors does not include any performance-related elements.

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 suspects breach of its licence.

The Single Oversight Framework applied from quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters of 2016/17 relating to the RAF has not been presented in this report as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

We have been placed in Segment 2. Providers in Segment 2 are described as being offered targeted support from NHS Improvement and have potential support needs in one or more of the five themes, but are not in breach of their provider licence and formal action is not needed. Current segmentation information for NHS Trusts and foundation Trusts is published on the NHS Improvement website.

Finance and Use of Resources

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

Area	Metric	2017/18 Scores				2016/17 Scores	
		Q4	Q3	Q2	Q1	Q3	Q4
Financial sustainability	Capital service capacity	1	1	1	1	1	1
	Liquidity	1	1	1	1	1	1
Financial efficiency	I&E Margin	1	1	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1	1	2
	Agency spend	4	4	4	3	4	3
Overall Scoring		**3**	**3**	**3**	**1**	**3**	**2**

At the end of March 2018, we are reporting a rating of '3' for the finance and use of resources metric, against a plan rating of '1'. This variance is a result of our score against the agency metric, which stands at '4' and is due to an increase in agency costs incurred during 2017/18. As demonstrated above, we did achieve an overall finance and use of resources rating of '1' at the end of Quarter 1 and this was due to an improvement in performance against the distance from financial plan metric.

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Greater Manchester Mental Health NHS Foundation Trust

The National Health Service Act 2006 (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 Direction which require Greater Manchester Mental Health 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 Greater Manchester Mental Health NHS Foundation Trust and of its income and expenditure, items of other comprehensive income 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 and Social Care Group Accounting Manual and the NHS Foundation Trust Annual Reporting 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 and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- Assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the NHS foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

Signed

Neil Thwaite, Chief Executive
21 May 2018

Annual Governance Statement

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation 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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Greater Manchester Mental Health 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 Greater Manchester Mental Health NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As Accounting Officer, I have overall responsibility for ensuring that an effective system of risk management is in operation within the Trust. I have delegated responsibility for this, including responsibility for the development and implementation of our 'Risk Management Framework' and for the identification, assessment, treatment and management of risk, to the Director of Nursing and Governance during the reporting period.

Our Risk Management Framework is consistent with best practice and Department of Health guidance. It provides a clear, structured, systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation.

The following senior managers are identified as accountable to me, and responsible for providing assurance on specific risk areas, in the Risk Management Framework:

Risk Area	Responsible Director
Safeguarding, clinical governance, infection prevention and control, health and safety, security (as the nominated Security Management Director) and emergency preparedness (as the Accountable Emergency Officer)	Director of Nursing and Governance
Human Resources, Estates and Facilities (including fire and food safety)	Director of HR and Corporate Affairs
Finance and information (as the Senior Information Risk Owner (SIRO))	Director of Finance and IM&T
Clinical and operational services	Director of Operations
Business development and compliance with Care Quality Commission standards	Deputy Chief Executive/Director of Strategic Development

Risk Area continued	Responsible Director
Clinical, medicines management and standards of medical practice	Medical Director

A supporting system for managing risk has been devolved to the Associate Director of Nursing and Governance with support from the Head of Risk Management. The Risk Management Framework also clearly defines risk and clinical governance structures within divisions and the responsibilities of senior managers, managers and all other staff in relation to risk.

The Audit Committee of the Board of Directors has delegated responsibility for the establishment and maintenance of an effective system of governance, risk management and internal control, which operates across the Trust and supports the achievement of our key strategic objectives. The Audit Committee is concerned with evidencing the probity and efficiency of the risk management system in relation to the Trust's financial, governance and clinical operations. The Board's Quality Governance Committee oversees the system of quality governance and the overall assurance process associated with managing clinical service delivery effectively. The Board of Directors routinely receive minutes and briefings from all committees.

The Risk Management Committee serves as a sub-group of the Audit Committee and is responsible for ensuring the effective application of risk management across the Trust. The Committee has been chaired by the Director of Nursing and Governance during 2017/18 and the membership includes the Associate Directors of Nursing and Governance, Finance and HR; the Director of Pharmacy; Heads of Service/Deputy Directors or their Risk Management Leads from each division/department; and senior Trust managers with responsibility for risk management.

The Risk Management Committee is able to constitute advisory sub-groups to deal with specialist and specific risk issues. Sub-groups monitor risks relevant to their specialist area and escalate risks scoring 12 and above to the Risk Management Committee.

Risk management training is provided for all new starters through our Trust induction programme. Our Trust-wide Training Needs Analysis identifies risk management training requirements for specific staff groups, which are appropriate to the grade, role and location of staff. Tailored training for specific roles is also identified by managers and agreed with individual members of staff via the annual appraisal and personal development planning process. Root-cause analysis training is provided to staff members with direct responsibility for risk management within their area of work. Training uptake is monitored on an ongoing basis.

We aim to ensure that lessons are learnt following incidents, events, complaints and inquests. We communicate our lessons learnt across the Trust via a range of mechanisms, including briefings, newsletters and learning events, and with external stakeholders. The Board of Directors receives reports on serious untoward incidents. Reflective practice is encouraged, including through clinical supervision.

We have effective mechanisms in place to act upon alerts and recommendations made by all relevant central bodies including the National Patient Safety Agency (NPSA), National Health Service Litigation Authority (NHSLA) (NHS Resolution) and the Health and Safety Executive (HSE).

The Risk and Control Framework

Risk management is embedded throughout the organisation and all staff are encouraged to report incidents and raise concerns. All services are required to identify core risks to the delivery of their business plans as part of the annual planning process.

Our Risk Management Framework establishes the formal structured approach to the identification, assessment, treatment and management of risks. The process starts with a systematic identification of risks throughout the organisation which are documented within risk registers. These risks are then analysed in order to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found. Higher scoring risks are managed at progressively higher levels within the organisation and escalated to the Risk Management Committee every two months for monitoring and consideration for inclusion in the Board Assurance Framework. Achieving control of the higher scoring risks is given priority over lower scoring risks. Risk control measures are identified and taken to reduce the potential for harm.

The Board reviews and approves the Board Assurance Framework on a quarterly basis. The Board receives updates on assurances, controls and actions being taken to mitigate risk from the designated lead Committees/groups and agrees any further actions required or changes to the Board Assurance Framework. Changes may include the addition of new strategic risks, which have arisen through Board papers or Board discussion and may reflect current or likely future challenge within the health economy. When approving the Board Assurance Framework, the Board considers risk appetite.

As documented elsewhere in this report, the most critical risks facing the organisation at the end of the reporting period, which are being managed and mitigated at Board level are:

- Future workforce supply – recruitment and retention of high quality staff
- Out of Area Placements (OAPs) – usage and expenditure
- Learning from deaths – implementation of robust mortality governance processes
- Cultural alignment – aligning the cultures of the two former organisations
- Agency – usage and expenditure
- Acquisition of MMHSCT – delivery of our agreed Post-Transaction Implementation Plan

Information governance and data security risks are also managed through the Risk Management Framework and assessed using the Information Governance Toolkit. We aim to deliver a high standard of excellence in information governance by ensuring that information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care to our service users. We have an established Information Governance Policy, which provides a framework for the management of all service user, staff and organisational information. Implementing the requirements of the Information Governance Toolkit is part of this framework. It is a mandatory requirement that all staff complete information governance training and we have established processes for identifying and managing breaches in data security. All portable storage devices are encrypted and data security is enhanced. Responsibility for the implementation of our 'Clinical System Data Quality Policy' sits with the Director of Finance and IM&T. Assurance on data quality is provided by the Information Governance Steering Group.

Actual and potential risks, which may impact on external stakeholders and key partner agencies, including local authorities, commissioners, other NHS providers, the judicial system, voluntary organisation and service users, are handled through structured mechanisms and forums such as Overview and Scrutiny Committees, contract monitoring meetings, Council of Governor meetings and service user forums.

Quality Governance

Our Quality Governance Framework defines our approach to quality improvement and innovation and is adapted from Monitor's Quality Governance Framework. The framework describes the structures and

processes in place at and below Board level for delivering effective quality assurance. It ensures that the Trust's intentions and systems for delivering robust quality governance are clear and accessible to all staff involved in the planning, delivery and monitoring of services. It also reinforces the importance of embedding the principles of quality within our clinical approaches to support the delivery of high quality, safe and effective care. By defining explicit roles and responsibilities, the framework ensures that we make effective use of Board executives, clinical leaders and service directors in driving the quality agenda. The framework also contributes to developing the Board's capability to understand and promote continuous quality improvement. Quality governance activities are routinely reported to the Board of Directors through the Quality Governance Committee, which leads on setting the quality agenda and measuring performance against agreed quality priorities.

We are fully compliant with the requirements of registration with the Care Quality Commission (CQC). Assurance has been obtained on compliance with the CQC registration requirements and the fundamental need to ensure the provision of services that are safe, effective, caring, responsive and well-led through the following mechanisms:

- Receipt of an overall 'Good' rating and an 'Outstanding' rating for well-led (leadership) from the CQC in February 2018, following a core service with well-led inspection conducted during September to December 2017
- Board Performance Reports framed around the CQC domains
- The establishment of a Sustainability Meeting with responsibility for co-ordinating the preparation for our CQC inspection
- Oversight of the implementation of our CQC action plan being carried out by the Quality Governance Committee

Compliance with NHS Foundation Trust Condition 4 (FT Governance)

I can report no principle risks to compliance with the NHS foundation Trust licence condition 4 (FT governance) other than the risks described elsewhere in this report. We have complied with this condition throughout this financial year and are planning continued compliance in 2018/19. We have effective systems in place for the collection, analysis and reporting of information, which provides assurance on our compliance with the licence. The Board of Directors review the Board Performance Report at every Board meeting. This Report summarises performance against key performance indicators and quality standards, including NHS Improvement targets, CQC requirements and contractual performance indicators. We have reviewed our governance structures, including the Terms of Reference for all committees of the Board of Directors, to ensure that they are sound and fit for purpose. Reporting lines and lines of accountability are clear and have been communicated across the organisation.

We are able to assure ourselves of the validity of our Corporate Governance Statement through the systems of oversight and scrutiny described in this Annual Governance Statement and the wider report.

Compliance with NHS Pension Scheme

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.

Equality, Diversity and Human Rights

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

Emergency Preparedness

The Foundation Trust has undertaken risk assessments and put carbon reduction delivery plans in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects. This ensures that the organisation's obligations under the Climate Change Act and adaptation reporting requirements are complied with.

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

We operate a robust, annual business planning process, which helps strengthen the organisation's clinical, financial and operational sustainability and supports delivery of our strategic objectives. Our 'Business Planning Framework' sets out basic principles and a clear process for business planning, including time-frames and responsibilities of key stakeholders. Individual services identify future priorities, workforce plans and cost improvement programmes in their business plan, and also report progress against previous years' plans. Cost improvement programmes are subject to a comprehensive quality impact assessment, which considers any potential impacts on service delivery and quality, before being approved by the Executive Management Team.

Local business plans are incorporated into a single, two-year Operational Plan for the organisation, which is approved by the Board of Directors and describes how we will progress our longer-term strategic agendas and also ensure short-term resilience and affordability. We have regard to the views of our Council of Governors when developing our Operational Plan and also proactively involve and engage other key stakeholders.

Performance against our strategic objectives is monitored via a number of channels, including:

- Monthly reporting to the Board of Directors on performance against key performance indicators and quality standards, including NHS Improvement targets, CQC requirements and contractual performance targets and workforce and activity measures
- Routine briefings to the Executive Management Team on changes to, influences on, the Trust's financial position and operational performance
- Routine reporting to the Council of Governors
- Periodic reporting to NHS Improvement
- Compliance with the requirements of our provider licence
- Performance management of individual divisions and services
- Compliance with our Standing Financial Instructions and Scheme of Reservation and Delegation
- Decision-making on all key strategic issues reserved for the Executive Management Team or Board of Directors

A programme of internal audits has also been undertaken over the year by our internal auditors (Mersey Internal Audit), with oversight provided by the Audit Committee. Our approach to internal audit is risk-based, aligned to our strategic objectives and focussed on core systems and other areas that present opportunities for improvement. In 2017/18, keys areas covered by our internal audit plan were:

- Financial Performance and Sustainability – Bank and Agency, Patient Funds and Property, Ledger Migration, Post-Transaction Implementation Plan and Combined Financial Systems
- IM&T – Cyber Security, Critical Applications, Information Governance Toolkit and General Data Protection Regulations (GDPR)
- Compliance and Performance – Safety and Suitability of Premises and Board Performance Dashboard

- Quality – Quality Spot Checks, Physical Health in Mental Health Settings, Mortality Framework and Safeguarding
- Workforce – Safe and Competent Workforce, Payroll/ESR
- Governance and Leadership – Serious Untoward Incidents, Conflicts of Interest and Assurance Framework Opinion

The Audit Committee has reviewed all completed internal audit reports and secured assurance on recommendations made. The Internal Audit review of our Board Assurance Framework found that our Assurance Framework is structured to meet NHS requirements, is visibly used by Board and that the content demonstrates clear connectivity with the Board agenda and external environment.

Information Governance

The Trust has reported four serious incidents relating to information governance to the Information Commissioner's Office (ICO) during the reporting period. All four incidents were categorised as unauthorised access/disclosure of information. Two of the cases have been closed with no further action required, two investigations are ongoing. The ICO has made no recommendations in respect of the reported incidents and has agreed the Trust's approach to handling the incidents.

The Trust has seen a rise in the number of incidents reported to the Information Governance Team during 2017/18. This is as expected due to the increased size of the organisation. The number of serious incidents subsequently reported to the ICO has, however, reduced compared to the previous year. This indicates that staff are increasingly aware of their roles and responsibilities with regards to information governance and feel confident to report issues, whilst the reduction in reportable incidents indicates that the current Information Governance agenda is working effectively.

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 has issued guidance to NHS foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

In producing our Quality Account for 2017/18, we have identified two new priorities for improvement focussed on improving the quality and effectiveness of service user care plans and developing a personality disorder strategy and framework. The content of our Quality Account 2017/18 presents a balanced view of this organisation over the period, with the views of governance and other internal and external stakeholders sought on our key priorities going forward. The Quality Account is consistent with sources of internal and external data including:

- Board of Directors minutes and papers for the period April 2017 to March 2018
- Complaints and compliments, including our 'Annual Complaints Report' which meets the requirements of Regulation 18 of the 'Local Authority Social Services and NHS Complaints (England) Regulations 2009'
- 2017 Community Mental Health Survey
- 2017 NHS Staff Survey
- Friends and Family Test responses
- Information Governance Toolkit
- Clinical audit reports
- Care Quality Commission inspection reports
- Other sources of service user feedback, including local inpatient surveys
- Board service visits
- Board Performance Reports for the period April 2017 to March 2018

- Quality Account quarterly progress reports to the Quality Governance Committee

In developing our Quality Account, feedback has been sought from key stakeholders including commissioners, governors, local Healthwatch organisations and our joint Scrutiny Committee.

Accuracy of data reported within our Quality Account is ensured through:

- Governance and Leadership - as set out in our Quality Governance Framework, I am ultimately responsible for achieving robust clinical quality across the organisation, whilst the Director of Nursing and Governance is responsible for ensuring compliance with our Quality Account. The Director of Nursing and Governance and Medical Director share responsibility for ensuring that quality governance principles are embedded throughout the organisation, monitoring trends in key clinical quality and clinical outcome measures, and accounting for quality governance.

  The Quality Governance Committee develops and defines our quality strategy on behalf of the Board of Directors and identifies our key quality priorities, goals and standards. This Committee also regularly tracks progress against our agreed Quality Account priorities, ensuring that the required standards are achieved and action is taken on sub-standard performance.

- Policies and Protocols – recognising the importance of high quality information to the effective functioning of the organisation, we operate a range of policies all aspects of information governance. Ensuring high quality data is the responsibility of all staff. Our 'Clinical System Data Quality Policy' provides guidance for all staff involved in the capture, processing or us of patient-related data and information. Our 'Information Governance Policy' provides guidance in relation to openness and information sharing, information security, information quality assurance and compliance with legal requirements. Considered alongside our other information governance policies, these provide an integrated framework of requirements, standards and best practice.

- Systems and Processes, Data Use and Reporting – we have robust systems in place for checking the quality and reliability of all performance information reported to the Board of Directors in the monthly Board Performance Report. Information is recorded in the relevant electronic system and then reviewed by relevant personnel in the local service via data validation reports issued by our Business Intelligence Team. This is followed by service-level reporting and review prior to the report to Board.

  Our Information Quality Assurance Team review data quality and support services to make improvements. This includes operating a regular audit cycle to check the accuracy of data. The remit of our 'Performance Measures and Data Quality Group' includes raising awareness of the importance of data quality, ensuring all staff are aware of their data quality responsibilities and supporting the development of policies and procedures to improve data quality.

- People and Skills – Roles and responsibilities in relation to quality are clearly defined in job descriptions and policies and procedures. Where new ways of collecting, monitoring or reporting data are agreed, these are shared with all affected staff. Information governance training is also provided to ensure staff have the necessary skills to deliver our data quality commitments.

Our external auditors, KPMG, have been engaged by the Council of Governors to complete a limited assurance report on the content of the Quality Account and to provide assurance over two mandated indicators and one local indicator.

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 NHS Foundation 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 Committee and the Quality Governance Committee and plan to address weaknesses and ensure continuous improvement of the system is in place.

The process applied in maintaining and reviewing the effectiveness of the system of internal control throughout this financial year has included:

- Completion of the annual, risk-based internal audit plan with scrutiny by the Audit Committee of all completed internal audit reports and associated controls
- Quarterly review of the Board Assurance Framework by the Board of Directors
- Risk Management Committee review of high scoring risks and regular review of local risk registers
- Assessment and monitoring of the quality of services by the Quality Governance Committee
- Quality Governance Committee oversight of the clinical audit programme through an annual report from our 'NICE Implementation and Audit Group'
- Weekly meetings of the Executive Management Team, providing opportunity for consideration of any performance concerns or emerging or changing risks
- Review of serious incidents and learning by the Quality Governance Committee, including those related to risk management and clinical effectiveness;
- Clear Terms of Reference and reporting lines for all committees of the Board of Directors, and any sub-groups, allowing any issues to be raised

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives have been reviewed. My review is also informed by the work of external audit, the Care Quality Commission, National Health Service Litigation Authority and other external inspections, accreditations and reviews.

Director of Audit Opinion

Mersey Internal Audit Agency, the Trust's internal auditors, have provided an overall opinion of 'Substantial Assurance' that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. This opinion is underpinned by the work conducted through the risk-based internal audit plan and is provided in the context that the Trust, like other NHS organisations, is facing a number of challenging issues and wider organisational factors.

Conclusion

No significant internal control issues or gaps in control have been identified in this Annual Governance Statement. The Trust has continued to strengthen the system of internal control during the period to ensure that it is fit for purpose for the enlarged organisation.

Neil Thwaite, Chief Executive
21 May 2018

Quality Report

Quality Account

We publish our Quality Account as a separate document. A copy of our 2017/18 Quality Account can be requested from communications@gmmh.nhs.uk.

NHS
Greater Manchester Mental Health
NHS Foundation Trust

Quality Account 2017/2018

Greater Manchester Mental Health
NHS Foundation Trust

Improving Lives

Independent Auditor's Report

KPMG

Independent auditor's report

to the Council of Governors of Greater Manchester Mental Health NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Greater Manchester Mental Health NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health and Social Care Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview		
Materiality: financial statements as a whole	£5m (2017:£3.35m) 1.73% (2017: 2%) of forecast total revenue	
Risks of material misstatement		**vs 2017**
Recurring risks	Valuation of Land and Buildings	◄►
	Recognition of NHS Income and Deferred Income	◄►
New risk	Valuation of LGPS Net Pension Liability	▲

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which 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. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows:

	The risk	Our response
Valuation of Land and Buildings (Land and Buildings £183.4m; 2017: £166.9m) *Refer to pages 41 to 46 (Audit Committee Report), pages 113 to 127 (accounting policies) and pages 107 to 161 (financial disclosures)*	**Subjective Valuation** Significant judgment involved in determining the appropriate basis (Existing Use Valuation or Depreciated Replacement Cost) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. This includes the risk that impairments are not appropriately identified or quantified for changes in use or valuation basis. Land and buildings are measured at Depreciated Replacement Cost (DRC) RC because many of the Trust's assets are specialised. The Group Accounting Manual sets out the need for DRC to be determined based on replacement cost of a modern equivalent asset since there is not an active market for specialised assets and it sets out any assumptions made about changes to the estate when determining how it would be replaced, e.g. change in location or size. The Trust completes a full valuation every five years, with interim desktop exercises performed annually. The Trust commissioned an external valuer ("the Valuer") to undertake a desktop valuation and impairment review in 2017/18. As a result of the desktop valuation, the value of the Trust's land and buildings increased by £18.8m to reflect their fair value. Given the materiality of these transactions and the judgement involved in determining the carrying amounts of land and buildings this has been identified as a key audit risk.	Our procedures included: **Assessing valuer's credentials:** We critically assessed the competence, capability, objectivity and independence of the Trust's external Valuer. This included a review of the Gerald Eve assurance report regarding their assessment of the Valuation Office Agency. **Assessing valuation assumptions:** We reviewed the valuation reports, terms of engagement of, assumptions used by, and the instructions issued to, the Valuer and compared these with the requirements of the GAM. **Assessing valuation assumptions:** We critically assessed the assumptions underpinning the Trust's calculation of market value movements to the Royal Institute Chartered Surveyors data obtained by the Valuer and corresponding with audit teams at other Trusts in the region, to assure ourselves that indices are comparable. **Test of detail:** We tested the completeness and accuracy of the estate covered by the desktop valuation by comparing he Trust's underlying records of the estate held in the fixed asset register to the assets in the prior year valuation report. We tested a sample of additions to land and buildings during the year. **Test of detail:** We reviewed the calculations of the Valuer to verify that the information provided by the Trust has formed the basis of the valuation and that the relevant assumptions and indices have been applied appropriately. **Test of detail:** We compared the asset value movements from the Valuer's report to the entries in the fixed asset register. This included a re-performance of the entries to confirm that any material movements in the value of land and building assets had been accounted for correctly. **Test of detail:** We tested the completeness and accuracy of the Trust's formal consideration of indications of impairment and surplus assets within its estate. This included an assessment of the adequacy of the written instructions communicated to the Valuer to inform the impairment process and a review of the evidence to support the conclusions formed, as well as a recalculation of any resulting impairments.

	The risk	Our response
Valuation of Land and Buildings (Land and Buildings £183.4m; 2017: £166.9m) *Refer to pages 41 to 46 (Audit Committee Report), pages 113 to 127 (accounting policies) and pages 107 to 161 (financial disclosures)*	**Subjective Valuation** Please see the previous page for detail of the risk relating to the valuation of land and buildings.	Our procedures included: **Test of detail:** We compared the numbers, included in the land and building values in the Statement of Financial Position and PPE note, alongside the impairment charges to the Statement of Comprehensive Income and revaluation reserve movements to the independent valuation report and the results of the Trust's impairment review, and investigated any variances.

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	The risk	Our response
Recognition of NHS Income and Deferred Income NHS Income £231m (2017: £163m) Deferred Income £18.5m (2017: £13.4m) *Refer to pages 41 to 46 (Audit Committee Report), pages 113 to 127 (accounting policies) and pages 107 to 161 (financial disclosures)*	**Subjective Estimate** The Trust receives funding for Education and Training and Research. These activities will frequently span years and as such a significant proportion of the income each year needs to be deferred. In addition, the Trust received a significant level of transition and transformation income from commissioners following the acquisition of Manchester Mental Health and Social Care NHS Trust (MMHSC) in January 2017. Regulators performance manage the Trust on delivery against its control total, and the receipt of Sustainability and Transformation Funding (STF) is dependent on this performance. The Trust has performed strongly against the control total in 2017/18, but forecasts indicate that the financial targets in 2018/19 will be more challenging to deliver. All NHS organisations take part in an agreement of balances (AOB) exercise at the end of the year, which is facilitated by the Department of Health and Social Care. A mismatch report is produced by Department of Health and Social Care showing where balances are not agreed between parties. This exercise would identify any variances between the income recognised by the Trust and expenditure incurred by commissioners. This would include differences relating to income which has been deferred by the Trust. With the pressure on management to deliver the control total each year, and knowing the Trust had achieved its targets in 2017/18, we identified a significant risk that management would inappropriately defer income in 2017/18 in order to release the income in future years to support the delivery of financial targets.	Our procedures included: **Test of detail:** We compared the income balances reported by the Trust as part of the 2017/18 Agreement of Balances (AoB) exercise to the balances reported in the accounts. **Test of detail:** For any variances or mismatches identified as part of the AoB exercise, we sought explanations and supporting evidence for the Trust's position from the client. This included mismatches arising from the deferral of income by the trust where the commissioner had recognised the full amount in expenditure in the year. **Test of detail:** We analysed the deferred income balances, and compared a sample of the balances carried forward to documentation to determine whether the income was being deferred appropriately, in line with conditions of the funding.

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	The risk	Our response
Valuation of LGPS Net Pension Liability LGPS Plan Assets £16.7m (2017: £16.2m) LGPS defined benefit obligation £17.9m (2017: £17.6m) *Refer to pages 41 to 46 (Audit Committee Report), pages 113 to 127 (accounting policies) and pages 107 to 161 (financial disclosures)*	**Subjective Valuation** The Trust is an admitted body of the Greater Manchester Pension Fund (GMPF), part of the Local Government Pension Scheme (LGPS), which as a defined benefit scheme. The Trust's share of the pension scheme assets is based on the last triennial valuation, which was completed as at 31 March 2016. Thereafter it is rolled forward to the accounting date using suitable estimates of the investment returns, contributions received and benefits paid out, all applicable to the employer's share. This forms the basis of the asset valuation for accounting purposes as at 31 March 2018. The pension liability is a significant estimate, based on the number of staff in the scheme and the characteristics of those staff, such as their age and their length of service. The liability is calculated using a range of assumptions, including estimates on inflation and lifespan. Due to the level of judgement and expertise required to prepare the IAS19 valuation for the purposes of preparing the financial statements, the Trust relies on the LGPS scheme actuary, who is appointed by GMPF. The actuary relies on the information provided by the GMPF on the employees, deferred members and pensioners of the Trust. There is a risk that the information, assumptions and methodology used in the valuation of the Trust's pension assets and liabilities are inappropriate. This could have a material impact on the gross pension liability or the gross pension asset reported in the financial statements.	Our procedures included: **Assessing actuary's credentials:** We critically assessed the competency, objectivity and independence of the Scheme's actuary. **Assessing valuation assumptions:** We reviewed the appropriateness of the key assumptions included within the valuation of the assets and the liabilities, with the use of a KPMG Actuary. Our actuary also reviewed the methodology applied in the valuation by Scheme's actuary. **Test of detail:** We used the IAS 19 valuation provided by the Scheme Actuary for accounting purposes to ensure that this reconciled to the pension balances in the Trust's financial statements. **Test of detail:** We liaised with the auditors of the Greater Manchester Pension Fund (Grant Thornton) in order to gain assurance that the controls in place at the Pension Fund were operating effectively. This included the process and controls in place to ensure data provided to the actuary by the pension fund for the purposes of the IAS19 valuation was complete and accurate. **Test of detail:** We agreed the estimated movement in the fair value of plan assets during the year included in the IAS 19 Actuarial Valuation as at 31 March 2018 for accounting purposes report to the Trust's financial statements. **Test of detail:** We performed substantive analytical procedures to create an expectation of the estimated cashflows (interest income, employee and employer contributions, benefits paid) used to determine the movements in plan assets during the year.

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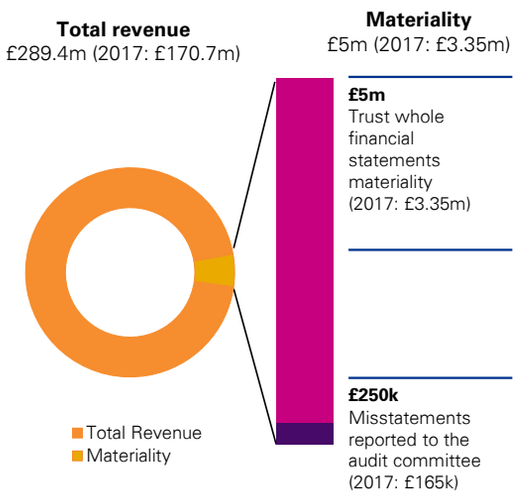
3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £5 million (2016/17: £3.35 million), determined with reference to a benchmark of total revenue (of which it represents approximately 1.73% (2016/17 2%)). We consider total revenue to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £250k (2016/17:(£165k), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Prestwich.



4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement of accounting officer responsibilities, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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 they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

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KPMG

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether 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. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

We did not identify any significant risks in 2017/18 relating to arrangements for securing economy, efficiency and effectiveness.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Greater Manchester Mental Health NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Amanda Latham

Amanda Latham
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
One St Peter's Square,
Manchester,
M2 3AE

23rd May 2018

Financial Review

Foreword To The Accounts

These accounts for the year ended 31 March 2018 have been prepared by Greater Manchester Mental Health NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the NHS Act 2006.

The financial position reported within these accounts comprises the first full 12 months' financial performance of GMMH as a combined entity following the acquisition of Manchester Mental Health and Social Care NHS Trust on 1 January 2017.

The comparative figures reported for 2016/17 comprise a full 12 months' performance for the former Greater Manchester West Mental Health NHS Foundation Trust and 3 months' performance for the former Manchester Mental Health and Social Care NHS Trust following its acquisition on 1 January 2017.

Neil Thwaite, Chief Executive
21 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	258,000	184,695
Other operating income	4	35,292	16,941
Operating expenses	5	(280,086)	(189,407)
Operating surplus/(deficit) from continuing operations		13,206	12,229
Finance income	10	149	97
Finance expenses	11	(195)	(272)
PDC dividends payable		(4,981)	(4,172)
Net finance costs		(5,027)	(4,347)
Other gains / (losses)	12	3	(4)
Gains / (losses) arising from transfers by absorption	13	-	9,488
Surplus / (deficit) for the year from continuing operations		8,182	17,366
Surplus / (deficit) for the year		**8,182**	**17,366**
Other comprehensive income			
Will no be reclassified to income and expenditure:			
Impairments	6	952	201
Revaluations		13,494	4,126
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability / asset	30	457	4,430
Other reserve movements		(15)	(15)
Total comprehensive income/ (expense) for the period		23,070	26,108

*Financial Performance for the year - Memorandum only does not form part of the accounts

Surplus/(deficit) for the year from continuing operations	**8,182**	17,366
Reversal of Impairments following revaluation of PPE	**(4,387)**	(6,176)
Impairments (excluding IFRC 12 impairments)	**-**	1,480
Adjustment re-absorption accounting	**-**	(9,488)
Non-cash element of on SOPF Pension Costs	**214**	-
Operating Surplus for the year	**4,009**	3,182

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	1,691	547
Property, plant and equipment	15	191,304	171,508
Investment property		-	-
Trade and other receivables	17	9,968	9,413
Total non-current assets		**202,963**	**181,468**
Current assets			
Inventories		-	-
Trade and other receivables	17	16,265	11,523
Cash and cash equivalents	20	38,748	31,473
Total current assets		**55,013**	**42,996**
Current liabilities			
Trade and other payables	21	(29,744)	(24,405)
Borrowings	24	(5,762)	(324)
Other financial liabilities		-	-
Provisions	26	(717)	(3,405)
Other liabilities	23	(14,947)	(10,924)
Liabilities in disposal groups		-	-
Total current liabilities		**(51,170)**	**(39,058)**
Total assets less current liabilities		**206,806**	**185,406**
Non-Current liabilities			
Trade and other payables	21	-	-
Borrowings	24	(2,449)	(8,211)
Other financial liabilities		-	-
Provisions	26	(3,262)	(3,377)
Other liabilities	23	(4,662)	(3,811)
Total non-current liabilities		**(10,373)**	**(15,399)**
Total assets employed		**196,433**	**170,007**
Financed by			
Public dividend capital		105,406	102,049
Revaluation reserve		30,552	16,723
Available for sale investments reserve		-	-
Pension reserve		924	467
Other reserves		425	440
Merger reserve		-	-
Income and expenditure reserve		59,126	50,328
Total taxpayers' equity		**196,433**	**170,007**

The notes on pages 113 to 161 form part of these accounts.

The financial statements were approved by the Trust Board on 21 May 2018 and signed on its behalf by:

Signed: 

Name: Neil Thwaite
Position: Chief Executive
Date: 21 May 2018

Statement of Changes in Taxpayers' Equity

Statement of Changes in Equity for the Year Ended 31 March 2018

	Public dividend capital	Revaluation reserve	Pension Reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**102,049**	**16,723**	**467**	**440**	**50,328**	**170,007**
Surplus/(deficit) for the year	-	-	-	-	8,182	8,182
Transfers by absorption: transfers between reserves	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(617)	-	-	617	-
Other transfers between reserves	-	-	-	-	-	-
Impairments	-	952	-	-	-	952
Revaluations	-	13,494	-	-	-	13,494
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	457	-	-	457
Public dividend capital received	3,357	-	-	-	-	3,357
Public dividend capital repaid	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-
Other reserve movements	-	-	-	(15)	-	(15)
Taxpayers' equity at 31 March 2018	**105,406**	**30,552**	**924**	**425**	**59,126**	**196,433**

Statement of Changes in Equity for the Year Ended 31 March 2017

	Public dividend capital	Revaluation reserve	Pension Reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**92,561**	**8,815**	-	**455**	**42,068**	**143,899**
Prior period adjustment	-	-	-	-	-	-
Taxpayers' equity at 1 April 2016 - restated	**92,561**	**8,815**	**-**	**455**	**42,068**	**143,899**
Surplus/(deficit) for the year	-	-	-	-	17,366	17,366
Transfers by absorption: transfers between reserves	9,488	3,882	(3,963)	-	(9,407)	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-
Impairments	-	201	-	-	-	201
Revaluations	-	4,126	-	-	-	4,126
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-
Re measurements of the defined net benefit pension scheme liability/asset	-	-	4,430	-	-	4,430
Public dividend capital received	-	-	-	-	-	-
Public dividend capital repaid	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-
Other reserve movements	-	(301)	-	(15)	301	(15)
Taxpayers' equity at 31 March 2017	**102,049**	**16,723**	**467**	**440**	**50,328**	**170,007**

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 (DHSC) on the acquisition of/or merger with another NHS Trust or for DHSC funded capital expenditure. 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.

Pension reserve

This relates to the Trust's membership as an admitted body of the Greater Manchester Pension Fund. Actuarial gains and losses arising from changes in the actuarial assumption used the annual IAS 19 valuation of the fund are recorded in the pension reserve.

Other Reserves

The balance of this reserve is from the transfer of a property to the Trust in 2000/01

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		13,206	12,229
Non-cash income and expense:			
Depreciation and amortisation	5	6,789	4,712
Net impairments	6	(4,387)	(4,696)
Non-cash movements in on-SoFP pension liability		214	75
(Increase) / decrease in receivables and other assets		(5,335)	(699)
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilties		9,853	(11,005)
Increase / (decrease) in provisions		(2,811)	1,167
Other movements in operating cash flows		(15)	(15)
Net cash generated from / (used in) operating activities		**17,514**	**1,768**
Cash flows from investing activities			
Interest received		149	97
Purchase of intangible assets		(1,664)	(363)
Purchase of property, plant, equipment and investment property		(6,354)	(9,500)
Sales of property, plant, equipment and investment property		3	732
Net cash generated from / (used in) investing activities		**(7,866)**	**(9,034)**
Cash flows from financing activities			
Public dividend capital received		3,357	-
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		(324)	(162)
Other interest paid		(138)	(76)
PDC dividend (paid) / refunded		(5,268)	(4,136)
Cash flows from (used in) other financing activities		-	37
Net cash generated from / (used in) financing activities		**(2,373)**	**(4,337)**
Increase / (decrease) in cash and cash equivalents		**7,275**	**(11,603)**
Cash and cash equivalents at 1 April - brought forward		**31,473**	**40,829**
Prior period adjustments			
Cash and cash equivalents at 1 April - restated		**31,473**	**40,829**
Cash and cash equivalents transferred under absorption accounting		**-**	**2,247**
Cash and cash equivalents at 31 March	20.1	**38,748**	**31,473**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires management to make an assessment of the NHS Foundation Trust's ability to continue operating as a going concern. At the Trust Board meeting held on 26 March 2018, the Trust Board considered the IAS 1 requirement and confirmed that a going concern basis for accounts preparation was appropriate.

Note 1.2 Critical judgements in applying accounting policies and key sources of estimation uncertainty

In the application of the NHS 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 the revision and future periods if the revision affects both current and future periods.

Note 1.2.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) 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:

The Trust as lessee, has classified a lease between the Trust and Manchester University NHS Foundation Trust (formerly University Hospital of South Manchester NHS Foundation Trust) relating

to Laureate House as an operating lease.This lease has been classified as an operating lease following an assessment of the lease agreement against the International Financial Reporting Standards (IFRS) criteria which identified that the asset does not transfer to the Trust at the end of the lease nor does the Trust have any option to purchase the asset. The lease is not for the major part of the economic life of the asset and the asset is not specialised in nature. Although the present value of the minimum lease payments at inception is substantially all of the fair value of Laureate House, the Trust has judged that this in itself is not sufficient to classify the lease as a finance lease and in substance therefore, the lease is an operating lease.

Note 1.2.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Modern Equivalent Asset Valuation

Independent valuers have provided valuations of the Trust's land and building assets (estimated financial value and estimated remaining useful life), applying a Modern Equivalent Asset method of valuation. For 2017/18 the Trust has engaged the District Valuer to undertake a desktop revaluation and has revalued its land and building assets accordingly. Future revaluations of the Trust's property may result in further material change to the carrying value of land and buildings assets. For 2017/18 the District Valuer has applied Royal Institute of Chartered Surveyors' forecast rebuild indices, the BCIS Tender Price Indices, for assets valued at depreciated replacement cost, resulting in a total increase in carrying values of £18.833m

Financial Value of Provisions for Liabilities and Charges

The Trust make financial provisions for obligations of uncertain timing or amount at the date of the Statement of Financial Position. These are based on estimates, using as much relevant information as is available at the time the accounts are prepared. They are reviewed to confirm that the values included in the financial statements best reflect the current relevant information, and where necessary the values of the provisions are amended**.**

Greater Manchester Pension Fund (GMPF)

To facilitate the TUPE transfer of social care staff from Manchester City Council to the former Manchester Mental Health and Social Care Trust on 1 September 2010, the Care Trust became an admitted body to the GMPF. With effect from 1 January 2017, this admitted body status transfered to Greater Manchester Mental Health Foundation Trust. Full actuarial valuations of the fund are undertaken every 3 years, the latest being March 2016. In between full actuarial valuations, the assets and liabilities are updated at each year end using principal actuarial assumptions as at that date.

An actuarial report is produced detailing the opening and closing assets and liabilities of the Trust share of the GMPF. The principal actuarial assumptions used at 31 March 2018 and 31 March 2017 in measuring the present value of the defined benefit scheme liabilities are:

Financial Assumptions	31 March 2018	31 March 2017
	%pa	
Pension Increase Rate (CPI)	**2.4%**	2.4%
Salary Increase Rate	**3.2%**	3.2%
Discount Rate	**2.7%**	2.6%

The expected return on assets is based on the long-term future expected investment return for each asset class.

Demographic Assumptions (life expectancies)	31 March 2018	31 March 2017
	Years	
Current Pensioners - Male	**21.5**	21.5
Current Pensioners - Female	**24.1**	24.1
Future Pensioners - Male	**23.7**	23.7
Future Pensioners - Female	**26.2**	26.2

Sensitivity Analysis

The sensitivities regarding the principal assumptions used to measure the scheme liabilities are as follows :

	31 March 2018	
	%	£000
0.5% decrease in real discount rate	**11%**	2,007
0.5% increase in salary increase rate	**2%**	274
0.5% increase in pension increase rate	**10%**	1,710
	31 March 2017	
	%	£000
0.5% decrease in real discount rate	**11%**	1,999
0.5% increase in salary increase rate	**2%**	298
0.5% increase in pension increase rate	**10%**	1,673

Note 1.3 Interests in other entities

The Trust does not have any interests in other entities and consequently is not required to produce consolidated accounts under IAS27.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

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 the Secretary of State in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as 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

Staff who transferred from Manchester City Council on 1 September 2010 can remain members of the GMPF, which in turn is a member of the Local Government Pension Scheme (LGPS). Details of this scheme can be obtained from the GMPF, Council Offices, Wellington Road, Ashton under Lyne, OL6 6DL.

Details of the Trust assets and liabilities as a member of the scheme have been calculated by an independent actuary, Hyman Robertson LLP. A full actuarial report for the full GMPF was produced in March 2016. This report set out member contribution rates up to and including 2019/20.

The Trust has a number of employees who are members of the above fund. The funds within the LGPS are multi-employer schemes and each employer's share of the underlying assets and liabilities can be identified. Hence a defined benefit accounting approach is followed. The scheme has full actuarial valuation at intervals not exceeding three years. In between the full actuarial valuations, the assets and liabilities are updated at the year end, using the principal actuarial assumptions at that date. The full disclosure requirements of IAS19 Employee Benefits are given in note 30.

The pension scheme assets are measured using market value. Pension scheme liabilities are measured using the projected unit actuarial method and are discounted at the current rate of return on a high quality corporate bond of equivalent terms and currency to the liability. The increase in the present value of the liabilities of the defined benefit pension scheme expected to arise from employee service in the period is charged to operating expenses.

The expected return on the scheme assets and the increase during the year in the present value of the schemes' liabilities arising from the passage of time are included in other finance costs.

Actuarial gains and losses are recognised within retained earnings in the Statement of Changes in Taxpayers' Equity and in Other Comprehensive Income.

National Employment Savings Pension Scheme (NEST)

Under the Pensions Act 2008 employers must offer a pension scheme to all its employees. As from the 1 July 2013, when the scheme came into operation in the Trust, staff who are not eligible to join the NHS Pensions Scheme or LGPS are automatically enrolled into NEST. This scheme is a defined contribution pension scheme created as part of the government's workplace pension's reforms. Accounting for defined contribution plans requires the Trust to report on the amounts contributed for that period. Consequently, no actuarial assumptions are required to measure the obligation for the expense and there is no possibility of any actuarial gain or loss. The Trust settles its obligations within the annual reporting period in which the employees render the related service.

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, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation.

Land and buildings are stated within the Statement of Financial Position at their revalued amounts as at 31 March 2018. IAS 16 requires that the accounts reflect changes in asset values. Revaluations of land and buildings are undertaken at a regularity which ensures that the carrying amounts are

not materially different from the fair value at the end of the reporting period. Desktop valuations are carried out on an annual basis and a full valuation undertaken at least every 5 years. The last full valuation was completed as at 31 March 2017.

Fair values are determined as follows:
1. Land and non-specialised buildings - market value for existing use
2. Specialised buildings - depreciated replacement cost using a Modern Equivalent Asset Valuation. Properties in the course of construction are carried at cost. Cost includes professional fees but not borrowing costs as allowed by IAS 23 for assets held at fair value.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- The sale must be highly probable i.e.:
  - Management are committed to a plan to sell the asset
  - An active programme has begun to find a buyer and complete the sale
  - The asset is being actively marketed at a reasonable price
  - The sale is expected to be completed within 12 months of the date of classification as 'held for sale' and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.4 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) and Local Improvement Finance Trust (LIFT) transactions

The Trust does not have any PFI or LIFT assets.

Note 1.7.6 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

Financial Assumptions	Min Life	Max Life
	(Years)	
Land	-	-
Buildings, excluding dwellings	1	72
Dwellings	-	-
Plant and machinery	5	15
Transport equipment	7	7
Information technology	3	5
Furniture and fittings	3	3

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- The Trust intends to complete the asset and sell or use it

- The Trust has the ability to sell or use the asset
- How the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- Adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- The Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min Life	Max Life
	(Years)	
Software licences	3	5
Other (purchased)	3	5

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

The Trust does not hold any inventories.

Note 1.10 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

The Trust does not hold any investment properties.

Note 1.11 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 entity]'s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as either: financial assets at fair value through income and expenditure, loans and receivables or available-for-sale financial assets.

Financial liabilities are classified as either fair value through income and expenditure or as other financial liabilities.

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date. The Trust does not hold any Available-for-sale Financial Assets.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices, independent appraisals or discounted cash flow analysis as appropriate.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.13 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 1.13.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives 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 1.13.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trusts' net investment outstanding in respect of the leases.

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 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 26.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 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 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, 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 1.16 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

1. Donated assets (including lottery funded assets),
2. 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
3. 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 of the audit of the annual accounts.

Note 1.17 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 1.18 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 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

The HM Treasury FReM does not require the following Standards and interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

IFRS 9 Financial Instruments - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

The DHSC GAM for 2018/19 was published on 27 April 2018. This contains the final guidance on the implementation of new accounting standards for NHS Group bodies in 2018/19 and the Greater Manchester Mental Health NHS Foundaton Trust will review and implement this guidance for that period.

Note 2 Operating Segments

All of GMMH's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein. Similarly, the large majority of the Foundation Trust's income originates with the UK Whole of Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of Healthcare is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes senior professional Non-Executive Directors. The Trust Board review the financial position of the Foundation Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Similarly only total balance sheet positions and cash flow forecasts are considered for the whole Foundation Trust. The Board as chief operating decision maker therefore only considers one segment of healthcare in its decision making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS8 which is to enable users of the financial statements to evaluate the nature and financial effects

of business activities and economic environments."

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
Mental health services		
Cost and volume contract income	4,557	3,455
Block contract income	187,805	123,705
Clinical partnerships providing mandatory services (including S75 agreements)	29,829	22,174
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	35,393	34,127
All services		
Other clinical income ***	416	1,234
Total income from activities	**258,000**	**184,695**

*** Other Clinical Income relates to funding received from Strategic Partnerships for clinical services.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:

	2017/18	2016/17
	£000	£000
NHS England	63,833	50,726
Clinical commissioning groups	135,161	87,400
Department of Health and Social Care	-	-
Other NHS providers	31,992	24,329
NHS other	37	747
Local authorities	25,211	21,361
Non NHS: other	1,766	132
Total income from activities	**258,000**	**184,695**
Of which:		
Related to continuing operations	258,000	184,695
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

The Trust's only overseas visitor activities are in respect of reciprocal EU treatments which do not generate income.

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	4,591	2,722
Education and training	13,627	8,540
Charitable and other contributions to expenditure	15	-
Non-patient care services to other bodies	-	717
Sustainability and transformation fund income	3,426	-
Rental revenue from operating leases	362	389
Other income ***	13,271	4,573
Total other operating income	**35,292**	**16,941**
Of which:		
Rental revenue from operating leases	35,292	16,941
Other income ***	-	-

*** Other Income comprises:

	2017/18	2016/17
	£000	£000
Car parking	247	206
Clinical excellence awards	323	15
Catering	193	169
Property Rentals	552	396
Apprentice levy reclaim	334	-
VAT reclaims	331	34
Transition and transformation income	5,888	-
Release of deferred income *	3,818	2,490
Other	1,585	1,263
	13,271	**4,573**

* Relates to the release of deferred income to match expenditure within operating expenses.
** Relates to income received from commissioners as part of the acquisition business case to fund the transition and transformation of Manchester services

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	258,000	184,695
Income from services not designated as commissioner requested services	35,292	16,941
Total	293,292	201,636

Note 5 Operating expenses

	Note	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies		10,864	1,017
Purchase of healthcare from non-NHS and non-DHSC bodies		15,122	6,671
Purchase of social care		589	572
Staff and executive directors costs		205,647	144,608
Remuneration of Non-Executive Directors	7	142	122
Supplies and services - clinical (excluding drugs costs)		3,378	3,671
Supplies and services - general		4,688	4,057
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		4,668	2,559
Consultancy costs		-	163
Establishment		3,270	3,064
Premises		8,519	9,104
Transport (including patient travel)		2,948	1,876
Depreciation on property, plant and equipment		6,269	4,538
Amortisation on intangible assets		520	174
Net impairments		(4,387)	(4,696)
Increase/(decrease) in provision for impairment of receivables		160	(133)
Increase/(decrease) in other provisions		-	40
Change in provisions discount rate(s)		114	-
Audit fees payable to the external auditor			
audit services- statutory audit		63	63
other auditor remuneration (external auditor only)		22	115
Internal audit costs		156	86
Clinical negligence		851	483
Legal fees		22	205
Insurance		49	23
Research and development		4,384	2,293
Education and training		3,312	2,204
Rentals under operating leases		5,765	2,258
Early retirements		-	-
Redundancy		728	2,737
Car parking and security		297	162
Hospitality		8	19
Losses, ex gratia and special payments		9	119
Other services, e.g. external payroll		229	184
Other		1,680	1,049
Total		**280,086**	**189,407**
Of which:			
Related to continuing operations		280,086	189,407
Related to discontinued operations		-	-

The main movements on expenditure in 2017/18 when compared to 2016/17 are as a result of the full year effect of the acquisition of MMHSCT on 1 January 2017.

Note 5.1 Other auditor remuneration	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	15	15
All taxation advisory services not falling within item 3 above	7	-
All other assurance services	-	100
Total	**22**	**115**

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: £2m).

Note 6 Impairment of assets	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	59
Changes in market price	(4,387)	(4,922)
Other	-	167
Total net impairments charged to operating surplus / deficit	**(4,387)**	**(4,696)**
Impairments charged to the revaluation reserve	(952)	(201)
Total net impairments	**(5,339)**	**(4,897)**

A desktop revaluation of land and buildings was undertaken as of 31 March 2018 by the District Valuer and resulted in a net impairment reversal of £5,339,000.

Note 7 Employee benefits	2017/18 Total £000	2016/17 Total £000
Salaries and wages	158,164	116,156
Social security costs	13,757	9,935
Apprenticeship levy	732	-
Employer's contributions to NHS pensions	18,811	13,644
Pension cost - other ***	412	95
Termination benefits	728	469
Temporary staff (including agency)	18,409	9,801
Total gross staff costs	**211,013**	**150,100**
Recoveries in respect of seconded staff	**(1,409)**	(1,150)
Total staff costs	**209,604**	**148,950**
Of which		
Costs capitalised as part of assets	217	216

*** Other pension costs relates to the Trust's membership of the Greater Manchester Pension Scheme

Note 7.1 Retirements due to ill-health

During 2017/18 there was 1 early retirement from the Trust agreed on the grounds of ill-health (5 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £83k (£289k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors, Remuneration

The aggregate amounts payable to directors were:

	2017/18	2016/17
	£	£
Salary	1,183,427	1,077,301
Taxable benefits	28,939	17,221
Pensions - final pay controls charge ***	90,660	-
Employer's pension contributions	112,123	138,978
Total	**1,415,149**	**1,233,500**

*** Additional charge made by NHS Pensions in relation to the retirement of the Chief Executive.

Further details of directors' remuneration can be found in the remuneration report.

There have been no payments to directors for long-term incentive schemes, other pension benefits, guarantees and advances.

Note 8 Pension costs

Note 8.1 NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial

assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 8.2 National Employment Savings Pension Scheme (NEST).

Under the Pensions Act 2008 employers must offer a pension scheme to all its employees. As from the 1 July 2013 when the scheme came into operation in the Trust (its staging date), staff who are not eligible to join the NHS Pension Scheme are automatically enrolled into NEST. The scheme is a defined contribution pension scheme. Under a defined contribution plan, an entity pays fixed contributions to a separate entity (a fund) and has no obligation to pay further contributions if the fund does not hold sufficient assets to pay employee benefits.

Contributions payable to a defined contribution plan are recognised as an expense as the employee provides services in exchange for the contribution. The Trust contributes 1% of their pensionable pay. The total contribution by the Trust for 2017/18 has been fully charged to expenses in the period. Details of the scheme can be found on the NEST Pensions website at;

http://www.nestpensions.org.uk/schemeweb/NestWeb/includes/public/docs/understanding-NEST.PDF.pdf

Note 9 Operating leases

Note 9.1 Greater Manchester Mental Health NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Greater Manchester Mental Health NHS Foundation Trust is the lessor.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	274	281
Contingent rent	-	-
Other	88	108
Total	**362**	**389**

	2017/18	2016/17
	£000	£000
Future minimum lease receipts due:		
- Not later than one year;	216	210
- Later than one year and not later than five years;	863	838
- Later than five years.	2,410	2,340
Total	**3,489**	**3,388**

The Trust is a lessor in a small number of operating leases for various premises, the longest of which expires in 2033.

Note 9.2 Greater Manchester Mental Health NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Greater Manchester Mental Health NHS Foundation Trust is the lessee.

Each lease has standard terms and conditions without the option to purchase upon the expiry of the lease.

Under existing arrangements there are no operating restrictions imposed by the leases. Proposals to change the use would require consultation with the relevant landlord.

In classifying its leases as operating leases, The Trust has assessed all leases against the IFRS criteria, and assessed that for all leases other than for Laureate House:

1. Ownership of the asset does not transfer to the lessee at the end of the lease
2. The Trust as lessee does not have the option to buy the asset at a price below the fair value of the asset
3. The lease is not for the major part of the economic life of the asset
4. At inception, the present value of the minimum lease payments is not at least substantially all of the fair value of the asset
5. The assets are not specialised in nature

The most significant of these in annual value are for the lease of Laureate House which ends in 2033.

In the case of the Laureate House lease, although the present value of the minimum lease payments at inception is substantially all of the fair value of Laureate House, the Trust has judged that this in itself is not sufficient to classify the lease as a finance lease and in substance, the lease is an operating lease as all the

other indicators set out above are met.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	5,765	2,258
Total	**5,765**	**2,258**

	31 March 18	31 March 17
	£000	£000
Future minimum lease receipts due:		
- Not later than one year;	5,550	4,298
- Later than one year and not later than five years;	16,036	18,939
- Later than five years.	43,587	43,965
Total	**65,173**	**67,202**

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	149	97
Total	**149**	**97**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money, the unwinding of discount and the finance costs associated with the GMPF.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	149	42
Total interest expense	**149**	**42**
Unwinding of discount on provisions	8	192
Other finance costs	38	38
Total interest expense	**195**	**272**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

The Trust did not incur any late payment of commercial debts interest.

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	4	5
Losses on disposal of assets	(1)	(9)
Total gains / (losses) on disposal of assets	3	(4)
Total other gains / (losses)	**3**	**(4)**

Note 13 Discontinued operations

The Trust has no discontinued operations.


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Note 14.1 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**1,258**	**10**	**76**	**1,344**
Transfers by absorption	-	-	-	-
Additions	1,654	-	10	**1,664**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	(10)	(10)	**-**
Transfers to/ from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Gross cost at 31 March 2018	**2,912**	**-**	**96**	**3,008**
Amortisation at 1 April 2017 - brought forward	**750**	-	**47**	**797**
Transfers by absorption	-	-	-	**-**
Provided during the year	493	-	27	**520**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2018	**1,243**	**-**	**47**	**1,317**
Net book value at 31 March 2018	**1,669**	**-**	**29**	**1,691**
Net book value at 1 April 2017	**508**	**10**	**54**	**547**

Note 14.2 Intangible assets - 2016/17

	Software licences	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**306**	**-**	**76**	**382**
Prior period adjustments	**-**	**-**	**-**	**-**
Valuation / gross cost at 1 April 2016 - restated	**306**	**-**	**76**	**382**
Transfers by absorption	627	-	-	**627**
Additions	353	10	-	**363**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	**-**
Disposals / derecognition	(28)	-	-	**(28)**
Valuation / gross cost at 31 March 2017	**1,258**	**10**	**76**	**1,344**
Amortisation at 1 April 2016 - as previously stated	**145**	**-**	**22**	**167**
Prior period adjustments	**-**	**-**	**-**	**-**
Amortisation at 1 April 2016 - restated	**145**	**-**	**22**	**167**
Transfers by absorption	**484**	-	-	**484**
Provided during the year	**149**	**-**	**25**	**174**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	**-**
Disposals / derecognition	(28)	-	-	**(28)**
Amortisation at 31 March 2017	**750**	**-**	**47**	**797**
Net book value at 31 March 2017	**508**	**10**	**29**	**547**
Net book value at 1 April 2016	**161**	**-**	**54**	**215**

Note 15.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction
	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**18,928**	**176,637**	**671**
Transfers by absorption	-	-	-
Additions	-	-	5,938
Impairments	-	(323)	-
Reversals of impairments	25	1,326	-
Revaluations	100	6,569	-
Reclassifications	-	2,320	(2,320)
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	(292)	-
Valuation / gross cost at 31 March 2018	19,053	(186,237)	4,289
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**28,697**	**-**
Transfers by absorption	-	-	-
Provided during the year	**-**	**4,639**	**-**
Impairments	-	12	-
Reversals of impairments	-	(4,323)	-
Revaluations	-	(6,825)	-
Reclassifications	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	(292)	-
Accumulated depreciation at 31 March 2018	**-**	**21,908**	**-**
Net book value at 31 March 2018	**19,053**	**164,329**	**4,289**
Net book value at 1 April 2016	**18,928**	**147,940**	**671**

Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
£000	£000	£000	£000	£000
940	**728**	**5,982**	**2,306**	**206,192**
-	-	-	-	-
75	24	1,099	97	**7,233**
-	-	-	-	**(323)**
-	-	-	-	**1,351**
-	-	-	-	**6,669**
-	1	(1)	-	**-**
-	38	-	-	**38**
(9)	(95)	(34)	-	**(430)**
1,006	696	7,046	2,403	**220,730**
632	**439**	**3,162**	**1,754**	**34,684**
-	-	-	-	-
87	**77**	**1,175**	**291**	**6,269**
-	-	-	-	**12**
-	-	-	-	**(4,323)**
-	-	-	-	**(6,825)**
(1)	1	-	-	**-**
-	38	-	-	**38**
(8)	(95)	(34)	-	**(429)**
710	**460**	**4,303**	**2,045**	**29,426**
296	**236**	**2,743**	**358**	**191,304**
308	**289**	**2,820**	**552**	**171,508**

Note 15.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**15,273**	**149,775**	**1,442**
Prior period adjustments	-	-	-
Valuation/gross cost at 1 April 2017 - restated	**15,273**	**149,775**	**1,442**
Transfers by absorption	**2,905**	**16,774**	**22**
Additions	-	150	8,779
Impairments	(215)	(1,379)	(59)
Reversals of impairments	354	636	-
Revaluations	611	1,168	-
Reclassifications	-	9,513	(9,513)
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Valuation / gross cost at 31 March 2017	**18,928**	**176,637**	**671**
Accumulated depreciation at 1 April 2016 - as previously stated	-	**31,566**	-
Prior period adjustments	-	-	-
Accumulated depreciation at 1 April 2016 - restated	-	**31,566**	-
Transfers by absorption	-	**1,490**	-
Provided during the year	-	**3,548**	-
Impairments	-	1,099	-
Reversals of impairments	-	(6,659)	-
Revaluations	-	(2,347)	-
Reclassifications	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Accumulated depreciation at 31 March 2017	**-**	**28,697**	**-**
Net book value at 31 March 2017	**18,928**	**147,940**	**671**
Net book value at 1 April 2016	**15,273**	**118,209**	**1,442**

Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
£000	£000	£000	£000	£000
544	**761**	**1,316**	**2,132**	**171,243**
-	-	-	-	-
544	**761**	**1,316**	**2,132**	**171,243**
294	-	**4,459**	-	**24,454**
117	66	708	174	**9,994**
-	-	-	-	**(1,653)**
-	-	-	-	**990**
-	-	-	-	**1,779**
-	-	-	-	**-**
-	(99)	-	-	**(99)**
(15)	-	(501)	-	(516)
940	728	5,982	2,306	**206,192**
412	**470**	**681**	**1,413**	**34,542**
-	-	-	-	-
412	**470**	**681**	**1,413**	**34,542**
172	-	**2,464**	-	**4,126**
63	**68**	**518**	**341**	**4,538**
-	-	-	-	**1,099**
-	-	-	-	**(6,659)**
-	-	-	-	**(2,347)**
-	-	-	-	**-**
-	(99)	-	-	**(99)**
(15)	-	(501)	-	**(516)**
632	**439**	**3,162**	**1,754**	**34,684**
308	**289**	**2,820**	**552**	**171,508**
132	**291**	**635**	**719**	**136,701**

Note 15.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction
	£000	£000	£000
Net book value at 31 March 2018			
Owned - purchased	19,053	164,329	4,289
NBV total at 31 March 2018	**19,053**	**164,329**	**4,289**

Note 15.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction
	£000	£000	£000
Net book value at 31 March 2017			
Owned - purchased	18,928	147,940	671
NBV total at 31 March 2017	**18,928**	**147,940**	**671**

Note 15.4 Gross carrying amount of any fully depreciated assets still in use

There are 257 (2016/17 145) equipment assets which are fully depreciated. The gross carrying cost of these totals £3,899,918 (2016/17 £1,701,896).

Note 16 Investment Property

The Trust does not hold any Investment Property.

Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
£000	£000	£000	£000	£000
296	236	2,743	358	191,304
296	**236**	**2,743**	**358**	**191,304**

Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
£000	£000	£000	£000	£000
308	289	2,820	552	171,508
308	**289**	**2,820**	**552**	**171,508**

Note 17.1 Trade receivables and other receivables

	31 March 18	31 March17
	£000	£000
Current		
Trade receivables	10,809	7,875
Accrued income	3,704	203
Provision for impaired receivables	(515)	(370)
Prepayments (non-PFI)	1,516	1,950
VAT receivable	735	873
Other receivables	16	992
Total current trade and other receivables	**16,265**	**11,523**
Non-Current		
Prepayments (non-PFI) ***	9,968	9,413
Total non-current trade and other receivables	**9,968**	**9,413**
Of which receivables from NHS and DHSC group bodies:		
Current	11,159	6,430
Non-current	9,968	9,413

*** The Non-current prepayment relates to the lease of Laureate House from Manchester University NHS Foundation Trust

The majority of trade is with Clinical Commissioning Groups and NHS England, as commissioners for NHS patient care services. As CCGs' and NHS England are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary

Note 17.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**370**	**245**
Prior period adjustments	-	-
At 1 April - restated	**370**	**245**
Transfers by absorption	-	387
Increase in provision	325	(49)
Amounts utilised	(15)	(129)
Unused amounts reversed	(165)	(84)
At 31 March	**515**	**370**

With the exclusion of NHS debtors, receivables 90 days past their due date are fully impaired. Additionally, where specific circumstances are known individual invoices are impaired in full. Other debts are partially provided for.

Note 17.3 Credit quality of financial assets

Ageing of impaired financial assets	31 March 2018	31 March 2017
	Trade and other receivables £000	
0 - 30 days	-	-
30 - 60 days	22	4
60 - 90 days	9	10
90 -180 days	158	44
Over 180 days	326	312
Total	**515**	**370**

Ageing of non-impaired financial assets past their due date	31 March 2018	31 March 2017
	Trade and other receivables £000	
0 - 30 days	-	-
30 - 60 days	266	865
60 - 90 days	74	809
90 - 180 days	73	476
Over 180 days	247	40
Total	**660**	**2,190**

Note 18 Other assets

The Trust does not hold any other assets in 2017/18 (2016/17 Nil).

Note 19 Liabilities in disposal groups

The Trust has no liabilities in disposal groups in 2017/18 (2016/17 Nil).

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.

	2017/18	2016/17
	£000	£000
At 1 April	**31,473**	**40,829**
Prior period adjustments	-	-
At 1 April (restated)	**31,473**	**40,829**
Transfers by absorption	-	2,247
Net change in year	7,275	(11,603)
At 31 March	**38,748**	**31,473**
Broken down into:		
Cash at commercial banks and in hand	595	2,108
Cash with the Government Banking Service	38,153	13,865
Deposits with the National Loan Fund	-	15,500
Total cash and cash equivalents as in SoFP	**38,748**	**31,473**
Total cash and cash equivalents as in SoCF	**38,748**	**31,473**

Note 20.2 Third party assets held by the Trust

Greater Manchester Mental Health NHS Foundation Trust held cash and cash equivalents on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 18	31 March17
	£000	£000
Bank balances	309	268
Monies on deposit	560	554
Total third party assets	**869**	**822**

Note 21.1 Trade and other payables

	31 March 18	31 March17
	£000	£000
Current		
Trade receivables	7,720	4,240
Capital payables	2,632	1,753
Accruals	12,589	13,600
Receipts in advance (including payments on account)	-	-
Social security costs	3,865	2,340
VAT payables	-	-
Other taxes payable	-	-
PDC dividend payable	145	432
Accrued interest on loans	11	7
Other payables ***	2,782	2,033
Total current trade and other payables	**29,744**	**24,405**
Total non-current trade and other payables	-	-
Of which receivables from NHS and DHSC group bodies:		
Current	3,092	1,708
Non-current	**-**	**-**

*** Other payables includes outstanding NHS Pensions contributions of £2,574k (2016/17 £1,603k).

Note 21.2 Early retirements in NHS payables above

The Trust has no payments due in respect of early retirements included within the payables figure above.

Note 22 Other financial liabilities

The Trust has no other financial liabilities.

Note 23 Other liabilities

	31 March 18	31 March17
	£000	£000
Current		
Deferred income	14,947	10,924
Total other current liabilities	**14,947**	**10,924**
Non-current		
Deferred income	3,530	2,436
Net pension scheme liability	1,132	1,375
Total other non-current liabilities	**4,662**	**3,811**

Note 24 Borrowings

	31 March 18	31 March17
	£000	£000
Current		
Bank overdrafts	-	-
Loans from the Department of Health and Social Care	5,762	324
Total current borrowings	**5,762**	**324**
Non-current		
Loans from the Department of Health and Social Care	2,449	8,211
Total non-current borrowings	**2,449**	**8,211**

Borrowings relate to a Capital Investment Loan (£2,773k) and a Revenue Support Loan (£5,438k) taken out by the former Manchester Mental Health and Social Care Trust (MMHSCT) and transferred to Greater Manchester Mental Health NHS Foundation Trust as part of the acquisition of MMHSCT on 1 January 2017.

Note 25 Finance leases

The Trust has no finance leases.

Note 26.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Legal claims £000	Re-structuring £000	Other £000	Total £000
At 1 April 2017	**3,540**	**180**	**2,462**	**600**	**6,782**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	114	-	-	-	**114**
Arising during the year	-	100	291	-	**391**
Utilised during the year	(164)	(55)	(2,310)	(92)	**(2,621)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	(69)	-	(230)	(396)	**(695)**
Unwinding of discount	8	-	-	-	**8**
At 31 March 2018	**3,429**	**225**	**213**	**112**	**3,979**
Expected timing of cash flows:					
- Not later than one year;	167	225	213	112	**717**
- Later than one year and not later than five years;	668	-	-	-	**668**
- Later than five years.	2,594	-	-	-	**2,594**
Total	**3,429**	**225**	**213**	**112**	**3,979**

Provisions relate to:

Pensions - Early departure costs — The pension rights of former employees who retired as a result of industrial injury

Legal claims — The amounts due from the Trust in respect of non-clinical claims lodged with the NHSLA's Liability for Third Party claims scheme (LTPS). The LTPS is a risk-pooling scheme under which the Trust pays an annual contribution to the NHSLA and in return, receives assistance with the costs of claims arising.

Re-structuring — The amount associated with planned organisational restructures.

Other — Includes amounts in respect of estates costs. No individual provision is greater than £1m.

Note 26.2 Clinical negligence liabilities

At 31 March 2018, £1,788k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Greater Manchester Mental Health NHS Foundation Trust (31 March 2017: £665k).

Note 27 Contingent assets and liabilities

	31 March 18	31 March17
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(222)	(151)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(222)**	**(151)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(222)**	**(151)**
Net value of contingent assets	-	-

Note 28 Contractual capital commitments

	31 March 18	31 March17
	£000	£000
Property, plant and equipment	2,116	4,150
Total	**2,116**	**4,150**

Note 29 Other financial commitments

The Trust does not have any other financial commitments.

Note 30 Defined benefit pension schemes - Greater Manchester Pension Fund

Note 30.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2017/18	2016/17
	£000	£000
Present value of the defined benefit obligation at 1 April	**(17,608)**	**-**
Transfers by absorption	-	(21,545)
Current service cost	(374)	(88)
Interest cost	(460)	(144)
Contribution by plan participants	(144)	(19)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses (SOCI)	386	4,120
Benefits paid	269	68
Past service costs	-	-
Business combinations	-	-
Curtailments and settlements	-	-
Present value of the defined benefit obligation at 31 March	**(17,860)**	**(17,608)**
Plan assets at fair value at 1 April	**16,233**	**-**
Prior period adjustment	-	-
Fair value of plan assets at 1 April -restated	**16,233**	**-**
Transfers by normal absorption	-	15,815
Interest income	422	106
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets (SOCI)	71	310
- Actuarial gain / (losses)	-	-
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	-	-
Contributions by the employer	198	51
Contributions by the plan participants	73	19
Benefits paid	(269)	(68)
Business combinations	-	-
Settlements	-	-
Plan assets at fair value at 31 March	**16,728**	**16,233**
Plan surplus/(deficit) at 31 March	**(1,132)**	**(1,375)**

Note 30.2 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 18	31 March17
	£000	£000
Present value of the defined benefit obligation	**(17,860)**	**(17,608)**
Plan assets at fair value at	**16,728**	**16,233**
Fair value of any reimbursement right	-	-
The effect of the asset ceiling	-	-
Net (liability) / asset recognised in the SoFP	**(1,132)**	**(1,375)**

Note 30.3 Amounts recognised in the SoCI

	31 March 18	31 March17
	£000	£000
Current service cost	(374)	(88)
Interest expense / income	(38)	(38)
Past service cost	-	-
Losses on curtailment and settlement	-	-
Total net (charge) / gain recognised in SOCI	**(412)**	**(126)**

Note 30.4 Changes in the defined benefit obligation and fair value of plan assets during the year

The fair value of the scheme's assets and liabilities recognised on the statement of financial position were as follows:

	Period ended 31 March 2018			
	Quoted prices in active markets	Quoted prices not in active markets	Total	Percentage of total assets
	£000s	£000s	£000s	
Equity Securities:				
Consumer	954		954	6%
Manufacturing	1,145		1,145	7%
Energy and Utilities	907		907	5%
Financial Institutions	1,378		1,378	8%
Health and Care	427		427	3%
Information Technology	268		268	2%
Other	164		164	1%
Debt Securities:				
Corporate Bonds (investment grade)	620		620	4%
Corporate Bonds (non-investment grade)				
UK Government	145		145	1%
Other	465		465	3%
Private Equity:				
All		560	560	3%
Real Estate:				
UK Property		573	573	3%
Overseas Property				
Investment Funds and Unit Trusts:				
Equities	4,527		4,527	27%
Bonds	2,169		2,169	13%
Hedge Funds				
Commodities				
Infrastructure		433	433	3%
Other	440	941	1,382	8%
Derivatives:				
Inflation				
Interest Rate				
Foreign Exchange				
Other				
Cash and Cash Equivalents:				
All	612		612	4%
Totals			**16,728**	**100%**
Present value of defined benefit obligation			**(17,860)**	
Net benefit deficit			**(1,132)**	

Period ended 31 March 2017			
Quoted prices in active markets	Quoted prices not in active markets	Total	Percentage of total assets
£000s	£000s	£000s	
1,320		1,320	8%
1,351		1,351	8%
1,081		1,081	7%
1,660		1,660	10%
582		582	4%
412		412	3%
276		276	2%
770		770	5%
214		214	1%
513		513	3%
	461		3%
	445		3%
4,064		4,064	25%
1,158		1,158	7%
	375	375	2%
291	809	1,100	7%
451		451	3%
14,143	**2,090**	**16,233**	100%
		(17,608)	
		(1,375))	

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the service provider relationship the Trust has with Clinical Commissioning Groups (CCG): and the way those CCG 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 undertaking its activities, creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has restricted powers to borrow or invest surplus funds, and 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.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority or transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from Government for capital expenditure subject to affordability as confirmed by NHS Improvement. The borrowings are for 1-25 years, in line with the associated assets and interest is charged at the national loans fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

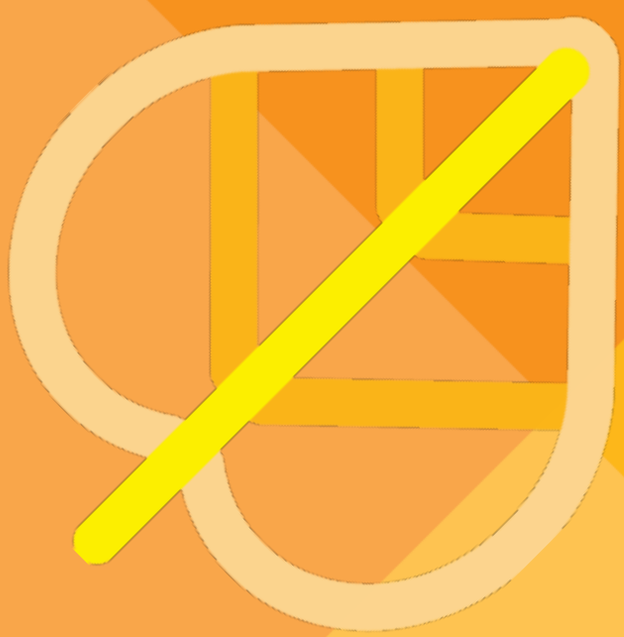
The Trust may also borrow from Government for revenue financing, subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The Maximum exposures as at 31 March 2018 are in receivables from customers as disclosed in the Trade and Other Receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not therefore exposed to significant liquidity risk.



Note 31.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	25,498	-	-	-	**25,498**
Cash and cash equivalents at bank and in hand	38,748	-	-	-	**38,748**
Total at 31 March 2018	**64,246**	-	-	-	**64,246**
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non-financial assets	20,063	-	-	-	**20,063**
Cash and cash equivalents at bank and in hand	31,473	-	-	-	**31,473**
Total at 31 March 2017	**51,536**	-	-	-	**51,536**

Note 31.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
Liabilities as per SoFP as at 31 March 2018	£000	£000	£000
Borrowings excluding finance lease and PFI liabilities	8,211	-	**8,211**
Trade and other payables excluding non-financial liabilities	25,723	-	**25,723**
Other financial liabilities	-	-	-
Provisions under contract	3,377	-	**3,377**
Total at 31 March 2018	**37,311**	**-**	**37,311**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	8,535	-	**8,535**
Trade and other payables excluding non-financial liabilities	22,065	-	**22,065**
Other financial liabilities	-	-	-
Provisions under contract	6,782	-	**6,782**
Total at 31 March 2017	**37,382**	**-**	**37,382**

Note 31.4 Fair values of financial assets and liabilities

The Trust deems that the book value (carrying value) of financial assets and liabilities is a reasonable approximation of fair value.

Note 31.5 Maturity of financial liabilities

	31 March 18	31 March 17
	£000	£000
In one year or less	26,214	34,035
In more than one year but not more than two years	491	185
In more than two years but not more than five years	1,473	631
In more than five years	9,133	2,531
Total	**37,311**	**37,382**

Note 32 Losses and special payments

	2017/18		2016/17	
	Total no. of cases	Total value of cases	Total no. of cases	Total value of cases
	Numbers	£000	Numbers	£000
Losses				
Cash losses	12	-	16	3
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	182	15	9	3
Stores losses and damage to property	2,029	101	1,681	109
Total losses	**2,223**	**116**	**1,706**	**115**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	41	8	27	4
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**41**	**8**	**27**	**4**
Total losses and special payments	**2,264**	**124**	**1,733**	**119**
Compensation payments received		-		-

Note 33 Gifts

There were no gifts.

Note 34 Related parties

In 2017/18 members of the Trust Board had relationships with organisations with which the Trust had transactions occurring in the normal course of business as detailed below:

Kathy Doran, GMMH Non-Executive Director, is Chair of The Reader Organisation. The Trust had transactions to the value of £69k (£97k 2016/17) with this organisation.

Julie Jarman, GMMH Non-Executive Director, is the Treasurer of MIND in Salford. Transactions between the Trust and MIND in Salford totalled £210k (£210k 2016/17).

Pauleen Lane GMMH Non Executive Director, is a visiting Lecturer at the University of Manchester and a member of Manchester University NHSFT. Transactions with these two organisations totalled £4,258k (£1,142k 2016/17) and £1,407k (£405k 2016/17) respectively.

Andrew Maloney, Director of HR and Corporate Affairs, is a member of the Executive Advisory Council of Manchester Metropolitan University with which the Trust had transactions to the value of £43k (£nil 2016/17)

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

	Receivables		Payables	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£1000	£000	£000
Value of balances with Related parties at 31 March 2018				
Department of Health and Social Care	223	62	47	432
Other NHS Bodies (DH Group)	20,904	15,781	2,889	1,387
Other (WGA + LA's)	2,599	1,938	7,624	5,026
Total	**23,726**	**17,781**	**10,560**	**6,845**

	Income		Expenditure	
	2017/18	2016/17	2017/18	2016/17
	£000	£1000	£000	£000
Value of balances with Related parties at 31 March 2018				
Department of Health and Social Care	2,673	1,394	3	5
Other NHS Bodies (DH Group)	257,409	172,900	19,888	9,859
Other (WGA + LA's)	27,003	22,814	35,020	25,005
Total	**287,085**	**197,108**	**54,911**	**34,869**

Note 35 Transfers by absorption

The Secretary of State approved the acquisition of Manchester Mental Health and Social Care Trust with an effective date of 1 January 2017. As of that date, all services and functions, assets and liabilities transferred to Greater Manchester Mental Health Foundation Trust and were accounted for as a 'Transfer by absorption' in line with the DH GAM in 2016/17.

Note 36 Events after the reporting date

There were no events after the reporting date having a material effect on the financial statements.

Annex 1 – Equality Impact Assessment

Consideration		Yes/No	Comments
1	Does the Annual Report and Accounts affect a group with a protected characteristic less or more favourably than another on the basis of: • Age • Disability • Gender Re-assignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race • Religion of Belief • Sex • Sexual Orientation	 No No No No No No No No No	
2	Has the Annual Report and Account taken into consideration any privacy and dignity or same sex accommodation requirements that may be relevant?	Yes	No requirements have been identified that are relevant to the Annual Report and Accounts
3	Is there any evidence that some groups are affected differently?	No	
4	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	Not Applicable	No valid, legal or justifiable discrimination has been identified in the production of the Annual Report and Accounts
5	Is the impact of the Annual Report and Accounts likely to be negative?	No	
6	If so, can the impact be avoided?	Not Applicable	No negative impact has been identified
7	What alternatives are there to achieving the Quality Account without impact?	Not Applicable	No negative impact has been identified
8	Can we reduce the impact by taking a different action?	Not Applicable	No negative impact has been identified

NHS

Greater Manchester Mental Health

NHS Foundation Trust

Quality Account 2017/2018

Greater Manchester Mental Health
NHS Foundation Trust

Improving Lives

Greater Manchester Mental Health NHS Foundation Trust

Quality Account 2017/2018

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

Quality Acount 2017/2018

Greater Manchester Mental Health NHS Foundation Trust

Our Commitment to Quality

1.1 Chief Executive's Welcome


Neil Thwaite
Chief Executive

On behalf of the Trust Board, I am proud to present our Quality Account for 2017/18. This report sets out the steps taken during the period to improve the quality of care we provide, particularly in relation to our identified quality priorities for 2017/18. This report also demonstrates our commitment to further quality improvement in the year ahead.

Through engagement with our key stakeholders, we have identified six key quality priorities for 2018/19. This includes two new priorities focussed on improving the quality and effectiveness of service user care plans and developing a personality disorder strategy and framework. Work has already started to strengthen our performance in these areas for the benefit of our service users and carers.

2017/18 has seen this organisation undergo significant change, following the acquisition of Manchester Mental Health and Social Care NHS Trust (MMHSCT). We have been focussed throughout on maintaining the quality, safety and effectiveness of our care. In February 2018, we received an overall 'Good' rating from the Care Quality Commission (CQC) following a core service with well-led inspection that took place between 18 September and 7 December 2017.

Achievement of a 'Good' rating at this stage in the transition period was a welcome reward for our efforts. It also provided further motivation for us to deliver on our future transformation plans. We were especially pleased to hear from the CQC that our service users felt well-supported and cared for.

As part of their inspection, the CQC focussed on assessing our leadership, management and governance arrangements to determine if the Trust is well-led. We received an 'Outstanding' rating in this area, demonstrating we are an organisation which provides high quality care based on individual needs, that encourages learning and innovation, and that promotes an open and fair culture. Our effective leadership approach has proved vital this year in helping individual members of staff, teams and services integrate as one organisation.

We were also proud to receive an 'Outstanding' rating for our substance misuse services, in their first CQC inspection. For services that operate in a fast-paced environment, characterised by repeated procurement exercises and organisational change, this is a real achievement.

As an outcome of their inspection, the CQC also identified opportunities for further quality improvement. We have robust plans in place to act on this feedback, which are reflected in a number of the quality priorities we have identified for 2018/19 in Part 4 of this report.

We have also continued to work hard to enable the meaningful involvement of our service users and their carers, friends and family in our service development activities. This approach has proved successful in Manchester, in particular, through our Manchester clinical transformation groups. We also co-produced our new Trust values and identity with our service users and carers from across GMMH.

With regard to the 2017 Community Mental Health Survey, I am pleased to note that Greater Manchester Mental Health NHS Foundation Trust

(GMMH) is in the top performing NHS trusts in the country for service users reporting that they had been involved in reviewing their care. Service users also provided positive feedback in terms of being told, who was in charge of organising care and services, agreeing the details of care to be received with mental health staff, getting the help that was needed if contacting services in a crisis and getting help with finding support for physical health needs. I would like to take this opportunity to thank all the staff at GMMH for the outstanding commitment and enthusiasm they have shown.

I would also like to highlight the support offered by our staff, in many cases on a voluntary basis, in the immediate aftermath of the tragic events at Manchester Arena on 22 May 2017. I am so proud of all those individuals, who headed to emergency departments across the city to offer mental health and spiritual first aid to those affected by the incident.

Many of those involved have continued to offer support through our role in the Manchester Resilience Hub, which was set up in partnership with Pennine Care NHS Foundation Trust to coordinate the continuing provision of care. At our Annual Members Meeting on 10 October 2017, we welcomed the opportunity to recognise the efforts of all 47 members of our staff, who played such a vital part in the Trust's response to the arena attack, through our Staff Awards.

During the last 12 months, we have seen the launch of 'Be Well', our new social prescribing service in North Manchester, the launch of 'Achieve', our new integrated drug and alcohol services in Bolton, Salford and Trafford, and the introduction of Child and Adolescent Mental Health Services (CAMHS) in Bolton, provided in conjunction with North West Boroughs Healthcare NHS Foundation Trust.

Over the coming months we will be opening our new Section 136 suite in North Manchester, and a new rehabilitation and recovery service for women at Honeysuckle lodge in Bolton, in partnership with Alternative Futures Group.

Looking ahead, 2018/19 promises to be just as challenging from both a financial perspective and in terms of increasing demand for our services and national shortfalls in workforce supply. As a Trust we will continue to take every opportunity we can to deliver continuous quality improvement in this environment.

A key area of focus, in addition to the priorities set out in this report, will be improving the quality of care provided by our community mental health teams in Manchester. Our aim is to implement an evidence-based model, providing flexible treatment to people in their own homes, or usual place of residence, seven days a week and 24 hours a day.

In addition, we have exciting plans to support the priorities in the Five Year Forward View for Mental Health and Greater Manchester Mental Health and Wellbeing Strategy. This will see investment in our IAPT, Early Intervention, RAID and Liaison services, Section 136 facilities and perinatal services.

As Chief Executive of Greater Manchester Mental Health NHS Foundation Trust (GMMH), I can confirm that, to the best of my knowledge, the information contained in this report is accurate. The 'Statement of Directors' Responsibilities at Annex 3 summarises the steps we have taken to develop this Quality Account and external assurance is provided in the form of statements from our commissioners, local HealthWatch organisations and Scrutiny Committees in Annexe 1. The report of an external audit undertaken by KPMG, which gives assurance on the content of this Quality Account, is also included for your information as Annex 2.

Neil Thwaite, Chief Executive
21 May 2018

1.2 Quality Assurance

As an organisation that seeks to continually improve, we take steps to quality assure our current activities to provide the best possible care to our service users. Our Trust Board holds ultimate accountability for the quality of the services that we provide. In order to ensure that there is robust quality assurance, the Board has established a subcommittee with delegated authority to set the strategy for quality and to ensure delivery against it.

The Quality Governance Committee (QGC) is chaired by a non-executive director and has representation from the Trust Board, lead clinicians from all clinical services and corporate leads with responsibility for risk management and quality improvement. The structure and business of the QGC has been informed by an assessment against the national Quality Governance Framework. QGC provides leadership and oversight for the Trust's quality and integrated governance framework. It maintains a strategic overview of the Trust's approach to quality improvement, and ensures that it encompasses a robust range of improvement methodologies that reflect our local and regulatory requirements. QGC develops the Trust's quality strategy on behalf of the Trust Board and identifies the Trust's key quality priorities, goals and standards. This is set out in our Quality Governance Framework.

Trust Board and QGC members are visible within clinical services. This provides members with opportunities to triangulate evidence, speak to service users and staff about their experience and ensure that there is an open and transparent culture within the Trust. We have also introduced our 'Quality Matters' approach, a quality improvement tool that provides a strategic framework offering ward to Board level assurance that our services are safe, positive and effective.

GMMH's Executive Management Team and Board review intelligence gathered from a wide range of sources. These include:

- Service specific performance monitoring frameworks
- Quality Account improvement priority reports
- Commissioning for Quality and Innovation (CQUIN) activity
- Contractual Performance Key Performance Indicators
- Care Quality Commission reports
- Intelligent monitoring
- Staff and patient surveys
- Quality Matters Walkaround reports
- Clinical governance reports (including incidents, compliments and complaints)
- Corporate governance reports (Compliance with the NHS Improvement Single Oversight Framework and Monitor 'Code of Governance')
- Board performance reports and presentations at Board meetings

We continue to work hard to ensure that our performance metrics are predominately RAG rated 'green'. However, when there are areas rated 'red' we respond. This has been the case during 2017/18 for our IAPT and staff sickness performance.

Plans to improve IAPT services in Manchester were developed prior to the acquisition. These started to be implemented during 2017/18 and improvement can already be seen. Business cases have also been developed with support of commissioners in Salford and Manchester to address current capacity and the future Five Year Forward View targets. It should be noted that IAPT services have also been affected by difficulties in recruitment given national workforce pressures. Another area that remains a concern is staff sickness, which was 5.9%, (as at December 2017). To address this issue, we continue to take steps in relation to improving sickness absence management and staff health and wellbeing, and this is summarised below.

Improving Staff Health and Wellbeing/ Sickness Absence Management

During 2017/18, we have taken a number of positive actions to support the health and wellbeing of our workforce, as we recognise the importance of having an engaged, motivated and healthy workforce in the delivery of high quality care. We have focussed on both physical and mental wellbeing and introduced a range of support, including:

- Health checks for staff
- Mindfulness training
- Promotion of wellbeing materials including sleep therapy, weight management, safe drinking, healthy eating
- Walking, running and cycling groups
- Yoga classes
- Reading challenge
- Introduced stress management and resilience training sessions available for staff as part of the development programmes
- Identified and supported Trust representatives to link into a national network of Health and Wellbeing champions to share good practice and initiatives
- Opened our small bids fund to process local bids to support staff health and wellbeing activities
- Introduced a section on 'your wellbeing' within our appraisal process
- Continued to ensure that our staff can access the Trust Employee Assistance/psychological therapy support available via PAM (People Asset Management) Assist
- Continued to ensure that our staff can access Physiotherapy support through Occupational Health (PHIL)
- Continued to run our seasonal Flu campaign
- Extended the current licence for delivering Schwarz rounds, which supports training, attendance at national conferences and on line resources for all staff
- Developed and introduced the Post Incident Debriefing Support (PIDS) Team, which provides structured support to GMMH staff following significant and distressing incidents at work

Throughout 2017/18, we have continued to implement robust sickness absence management processes and support line managers to manage absence effectively. To support this we have increased the occupational health support for staff and managers by commissioning an enhanced service that provides:

- Improved access to a range of psychological therapies
- Fast track access to physiotherapy
- Improved management information to aid case management
- Online employee assistance programme
- Access to a wide range of health information

We recognise that vacancies and other factors can cause pressure on staff teams and continue to focus our recruitment strategies to improve the time it takes to fill posts, and also continually promote opportunities within the Trust across a wide geographical footprint. We have attended local, regional and national job fairs during 2017/18, and have linked into a number of universities to facilitate rolling recruitment for key nursing roles.

1.3 A Year of Accolades

The last 12 months has seen a significant amount of change as we entered the first year of being Greater Manchester Mental Health NHS Foundation Trust (GMMH). This is a major accolade in itself as the acquisition of Manchester Mental Health and Social Care NHS Trust was one of the largest and fastest in NHS history. Nevertheless, teams and individuals have continued to exceed expectation and continue to make remarkable achievements during 2017/18. We are fortunate to have some amazing staff working at GMMH, and we are very proud when their hard work and achievements are recognised. Here is roundup of our award-winning staff:

- Dr. David Shiers, Honorary Research Consultant received an OBE for services to vulnerable people. Dr. Shiers received his medal from HRH Prince Charles at Buckingham Palace on 10 February. His achievements include forming the Initiative to Reduce the Impact of Schizophrenia group; contributed to the Early Psychosis Declaration involving the World Health Organisation (WHO) and the International Early Psychosis Association, and more recently participated in developing National Institute for Health and Clinical Excellence (NICE) guidelines for the care of young people experiencing psychosis.

- Support, Time and Recovery worker, Donna Bostock from the Salford Community Engagement and Recovery Team was chosen as the regional winner for Clinical Support Worker of the Year at the Skills for Health's Our Health Heroes Awards 2017. The Our Health Heroes Awards, sponsored by Health Education England, were established in 2016 and aim to celebrate the unsung healthcare heroes from across the UK, including those working in the NHS, that go above and beyond in their roles every day. Donna was nominated for her commitment and the difference she has helped make to her service users' lives. Some have described her as the best mental health worker they have ever had, saying she has given them the confidence to start volunteering and help others.

- Community nurse Ann Collins joined a unique group of professionals to be named a Queen's Nurse. Ann, GMMH Senior Manager of Older Adults Community Mental Health Services in Bolton, became one of a handful of mental health nurses to be recognised by charity The Queen's Nursing Institute (QNI) for her commitment to high standards of patient care, learning and leadership. Nurses who hold the title benefit from developmental workshops, bursaries, networking opportunities, and a shared professional identity. Ann received the award at a ceremony at the Royal Garden Hotel in London from Professor Jean White CBE, QNI Fellow and Chief Nursing Officer in Wales.

- Manchester nurse, Joanne Noble RGN was awarded an MBE by HRH Queen Elizabeth II in Buckingham

Palace for her at HMP Manchester for 24 years and her dedication to tackling the spread of Hepatitis in prisons. Joanne has been on the vanguard of prison health care leading a Kings Fund project, Enhancing the Healing Environment, alongside her work to tackle blood borne diseases. Her work has been a vital part of preventing the spread of Hepatitis and other blood borne diseases from prison into the community. The impact of the work has been such that Joanne and her colleagues from North Manchester General were invited to speak to the All Parliamentary Group on Hepatitis in Prisons at the House of Commons.

Our teams have also won many accolades over the last 12 months. These include:

- The Trust's Moorside Unit in Trafford was praised by a national campaign group for its work to improve inpatient care. Star Wards, which works with mental health wards to discover, celebrate, share, publicise and inspire excellence in inpatient care, described Moorside's Recovery-Based Activity Team, based at Trafford General Hospital, as 'wonderful'.

- Bolton's Home Based Treatment Team was accredited by the Royal College of Psychiatrists' (RC Psych). They successfully met the RC Psych standards related to service provision and structure, staff, appraisal, supervision and training, assessment, care planning and transfer or discharge and interventions. Accreditation to the RC Psych Home Treatment Accreditation Scheme (HTAS) assures staff, service users and carers, commissioners and regulators of the quality of the service being provided.

- The Royal College of Psychiatry has also accredited three wards for older adults as part of the Quality Network for Older Adults. Hazelwood and Delamere Wards at The Woodlands in Salford and Bollin Ward at Trafford General Hospital have all received accredited status from the College. Achieving accreditation as part of the Quality Network for Older Adults means each ward demonstrated it meets high standards across five areas:

  - General standards, including policies, protocols and staffing related issues
  - Timely and purposeful admission
  - Environment and facilities
  - Therapies and activities
  - Safety

The award recognises good practice, it also helps members improve their services and share good practice with other services. Accreditation by the Royal College of Psychiatry assures service users, carers and the public about the quality of care offered to older adults by GMMH in these locations.

- We are one of only four Trusts in the North West registered with the Education and Skills Funding Agency to deliver apprenticeship training to staff. GMMH is accredited with Pearson, an official awarding body for nationally recognised qualifications, as the Trust provides vocational training for staff, including core skills in Math's, English and Information and Communications Technology (ICT).

- The Trust's Unity Drug and Alcohol services in Cumbria was named Public Sector Champion of the Year at the Diverse Cumbria Awards 2017. The award recognised the work Unity has carried out across Cumbria, breaking down barriers and stigma in supporting people recovering from drug and alcohol issues. They have also supported organisations with the Community Development Fund that actively challenges how people with mental health issues are seen within Cumbria. The Unity team have been supporters of Cumbria and Winter Pride and have taken many opportunities to ensure that issues within the LGBT community are challenged and supported.

- The Trust welcomed new police recruits and the Chief Constable to its Moorside Unit at Trafford General Hospital as part of an induction week, designed to introduce the recruits to the communities they will be serving. Chief Constable Ian Hopkins for Greater Manchester Police

said: "By familiarising themselves with the issues and diversity alongside their more experienced Greater Manchester Police colleagues, the recruits will be better equipped once they are officially posted into their boroughs".

- GMMH helped the renowned Hallé Orchestra become a Dementia Friendly Organisation. The Hallé took part in a Dementia Awareness Training in which both musicians and organisational staff in the orchestra participated. The Hallé's Education Director, Steve Pickett said: "I am delighted that our whole organisation can become Dementia Friendly. This is so important for us all at the Hallé and we very much look forward to developing closer ties with GMMH so that in the future we can bring our music and experience in this sector to the region".

- Dementia care in Bolton was been given an outstanding rating by NHS England. NHS Bolton Clinical Commissioning Group (CCG) has received an overall 'good' rating in the national annual assessment of CCGs. Bolton was judged to have performed particularly well in a number of national priority areas, achieving 'outstanding' for dementia care and 'good' for mental health. The outstanding rating for dementia care follows partnership work with GP practices, with the support of Bolton's Memory Assessment Service provided by GMMH to enable more people with dementia to receive a formal diagnosis and access care and support.

- The Trust committed to TUC's Dying to Work Charter aimed at helping employees who become terminally ill at work, following in the footsteps of employers such as Rolls Royce, Royal Mail and the Co-op. The Charter is part of the TUC's wider 'Dying to Work' campaign which is seeking greater security for terminally ill workers where they cannot be dismissed as a result of their condition.

- PQ Magazine awarded the Trust's Finance Team Accountancy Team of the Year Award. The awards recognise the achievements accountancy students, apprentices, colleges and training providers, as well as accountancy teams nationally. The team were nominated for their work during the acquisition of Manchester Mental Health and Social Care Trust, going above and beyond their 'normal business as usual' processes, to ensure the safe and smooth transition of the Manchester Mental Health and Social Care Trust finance staff, and to integrate them within the wider team.

In its latest inspection, the Care Quality Commission gave the first rating for GMMH as 'GOOD'. The report stated staff supported our service users with "commitment, energy and patience." Also, service users and carers reported to the inspectors that staff were "supportive and kind". Substance misuse services were rated as 'OUTSTANDING', which is a great accomplishment. The Trust's work creating resilient communities was commended – in particular, the community asset funds which are used to support recovery groups and projects. For the area of Well-Led, the Trust was also given a rating of 'OUTSTANDING', which is another success to be, proud of. Throughout periods of change, strong leadership is vital and the Trust values which were worked on collaboratively with service users and carers, and the leadership approach taken has contributed to this.


We are open and honest

Statements of Assurance from the Board for 2017/18

This section of our Quality Account includes mandated information that is common across all organisations' Quality Accounts. This information demonstrates that we are performing to essential standards; measuring clinical processes and performance and are involved in national projects and initiatives aimed at improving quality.

2.1 Review of Services

During 2017/2018 Greater Manchester Mental Health NHS Foundation Trust provided and/or sub-contracted a wide range of relevant health services.

Services provided include:

- Community and inpatient mental health services
- Adult forensic mental health services
- Adolescent forensic mental health services
- Adolescent psychiatry services
- Mental health and deafness services
- Community and inpatient alcohol and drug services
- Prison healthcare and in-reach services
- Working Well Talking Therapies/IAPT– primary care psychology
- Rehabilitation services
- Perinatal services

More detail on the services provided by us can be found on our website – www.gmmh.nhs.uk

GMMH has reviewed all the data available on the quality of care in all of these services.

During 2017/2018 Greater Manchester Mental Health NHS Foundation Trust provided and/or sub-contracted a wide range of relevant health services.

The data reviewed has covered the three domains of quality (clinical effectiveness, safety and patient experience), ensuring that this Quality Account presents a rounded view of the quality of services provided. We hope that this will enable readers to gain a clear and balanced understanding of what quality means to us. Data has been captured by our robust business intelligence and clinical information systems. These systems include our current integrated clinical information systems (PARIS and AMIGOS), our integrated risk management software (DATIX), and our finance, and contract monitoring systems.

We are taking the opportunity to standardise as many business processes as possible across the Trust and reduce the duplicate collection of data. This will include the implementation of PARIS as the clinical information system across the Trust. There are many benefits to be achieved through this change as PARIS offers flexibility around data collection, integration with other Trust systems and enhanced reporting, all of which will improve the support for clinical activities. A comprehensive training package supported by eLearning, is available through our Learning Hub. This ensures that all staff receive the appropriate training needed for the effective use of clinical information systems and the timely recording of information. PARIS supports more flexible access to patient information for clinical users, which is underpinned by improved audit controls.

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

2.2 Participation in Clinical Audits and National Confidential Enquiries

During 2017/18, There were 5 national clinical audits and 2 national confidential enquiries covering relevant health services that GMMH provides.

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

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

- Prescribing Observatory for Mental Health; Prescribing High Dose and Combined Antipsychotics on Adult Psychiatric Wards
- Prescribing Observatory for Mental Health: Use of Depot/Long Acting Medication for Relapse Prevention
- Prescribing Observatory for Mental Health: Prescribing Valproate for Bi-polar Disorder
- National Clinical Audit of Psychosis
- National Audit of Early Intervention in Psychosis
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
- National Confidential Enquiry into Patient Outcome and Death Young People's Mental Health (Y PMI-I) Study

National Clinical Audit

Audit Title	Participation	% of cases submitted
Prescribing Observatory for Mental Health: Prescribing High Dose and Combined Antipsychotics on Adult Psychiatric Wards	Yes	100%
Prescribing Observatory for Mental Health: Use of Depot/Long Acting Medication for Relapse Prevention	Yes	100%
Prescribing Observatory for Mental Health: Prescribing Valproate for Bi-polar Disorder	Yes	100%
National Clinical Audit of Psychosis	Yes	95%
National Audit of Early Intervention in Psychosis	Yes	60%*

*The Royal College of Psychiatrists requested that all service users on the caseload were to be audited; it was identified that this could potentially have an enormous effect on the time and resources of clinical staff and was likely to impact on the time available for clinical care.

Following discussions with our commissioners, an agreement was made to audit a minimum of 20% of the caseload. By the end of the data collection period, 60% of service user records from the early intervention service caseload were submitted.

Information about the Audits

Prescribing Observatory for Mental Health: Prescribing High Dose and Combined Antipsychotics on Ault Psychiatric Wards. **Report date February 2018**

The practice standards for the audit are derived from NICE Guidelines (CG185) Bipolar Disorder: Assessment and management, September 2014. The aim of the audit is to examine prescribing practice to establish if patients prescribed valproate are given written information about its use and that body weight and/or BMI, blood pressure, plasma, glucose and plasma lipids are measured prior to initiating treatment and at least annually during continuing valproate treatment.

The criteria for the audit also covers prescribing valproate for women of child-bearing age to ascertain that if valproate is prescribed for a woman of child-bearing age, there should be documented evidence that the woman is aware of the need to use adequate contraception and has been informed about the risks that valproate would pose to an unborn baby.

Prescribing Observatory for Mental Health: Use of Depot/Long Acting Medication for Relapse Prevention.
Report date December 2017

The practice standards for the audit are derived from NICE Guidelines (CG185) Bipolar Disorder: Assessment and management, September 2014. The aim of the audit is to examine prescribing practice to establish if patients prescribed valproate are given written information about its use and that body weight and/or BMI, blood pressure, plasma, glucose and plasma lipids are measured prior to initiating treatment and at least annually during continuing valproate treatment.

The criteria for the audit also covers prescribing valproate for women of child-bearing age to ascertain that if valproate is prescribed for a woman of child-bearing age, there should be documented evidence that the woman is aware of the need to use adequate contraception and has been informed about the risks that valproate would pose to an unborn baby.

Prescribing Observatory for Mental Health: Prescribing Valproate for Bi-polar Disorder
Report date February 2018

The practice standards for the audit are derived from NICE Guidelines (CG185) Bipolar Disorder: Assessment and management, September 2014. The aim of the audit is to examine prescribing practice to establish if patients prescribed valproate are given written information about its use and that body weight and/or BMI, blood pressure, plasma, glucose and plasma lipids are measured prior to initiating treatment and at least annually during continuing valproate treatment.

The criteria for the audit also covers prescribing valproate for women of child-bearing age to ascertain that if valproate is prescribed for a woman of child-bearing age, there should be documented evidence that the woman is aware of the need to use adequate contraception and has been informed about the risks that valproate would pose to an unborn baby.

National Audit of Psychosis. **Report due in June 2018**

This audit seeks to demonstrate that full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with schizophrenia in an inpatient and community setting. The standards for the audit are derived from NICE Clinical Guidelines for Schizophrenia (CG82) and the Lester tool.

The aim is to achieve compliance and provide evidence to NHS England that patients have been screened for all seven cardio metabolic parameters (as per the 'Lester tool') which are:

- Smoking status
- Alcohol
- Drugs
- Body Mass Index
- Blood pressure
- Glucose regulation (HbA1C or fasting glucose or random glucose as appropriate)
- Blood lipids

Where clinically indicated they were directly provided with, or referred onwards to other services for interventions for each identified problem.

National Audit of Early Intervention in Psychosis
Report due in July 2018

Early intervention in psychosis (EIP) services are specialist community services providing care and treatment to people who are experiencing their first episode of psychosis, and for those who are at high risk of developing psychosis.

The EIP audit will help to establish the extent to which these services comply with a framework of NICE standards of care, NICE quality standard for psychosis and schizophrenia in adults (QS80), which put particular emphasis on early access, physical health, family intervention and supported employment programmes.

The results of the audit will provide a national overview of the EIP services' quality of care in England relative to those standards. In addition, the audit will enable participating services to identify their strengths as well as the areas of improvement.

National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

National confidential inquiry	Questionnaires received from NCI 2017/2018	Questionnaires completed and returned back to NCI	%
Suicide	25	15	60

The National Confidential Inquiry examines suicides and homicides by people who have been in contact with secondary and specialist mental health services in the preceding 12 months. Previous findings of the Inquiry have informed recommendations and guidelines produced by the National Institute for Clinical Excellence (NICE), the National reporting and learning system (NRLS) and the Inquiry itself aimed at improving outcomes and reducing suicides rates for individuals with mental illness.

National Confidential Enquiry into Patient Outcome and Death Young People's Mental Health (Y PMI-I) Study

National confidential inquiry	Questionnaires received from NCI 2017/2018	Questionnaires completed and returned back to NCEPOD	%
Total	10	6	60

Based on case note reviews, routinely collected national data and surveys, the study focuses on the quality of care provided to young people aged 11 to 25 years old with depression, anxiety,

eating disorder and/or who self-harm and to examine the interface between different care settings and the transition of care.

The reports of 3 national clinical audits were reviewed by GMMH in 2017/18 and GMMH intends to take the following actions to improve the quality of healthcare provided as per the table below:

Audit Title	Key Actions
Prescribing Observatory for Mental Health: Prescribing High Dose and Combined Antipsychotics on Adult Psychiatric Wards	• Standardise documentation for high dose antipsychotics across the Trust • Harmonise policies including physical health • Each service to review own results and produce locally agreed action plan • Review reasons for high dose/combination prescribing and include justifiable reasons in Trust policy for reference
Prescribing Observatory for Mental Health: Use of Depot/Long Acting Medication for Relapse Prevention	• The report was received in January 2017 and was discussed in the Trust Medicines Management Meeting. Improvement actions were agreed, and these will be monitored at future meetings
Prescribing Observatory for Mental Health: Prescribing Valproate for Bi-polar Disorder	• An action plan was developed to ensure all ensure all girls and women of or nearing childbearing age taking valproate are systematically identified so that all relevant resources can be used to plan their care. • We will ensure relevant resources are embedded in clinical practice for current and future patients by revisiting local training, procedures and protocols.

We also undertook and reviewed the reports of 99 local trust clinical audits in 2017/18. A full list of these local audits is included in Annex 5. Recommendations and action plans for each local audit has been agreed and shared with relevant people/services in line with our Clinical Audit Policy. If you are interested in learning more about the actions we are taking to improve the quality of healthcare provided based on the outcomes of these audits, please contact:

Patrick Cahoon, Head of Quality Improvement
Tel: 0161 357 1793
E-mail: Patrick.cahoon@gmmh.nhs.uk

All national and local clinical audit reports, and resulting action plans, are reviewed by our NICE Implementation and Audit Group (NIAG), which meets on a bi-monthly basis and is chaired by the Trust's Medical Director, NIAG aims to ensure that actions agreed following audit reports are supported and completed. The outcomes of discussion at NIAG are reported up to, and considered at, the Trust's Quality Governance Committee.

2.3 Participation in Clinical Research

The Research & Innovation Service has undergone a significant period of change in the last 12 months following the acquisition of MMHSCT Our research portfolio has been significantly strengthened enabling us to offer increased access for service users, patients and carers to high quality research including a growing National Institute for Health Research (NIHR) and commercial research portfolio.

Our new R&I Strategy has been developed taking into account the new Shared Values for the Trust, the Five Year Forward View for Mental Health (February 2016) and the former Trusts' research strategies ensuring we are taking the best from both organisations. The 6 key aims are:

- Ensure our research and innovation activity is relevant to Trust, NHS and service user and carer priorities
- Maximise the opportunities for the community served by GMMH to participate in research and to benefit from developments in both research and innovation
- Ensure that clinical services are informed and improved by research involvement, dissemination and translation and innovation adoption
- Ensure the Trust maximises financial opportunities and income from research and innovation while ensuring value for money
- Ensure the Trust becomes a world-leading organisation for mental health research and innovation
- Ensure our research includes an emphasis on prevention in addition to treatment of established mental health problems

Our total NIHR grant income for 2017/18 for all active grants is £2,354,674. This income generates additional Research Capability Funding (RCF) from the NIHR, which enables us to support research growth. As a result of grant successes, in 2017/18 the Trust received £854,803 in Research Capability Funding. In line with our strategy, this funding has supported a number of internal research initiatives including the development of five Research Units in the following areas:

Research Unit	Lead	Vision
CAMHS Digital	Kathryn Abel	The GMMH CAMHS Digital Unit is affiliated to the University of Manchester Centre for Women's Mental Health and builds on their work by adding missing digital platforms and e-mental health elements to the existing portfolio. This delivers projects focussed on improving health and social outcomes of vulnerable families and children.
Trauma and Resilience	Filippo Varese	This Unit will support research into complex trauma and trauma-focussed approaches/therapies. Primary aims include: developing systems of routine enquiry for the assessment of complex trauma in the NHS; building an evidence base for interventions for management and treatment of complex trauma-related difficulties; developing and evaluating interventions to promote long-lasting resilience in vulnerable service users and, in the longer term, facilitating the translation of our trauma and resilience research into improved care planning and care provision in the NHS.
Dementia and Healthy Brains	Iracema Leroi	The vision for this Unit is to develop into a leading national and international centre of excellence for dementia clinical research, fully embedded within clinical services. The Unit will be a test bed for new digital applications for brain health in elderly people,

		will be a leading clinical trials' site (industry and non-industry) and will generate funding from commercial and non-commercial partners.
Patient Safety	Gillian Haddock/ Dan Pratt	This Unit will be focussed upon further work into improving understanding of suicide and substance misuse; the development and evaluation of psychological interventions (PSIs) for suicide; piloting and evaluating the feasibility of intervention(s) designed to reduce the burden of PSIs in mental health hospitals and prisons; and the large scale implementation and evaluation of these PSI interventions in mental health hospital and prison settings including accompanying process and economic evaluations.
Youth Mental Health	Alison Yung	The development of a specialised Youth Mental Health Research Unit will address a key aim of the GMMH R&D strategy. Our planned research will broaden the portfolio of research by increasing funding applications in youth mental health.

The Research Units will be required to demonstrate clear service user involvement, alignment with clinical services and applications for NIHR or commercial funding. These newly established Research Units will build on the ongoing success of the already well established Psychosis Research Unit which employs 20-30 staff at any one time working on a number of single and multi-centre interventional clinical trials. The aim of the Psychosis Research Unit is to produce world-class research in line with the key research themes of prevention and early intervention, reducing stigma, creating and promoting treatment choice and promoting recovery.

Research Delivery

The number of patients receiving relevant health services provided or sub-contracted by GMMH in 2017/2018 that were recruited during that period to participate in research approved by the Health Research Authority was 587.

In total 1251 patients, staff, relatives and carers participated in a variety of research projects at GMMH during 2017/18. GMMH was involved in 158 clinical research studies throughout the year ending 31 March 2018, 98 of these studies were on the National Institute of Health Research (NIHR) Portfolio and supported by NIHR Clinical Research Network: Greater Manchester (CRN:GM).

Our 2017/18 annual project audit showed that 55% of Principal Investigators of studies declared some level of service user involvement in the research process itself.

Bringing research to our service users

Current legislation and guidance make it clear that research should be embedded as a core function of the NHS. The Health and Social Care Act 2012 gives the NHS in England a statutory responsibility to promote health and social care research. The NHS Constitution commits the NHS to inform patients and the public of research in which they may be eligible to participate.

The Department of Health Mandate 2014 states that NHS England has an objective to ensure that the new commissioning system promotes and supports participation by NHS organisations and NHS patients in research funded by both commercial and non-commercial organisations, most importantly to improve patient outcomes, but also to contribute to economic growth. This includes ensuring payment of treatment costs for NHS patients taking part in research funded by Government and research charity partner organisations. Our Trust R&I Service has been influential locally and nationally and supports our Quality

Account improvement priorities.

We continue to work closely with the NIHR Greater Manchester Clinical Research Network (GM:CRN) to bring more opportunities to GMMH service users and carers. GM:CRN supports research office staff, research nurses and clinical studies officers to set up, publicise and recruit participants for a wide range of mental health and dementia research.

NHS
National Institute for Health Research

This team has benefitted from a recently approved standard operating procedure enabling the delegation of screening and first approach from direct care teams to the clinical research team on a study by study basis leading to further opportunities for service users to hear about opportunities to participate in research.

Service user involvement is central to our strategy and is a key deliverable for all Research Units. The Psychosis Research Unit provides an excellent model for others to follow with three service user researchers currently employed and a very well established Service User Reference Group, which contributes, to development of research questions and the design, conduct and dissemination of all research studies including clinical trials.

This group is overseen by Dr Eleanor Longden, who is internationally known for her inspirational TED talk: The Voices in My Head, in which she shares her own experiences of hearing voices and embodies a message of hope and recovery. Eleanor's recent NIHR Fellowship success securing £164,400 for her study entitled 'A feasibility and acceptability study of the Talking With Voices intervention amongst adults with psychosis' is further evidence of our strengths in this area. Our new Research Units have taken steps towards developing Service User Reference Groups based on the Psychosis Research Unit model and dedicated service user involvement posts have been included in two of the Units.

GMMH has been actively involved in the ongoing development of Join Dementia Research (JDR), which is a NIHR service for people in the UK to register their interest in participating in dementia research. It is supported by the Alzheimer's Society, Alzheimer's Research UK and Alzheimer Scotland. It allows people living with dementia or memory problems, their carers, or anyone with an interest to sign up and learn all about the most innovative and up to date dementia research happening in their area.

Our Medical Director, Dr Chris Daly, registered with JDR after he worked with the NIHR's Greater Manchester Clinical Research Network (CRN) on a Healthy Brains awareness day in autumn 2017 and arranged for his North West peers to do the same in order to promote the service amongst service users, carers and staff.

The Open Doors Network, a gateway for service user involvement/development involving Professor John Keady, is continuing to thrive with GMMH colleagues being involved in a number of dissemination opportunities and publications relating to this work including presenting the 'Changing Face of Our Neighbourhood' at the UK Dementia Congress at Doncaster Racecourse (November 2017) and are also working on a 'Language Matters…' project as part of the Economic and Social Research Council/NIHR Neighbourhoods study. Their accessible blog can be found at: https://salfordneighbourhoods.wordpress.com/.

Impact of research

In line with our strategy and the key objectives of our Research Units, it is essential that we ensure that clinical services are informed and improved by research involvement, dissemination and translation. Examples of previous successes in this area include:

- User-led research on recovery from psychosis and a subsequent NIHR programme grant has led to development of Questionnaire about Process of Recovery (QPR), which has become a mandatory PROM used nationally in the evaluation of early intervention services.
- EDIE and EDIE-2 trials led to the NICE recommendation of CBT for young people at risk of developing psychosis which is part of the recent access and waiting standard.
- Planned participation in a conference to share developments in our Trust following EQUIP training. EQUIP learning also going to be utilised in Trust's prioritisation of ensuring greater user involvement in care plans following a recent audit that highlighted the need to improve in this area.

For further information about any aspect of our Research and Innovation work streams please contact Sarah Leo, Head of Research & Innovation Office (0161 271 0076 or sarah.leo@gmmh.nhs.uk)

2.4 Commissioning for Quality and Innovation (CQUIN)

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

For 2017/18 the value of the CQUIN payment was £ 4,999,484.

At the time of writing, we are pleased to report that we have made significant progress towards GMMH agreed CQUIN schemes as at Q3 for 2017/18, which is a reflection of the hard work of staff across the organisation. The Q4 report is under development. We would like to take this opportunity to say thank you to everyone involved. There are three categories of CQUINs in 2017/18 – national, local CCG and NHS England. For 2017/18, there was a two year agreement for national CQUINs which cover until March 2019. In 2017/18 these focussed on delivering improvements in the following areas for GMMH:

National indicators

Indicator N1a – Improvement of health and wellbeing of NHS staff
The further development of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with muskulosketal issues. A wide range of activities is being delivered. A Health and Wellbeing action plan is regularly updated with champions in local services.

Indicator N1b – Healthy Food for NHS Staff, Visitors and Patients
This is aimed at providers improving the health of the food offered on their premises including the banning of price promotions on, and advertisements for sugary drinks and foods high in fat, sugar and salt. It also includes ensuring healthy options are available for night staff.

Indicator N1c – Improving the Uptake of Flu Vaccinations for Frontline Clinical Staff
This was aimed at achieving an uptake of flu vaccinations of 70% by February 2018. This was met by GMMH and was a significant achievement.

Indicator N3a - Cardio Metabolic Assessment and Treatment for Patients with Psychoses
Implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors for inpatients with psychoses, community patients in Early Intervention psychosis teams, and for those on the Care Programme Approach (CPA) in community mental health services. This monitors the use of physical health intervention tools and cardio metabolic tools by staff to ensure competent undertaking of physical health assessments. Achievement is evidenced via the results of national audits. Further internal audit is planned to provide further assurance of improvement in relation to inpatients and community services.

Indicator N3b – Collaboration with primary care clinicians
This CQUIN aims to improve the physical health care of patients with serious mental illness in primary and secondary care. GP's and mental health services are required to share information about those with serious mental illness in their care and work together to establish shared care protocols to ensure annual physical health review takes place that reflects the needs of the patient. A local audit of communication with patients' GPs is also undertaken, demonstrating that, an up-to-date care plan or a comprehensive discharge summary has been shared with the GP. 90% compliance is required.

Indicator N4 – Improving services for those with mental health needs who present to A&E
Mental health and acute hospital providers are working together with other partners (primary care,

police, ambulance, substance misuse for example), to ensure that those people presenting at A&E with mental health needs have an improved, integrated service offer. There has been a focus on improving understanding of the complex needs of a small cohort of people who use A&E most intensively and on improving the quality of coding of mental health needs in A&E. The aim is to reduce the number of frequent attenders at A&E by 20% in the agreed cohort of patients.

Indicator N5 - Improving transitions out of Children and Young Peoples mental health services
This aims to encourage collaboration between providers across the care pathway from children's services to adult services. Transition protocols have been developed and care pathways mapped. Comprehensive action plans are in place. Questionnaires have been developed to assess service user views. Multi agency groups are in place to drive this forward in each area.

Indicator N9a-e - Preventing Ill Health from Risky Behaviours
This CQUIN measures improvement in the screening, brief advice and referral on for inpatients who are smokers or drink alcohol above recommended levels. Much work has taken place training staff to deliver interventions and identifying local champions to maximise opportunities for screening and intervention as appropriate.

Local CCG indicators for GMMH

Indicator L1 – Suicide Prevention
This is aimed at implementing best practice and enhancing current policies in suicide prevention and reducing self-harm. This is a two year CQUIN agreed in 2016/17 for Bolton, Salford and Trafford. A similar CQUIN was agreed for 2017/18 for Manchester services, which will run until March 2019. Multi agency Suicide Prevention Strategy groups have ensured a collaborative approach and comprehensive action plans are in place. Training is a key part of this CQUIN.

NHS England Indicators

Our CQUIN scheme was agreed with NHS England and included quality measures for our specialist services commissioned by NHS England (Adult Medium and Low Secure, Young People's Forensic Service, the Child and Adolescent Mental Health In-patient Services, and our Mental Health and Deafness Service). Two of these CQUINs are in their second year, two are new. All schemes will cover until March 2019. The schemes are:

Recovery Colleges for Low and Medium Secure Patients
Requiring the development of Recovery Colleges to deliver peer-led education and training programmes within low and medium secure mental health services. This is Year 2 of this CQUIN. The service were able to expand on the established Edenfield Recovery Academy and co-produce a prospectus with service users and experts by experience. The further promotion of the prospectus, development of courses and robust outcome measures has been ongoing this year. For 2017/18, 90% of the target patient group should participate in courses and 80% report positive outcomes.

Reducing Restrictive Practices within Low and Medium Secure Services
Development, implementation and evaluation of a service specific framework on the reduction of restrictive practices within adult low and medium secure services. This is Year 2 of this CQUIN. During Year 1, the framework was successfully piloted and evaluated. Findings demonstrated a reduction in use of seclusion and restraint in the targeted areas. Year 2 has focussed on extending this to all wards in medium and low secure services.

Discharge and Resettlement for all specialist mental health inpatient services
Delays in discharge impact significantly and adversely on quality of life, speed of recovery and on availability of beds for others. This CQUIN is new for 2017/18 and requires a system to be put in place for recording estimated discharge dates and review of each delay with a target of 10% reduction in the current average

length of stay. A draft strategy and baseline data is in place and the focus is on successful discharges.

CAMHS Inpatient Transitions

This CQUIN is in its first year of delivery and will improve transition planning, patient and carer involvement and the experience of and outcomes for patients moving from inpatient CAMHS services to adult services. Surveys of staff, service users and families have been developed. Joint discharge and admission working is in place between staff in CAMHS and adult services. Case note audit of those discharged is also informing the work.

Further details of the agreed CQUIN goals and achievements for 2017/18 and for the following 12 month period are available on request from:

Miranda Washington, Deputy Director of Performance and Business Development
Greater Manchester West Mental Health NHS Foundation Trust
Trust Headquarters, The Curve, Bury New Road, Prestwich, Manchester, M25 3BL.

Telephone: 0161 358 1366 **Email:** Miranda.washington@gmmh.nhs.uk

2.5 Registration with the Care Quality Commission (CQC)

GMMH is required to register with the CQC at 13 registered locations serving the mental health needs of our service user population. In February 2018, we received an overall 'Good' rating from the CQC following a core service with well-led inspection that took place between 18 September and 7 December 2017.

Our substance misuse services received 'outstanding' as part of the well-led inspection. Substance misuse services at GMMH offer a range of community and inpatient alcohol and drug services, and provide information, support and advice to aid people in their recovery. These services are provided from our Chapman Barker Unit, a regional detoxification inpatient unit that offers a truly unique, medically managed and recovery-focussed treatment for men and women with substance misuse problems and our 'Achieve' substance misuse treatment and recovery service in the boroughs of Bolton, Salford and Trafford. GMMH also provides the 'Discover' Drug and Alcohol Services to adults, who are experiencing problems with drugs or alcohol in Central Lancashire, and the 'Unity' substance misuse services in Cumbria.

Our Substance misuse services, who received the highest proportion of compliments from patients, and the rapid access to the alcohol pathway provided by the Chapman Barker Unit was felt to be an innovative and effective service. The service accepts referrals from accident and emergency services across Greater Manchester and provides rapid access to specialist detoxification as an alternative to hospital admission.

The CQC inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, they look at the quality of leadership at every level, within the ''well-led' domain. The CQC also looks at how well a trust manages the governance of its services, how well leaders continually improve the quality of services and how leaders safeguard high standards of care by creating an environment for excellence in clinical care to flourish. We were very proud that the CQC rated GMMH as outstanding for this well-led element.

In their inspection report, the CQC indicated how the entire inspection team were struck by how well the leadership team at GMMH had brought Manchester services into the trust and improved them. They also felt that leadership, governance and culture promoted the delivery of high quality care, and that leaders were visible and approachable.

The ratings of our recent CQC inspection published in February 2018 are shown below.

Domain	Rating
Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well Led	Outstanding
Overall Trust Rating	**Good**

A comprehensive action plan identifying all recommended areas of improvement identified during the CQC inspection is currently being developed. Some examples of key areas considered by the CQC inspectors for further improvement includes:

- Some of our training courses that fell below the Trust attendance target
- Although the CQC found that Care Plans were holistic and patient centred some were not always personalised in acute wards for adults of working age and psychiatric intensive care units
- While the rights of people who were detained were protected, there were some issues with forms of authorisation and requests for second opinion doctors in wards for older people.

2.6 CQC Mental Health Act Monitoring

Between 1 April 2017 and 31 March 2018, CQC undertook Mental Health Act monitoring visits to the following GMMH wards:

- Bolton: Oak Lodge
- Manchester: Juniper, Poplar, Anson Road, Acacia, Laurel, Redwood
- Salford: Eagleton, Chaucer, McColl, Keats, Light Oaks, The Crescent, Delamere, Buile Hill, Hazelwood, Delamere, Holly
- Trafford: Bollin and Greenwood, Brook
- Specialist services: Hayeswater, Isherwood, Rydal, John Denmark Unit, Ferndale, Gardener Unit, Wentworth House, Keswick, Borrowdale, Ullswater, Phoenix

Areas for improvement identified on these visits have been rigorously addressed through implementation of the provider action statements that are submitted promptly to CQC after each visit.

2.7 Data Quality

The Trust recognises that accurate, complete and timely information is vital to support both the delivery of safe and efficient patient care and the management, planning and monitoring of its services.

GMMH submitted records during 2017/2018 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics, which are included in the latest published data (October 2017). The percentage of records in the published data:

- Which included the patients valid NHS Number was: **100%**
- Which included the patient's valid General Practitioner Registration Code was: **99%**

Staff are supported with training and guidance to record information accurately. As part of our work to improve data quality, the information quality team work with data quality contacts across all services to address any data quality issues.

GMMH has made a concerted effort during 2017/18 to ensure that the importance of accurate quality data and ensuring effective collection processes are embedded across the new organisation, this is achieved by:

- Using appropriate policies and procedures, which have all been subject to a comprehensive review.
- Providing constructive and supportive feedback to colleagues when data quality errors are identified.
- A proactive programme of audits undertaken throughout the year, the findings of which inform the Trust on areas of strengths and weaknesses and ultimately guide ongoing developments.
- Continuing to communicate key messages regarding accurate recording of clinical activity.

2.8 Information Governance

We aim to deliver a standard of excellence in Information Governance by ensuring that information is collated, stored, used and disposed of, securely, efficiently and effectively and that all our processes adhere to legal requirements. This ensures that information is accessible when needed, to support the delivery of the best possible care to our service users. We have an established Information Governance Policy, which provides a framework for the management of all service user, staff and organisational information. Implementing the requirements of the Information Governance Toolkit is part of this framework. The Information Governance Toolkit sets national standards for achievement to ensure that organisations maintain high levels of security and confidentiality of information at all times.

The GMMH Information Governance Toolkit, version 14.1, submitted for the period of 2017/18 successfully achieved an overall score of 82%, which is graded as 'Satisfactory' (green). GMMH reported a 95.2% compliance rate within the National Information Governance Toolkit against the requirement for Information Governance training for all staff.

2.9 Clinical Coding

GMMH outsources its clinical coding processes. During 2017/18, this arrangement and the accuracy of the results received by GMMH were subjected to audit as part of the Information Governance Toolkit, version 14.1. The audit confirmed an accuracy level of 96% for primary diagnosis and 96.7% for secondary diagnosis against a sample of 50 records. This has reaffirmed confidence in the existing system for the Trust.

2.10 Department of Health Mandatory Quality Indicators

We have reviewed the required core set of quality indicators which Trusts are required to report against in their Quality Accounts and are pleased to provide you with our position against all indicators relevant to our services for the last two reporting periods (years).

2.10.1 Preventing People from Dying Prematurely - 7 Day Follow-Up

GMMH achieved the Single Oversight Framework (SOF) target of >95% of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care

The latest published benchmark results available for comparison of performance against this indicator relate to quarter three 2017/18. We have therefore also provided the quarter three position for 2016/17, which excludes the Manchester services as this was prior to Greater Manchester Mental Health NHS Foundation Trust being formed.

Performance	**CPA 7 Day Follow-Up**	
	Q3*** 2016/17 (%)	Q3 2017/18 (%)
GMMH*	98.2 (GMW)	97.3
National Average**	96.6	96.3
Lowest Trust**	59.5	84.6
Highest Trust**	99.5	99.7

*Source: Board Report December 2017, page 8 (calculation of figures supporting percentage)
**Source:
https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/
*** This data relates to the former GMW Trust only

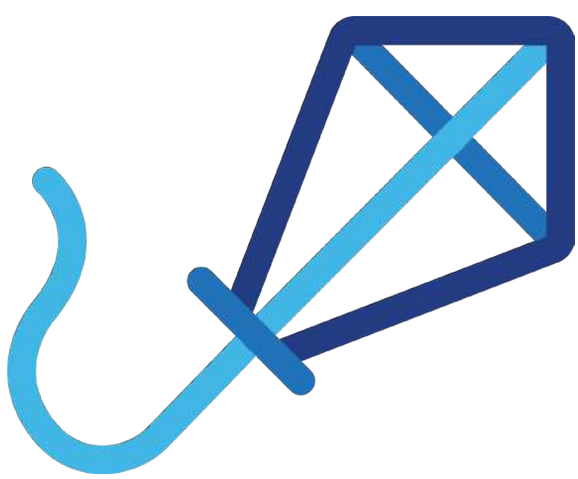
GMMH considers that this data is as described for the following reasons:

- All of our staff understand the clinical evidence underpinning this target and are committed to improving clinical outcomes for patients
- We have appropriate and well-established mechanisms in place to enable validation of data, monitoring of data quality and robust performance reporting from Team to Board and vice versa

GMMH intends to take the following actions to consolidate this high performance, and so the quality of our services, by:

- We will continue our work to harmonise the two current polices on 7-day follow up to an agreed GMMH standard. This affords an opportunity to update practice, review guidance and re-iterate this process as a suicide prevention intervention. The implementation of the new harmonised policy will enable a review of the operational delivery of the 7 day follow up procedure through analysis of our governance information, for example serious untoward incidents, complaints and associated learning events. A first draft of the harmonised policy has been drafted, and is currently out for consultation with operational and clinical staff.
- Alongside the policy review we will continue to raise awareness of the importance of the clinical evidence that supports the achievement of this indicator
- We will Identify any potential training issues, as they arise, regarding the collection and timely recording of data and provide training to address these issues
- We will continue to develop our data quality policies and procedures to ensure they remain up to date and that we maintain a consistent, high level of data quality
- We will sponsor audits to identify specific areas for data quality improvement and act upon the outcomes of those audits
- We will contribute, where appropriate, to the data quality requirements of the Information Governance toolkit

The above actions are key to ensure a consistent high quality approach across the new organisation.



2.10.2 Enhancing Quality of Life for People with Long-term Conditions – Gatekeeping

GMMH achieved the UNIFY target of >95% of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period

The latest published benchmark results available for comparison of performance against this indicator relate to Q3 2017/2018. We have therefore also provided the Q3 position for 2016/17, which excludes the Manchester services as this, was prior to Greater Manchester Mental Health NHS Foundation Trust being formed.

Performance	Gatekeeping	
	Q3*** 2016/17 (%)	Q3 2017/18 (%)
GMMH*	99.8 (GMW)	99.1
National Average**	98.4	98.7
Lowest Trust**	89.0	91.5
Highest Trust**	100.0	100.0

*Source: Board Report December 2017, page 5 YTD column
**Source:
https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/
*** This data relates to the former GMW Trust only

GMMH considers that this data is as described for the same reasons outlined in 2.10.1 above. We intend to take the actions described in 2.10.1 above to consolidate this high performance and so the quality of our services.

2.10.3 Ensuring that People have a Positive Experience of Care – Staff Survey

In February 2018, GMMH received the results of the 2017 national staff survey. The survey is carried out independently by the Picker Institute and the aim is to collect the experience and opinions of our staff on a range of matters such as job satisfaction, wellbeing and raising concerns. This report is the first report for the combined GMMH Trust therefore there is no comparative data for the previous year survey. GMMH considers that this data is as described for the following reasons:

The areas where GMMH compared most favourably with other mental health trusts were:

- Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse
- Percentage of staff agreeing their role makes a difference to patients/service users
- Percentage of staff working extra hours
- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

The areas where the Trust compares least favourably with other mental health trusts were:

- Percentage of staff/colleagues reporting most recent experience of violence
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

- Quality of appraisals
- Percentage of staff experiencing physical violence from staff in the last 12 months

GMMH intends to take the following actions to improve these scores, and so the quality of our services, by using the results to identify areas for action and improvement. Staff focus groups will be held to inform these developments as we continually strive to improve the experience of our staff. GMMH results for specific indicators relating to bullying and equal opportunities are set out below:-

GMMH results for specific indicators relating to bullying and equal opportunities are set out below:-

Indicator KF 26 - % of staff experiencing harassment, bullying or abuse from staff was 21% (national average 21%)
Indicator KF21 - % of staff believing that the Trust provides equal opportunities for career progression or promotion was 87% (national average 85%)

2.10.4 Ensuring People have a Positive Experience of Care – Community Mental Health Patient Survey

The annual community mental health patient survey undertaken by the Care Quality Commission compares 56 mental health providers from across the country with results published nationally in November 2017. As in previous years, we used an independent approved contractor (Quality Health) to run the survey on our behalf in 2017.

GMMH considers that this data is as described for the following reasons. For 2017, overall Trust scores were more or less the same as the other mental health trusts that took part in the survey programme. The Trust's highest thematic scoring category was for reviewing care for our service users. Scores here were generally better than those reported by other mental health trusts.

GMMH did not receive any results in the worst scoring 20% of all mental health trusts. Scores relating to organising care, planning care, changes in who people see, crisis care, treatments and overall views of care and services are all within the above average quadrant of the intermediate scoring Trusts.

There were a number of areas, where service users continue to feedback a positive experience of the Trust's community mental health services including:

- Being told who is in charge of organising care and services
- Agreeing the details of care to be received with mental health staff
- Having a formal meeting in the last 12 months to review care
- Being involved in decisions about care and treatment
- Getting the help that was needed if contacting services in a crisis
- Getting help with finding support for physical health needs

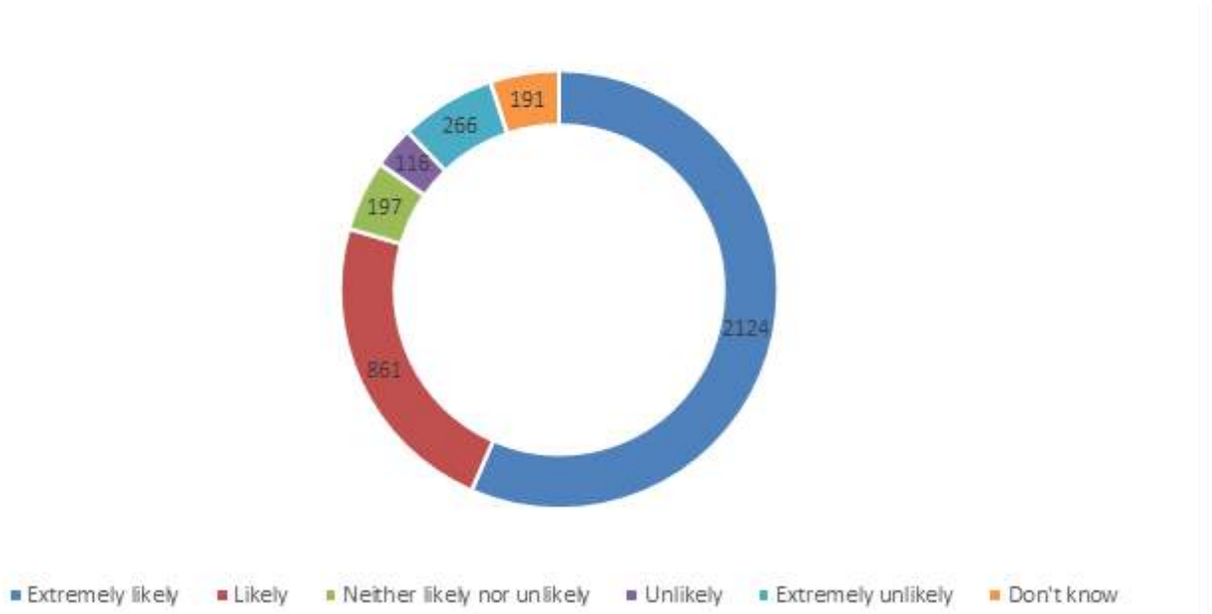
We analysed the findings of the survey to see where we can further improve the care we deliver and we intend to take the following actions to continue to improve the quality of our services, by:

- Giving better information to service users in relation to treatments and therapies
- Undertaking a deep dive into service user support and wellbeing, with a focus on employment support
- Establishing local directorate forums to support service users to find or keep work, improve their physical health care and access support from people who have experienced the same mental health problems
- Maintaining an ongoing focus on care planning as part of our Quality Matters programme

GMMH intends to take the following actions to improve these scores, and so the quality of our services by sharing the results from the 2017 survey widely across the Trust so that each district can identify local improvement actions. These will be agreed and monitored at our quarterly Care Hub meetings.

2.10.5 Ensuring that People have a Positive Experience of Care – Friends and Family Test (FFT)

Across GMMH, we continue to implement the patient FFT, as a consistent way to measure the patient experience across the breadth of our services. At the end of Quarter 3 2017/18, 3755 service users had answered the FFT question. This is an increase from the 2110 service users from the same reporting period of the previous year. GMMH considers that this data is as described for the following reasons. There were 79% of service users (2986 out of 3755) who would recommend GMMH services to their friends and family if they needed similar treatment.



Below is a word cloud of common words service users use when adding narrative to their feedback. Common words used are **Staff, Good, Support.**

Included below are some typical comments from the service users and carers who completed the FFT in 2017/18:

- Holly, Salford Inpatients: "Amazing, amazing care. Having come all the way from Newcastle upon Tyne I, leave feeling secure that my dad is in safe caring hands. Thank you so much"
- Bolton Asperger's Service: "Very friendly service"
- Chapman Barker Unit: "I was in a desperate mess with nowhere to turn CBU have shown me where I was going wrong and that I need not be alone in this anymore, and that I can have a good life even at my age. I feel so confident now that as long as I follow what has been taught life will be so different and I look forward to coming back in a different capacity and helping others. I cannot thank CBU and their staff enough"
- Trafford Memory Assessment Team: "Consultant was very thorough, explained very well and had an excellent manner"
- JDU: "Staff are very helpful and always smiling"
- Gardener Ward: "I feel I got the care I needed. Staff support me when I need it"
- Keswick ward: "Helped to change my life for the better"
- Acacia, Manchester: "Very positive treatment, restoring of optimism and hope...."

Occasionally we receive feedback where people are dissatisfied with the service they have received. Whenever we receive such feedback, our governance framework ensures services take action to respond and improve. GMMH has continued to implement a 'You said - We did' campaign which is communicated locally and trust wide. This is part of a wider suite of quality improvement tools, which we intend to build on during the coming year.

Below are some examples of where we have used feedback to improve our services:

"I would like to be more involved with my care and treatment"

The CARE Hub has delivered a series of workshops with clinicians to explore barriers to involve service users and carers in their care plans. A steering group has been established and plans are in place to develop care- planning training, create a care-planning good practice guide and co-designing with service users a personalised, user-friendly care plan.

"I don't like the hospital food"

Catering services have introduced a real time feedback process, whereby service users can leave their feedback immediately after a meal. This information is then provided directly to the chef that cooked that particular meal and any improvements can be considered. Catering services frequently visit wards and encourage feedback.

GMMH intends to take the following actions to improve these scores, and so the quality of our services. We will ensure that all feedback, including complaints and service user engagement information, is triangulated and analysed at the CARE Hub Committee. The CARE Hub leads and local Service User Engagement leads have action plans to address any trends or hotspots. Additionally, there is a communication strategy in place to communicate the Trust's achievements in relation to this agenda. The FFT monthly results are published and available on NHS Choices (via GMMH's webpage).

2.10.6 Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm – Patient Safety Incidents:

Information within this section of the Quality Account highlights the number and, where available, rate of patient safety incidents reported by GMMH to NHS Improvement via the National Reporting and Learning System (NRLS). The data below includes the number and percentage of patient safety incidents that resulted in severe harm or death and compares this data against the national average along with the highest and lowest incidents reported by other mental health organisations.

At GMMH, maintaining patient safety remains a key priority for our Board. When things go wrong during the care of a service user it is vital that our staff report incidents as soon as possible, so we can find out what went wrong so effective and sustainable actions are taken to reduce the risk of similar incidents occurring again. In 2017, we were proud to have received significant assurance by our internal auditors for our Incident management and review processes, demonstrating a positive reporting culture and ongoing commitment by all our staff in improving patient safety.

The progression of the new organisation, has resulted in the harmonisation of patient safety polices, working collaboratively with our partners in care on the development and implementation of the suicide prevention strategy across the Greater Manchester footprint, including the development of GMMH's suicide prevention website.

The data in the table below indicates that the number of patient safety incidents resulting in severe harm or death is low in comparison to the number of patient safety incidents reported. This has been a consistent picture for the Trust year on year and demonstrates our learning culture.

We are aware however that the number of incidents reported across GMMH relating to service users, who are engaging in self-harming behaviours is relatively high, and are taking a number of steps to address this.

We are aware from national research by our colleagues working within the Manchester Self-Harm Project at the University of Manchester that self-harm figures have significantly increased at a national level over recent years.

We acknowledge that there are no simple solutions in reducing self-harm across our service user population, and as a result, will be engaging in a number of quality improvement programmes over the next twelve months to continue in our efforts to address this. This includes skilling up our front line teams to work effectively in maintaining patient safety, particularly with services users who are engaging in self-harming behaviours.

Data Source: National Reporting and Learning System (NRLS). The data reported only includes data released by the NRLS in October 2017. This data includes the period of October 16-March 17.

Please note: Because the data reported includes data released by the NRLS from the period of October 16-March 17, it will therefore not include incident data for our Manchester services due to reporting for these services commencing after the NRLS data range. This information will however be reflected in the 2018/19 Quality Account.

	Reporting period	No of incidents occurring	Rate per 1000 bed days	No of incidents reported as severe harm	% of incidents reported as severe harm	No of incidents reported as death	% of incidents reported as death
Greater Manchester Mental Health NHS Foundation Trust	Oct 16 – Mar 17	5117	36.03	7	0.1	14	0.3
	Apr 16 – Sept 16	4635	47.4	5	0.1	14	0.3
	Oct 15 – Mar 16	3223	3223	5	0.2	12	0.4
Total number of incidents for mental health organisations	Oct 16 – Mar 17	157154	Data not available	538	0.3	1233	0.8
	Apr 16 – Sept 16	162954	Data not available	562	0.3	1240	0.8
	Oct 15 – Mar 16	146325	Data not available	501	0.3	1167	0.8
Highest value reported from any mental health organisation	Oct 16 – Mar 17	6447	88.21	72	1.8	100	3.8
	Apr 16 – Sept 16	6349	88.97	50	2.9	84	10
	Oct 15 – Mar 16	5572	60.93	49	0.9	31	0.6
Lowest value reported from any mental health organisation	Oct 16 – Mar 17	68	Data not available	0	0	0	0
	Apr 16 – Sept 16	40	Data not available	0	0	0	0
	Oct 15 – Mar 16	25	Data not available	0	0	0	0

Over the last two years, our Suicide Prevention Group has implemented a variety of initiatives with the aim of reducing suicide involving our service users. GMMH has developed excellent partnership working with the Samaritans, who now offer a supportive telephone call within 48hrs for those service users who are discharged from A&E back to the care of their GP. Safety Plans have also been developed in collaboration with service users and carers resulting in service users discharged from A&E with a safety plan.

GMMH has taken on board learning from the National Confidential Inquiry into Suicides around high-risk periods following hospital discharge. Our inpatient teams across our Bolton Salford and Trafford areas have implemented wellbeing telephone calls to service users within 48hrs of discharge from hospital. This is in addition to the 7-day follow up contact that our service users already receive. We are currently working towards rolling this work out to our Manchester services and exploring how we can replicate some of these initiatives in our substances misuse services.

Through the Suicide Prevention CQUIN work, we are currently recruiting into a Bereavement Liaison Nurse role who will work with relatives and also staff who have been affected or bereaved by suicide so that timely support can be offered.

GMMH considers that the data is as described for the following reasons:

Policy
The Incident, Accident and Near Miss Policy and Procedure (2015-20) is regularly reviewed in light of national guidance on incident management. All staff are consulted on any amendments to the policy; the Trust's Risk Management Committee signs off the policy, which is accountable to the Audit Committee a sub-committee of the Trust Board. This policy provides a framework for all Trust employees to identify, manage and report incidents in order that learning can take place. The policy ensures that reported incidents are analysed to identify their root causes and to evaluate the likelihood of reoccurrence – this enables effective mitigating controls to be put in place.

Integrated Risk Management System (Datix)
All incidents are recorded on and managed through the web based Integrated Risk Management System (Datix). Our staff receive training and dedicated on-going support with Datix. This web-based system enables prompt sharing of accurate, timely information, which underpins our approach to risk management and increases our safety profile. This system enables the prompt recording of any patient incidents directly into PARIS, the electronic patient clinical record.

External Reporting
All of our patient safety incidents are reported weekly to the National Reporting and Learning System (NRLS) via Datix and to external regulators as per policy and to commissioners as per individual contracting arrangements. GMMH intends to take and has taken the following actions to continually improve and sustain our robust incident management reporting, and so the quality of our services by:

Review and Lessons Learned
All serious untoward incidents are reviewed by an Executive Review Panel on a weekly basis and is responsible for commissioning more detailed and, where required, externally-led investigations to establish the root causes of serious untoward incidents. The Quality Governance Committee and the Trust Board review the findings from these reports and the lessons learned. Lessons learned and good practice are shared across the organisation enabling other services to reflect on their own practice and to identify any training issues, which are then incorporated into our annual training plans. The sharing of learning is cascaded via monthly lessons learnt screenshots, newsletters; Positive multi-disciplinary team (MDT) learning events and team meetings. In addition, our lessons learnt are shared with commissioners through the Quality Monitoring Group and Contract meetings.

Quality Walkarounds
Quality Walkarounds are a part of our Quality Matters Framework, a quality improvement tool that provides a strategic framework offering ward to Board level assurance that our services are safe, positive and effective. Walkarounds are completed by a team of people independent from the clinical area being visited. The teams are clinically led and include representation from clinical staff. At the conclusion of the Walkaround, the team provide some initial feedback to ward management, highlighting positive practice, as well as any areas that may benefit from focussed quality improvement. Shortly after this, a report is then produced and once approved it is shared with the ward team, and with the Senior Leadership Team for further consideration. Final reports are also shared at the Quality Governance Committee and the Operational Leadership Committee. The reports reflect the breadth of the discussions on the day of the visit and highlight both strengths and challenges – they are also RAG rated following a final review by the Walkaround team.

Duty of Candour
Our Duty of Candour policy has been embedded within our incident management processes, with audits commissioned to demonstrate the implementation of the principles. This policy supports clinicians to be transparent and apologise when things go wrong during care. Our trained incident investigation staff will then offer relatives supported reading and a copy of the final investigation report. In order to embed the Statutory Duty of Candour into clinical practice regular training and awareness raising workshops are delivered by our Governance team.

Continually improving incident reporting and maintaining our culture of learning
All staff continue to be encouraged and supported to report incidents. All staff receive training on our incident process and associated policies, which actively encourage the reporting of patient safety incidents directly involving our service users. Other initiatives to support incident reporting include our Datix Help Line, our governance newsletter and lessons learnt events that occur following serious untoward patient safety incidents.

NRLS incident benchmarking data is discussed at our Quality Governance Committee, shared at senior leadership team meetings and discussed at Quality and Performance meetings with commissioners. Benchmarking data reports from the NRLS demonstrates that we have a consistent incident reporting culture with a low degree of harm.

2.10.7 Learning from Deaths

In March 2017, the National Quality Board published the first National Learning from Deaths Guidance 'A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. In response to this guidance, our Mortality Review Group has developed a 'Learning from Deaths' policy which is on our Trust website.

This policy in conjunction with other associated polices highlights to staff what action to take following the death of a service user with a learning disability and or mental health needs, the level of investigation processes to implement and how learning from deaths is shared.

Learning from a review of the care provided to patients who die is now integral to GMMH's clinical governance and quality improvement approaches. In November 2017, our internal auditors' Mersey Internal Audit Agency, reviewed our Mortality Review processes in line with the national guidance and provided a 'Significant Assurance' rating. Recommendations following this review have now been implemented.

In January 2018, the GMMH Board published its quarterly mortality figures using the NHSI recommended Mortality dashboard though its public Board meeting. This is now a requirement of all NHS providers in line with the national guidance. The mortality data published includes the total number of Trust's in-patient and community deaths and those deaths that the Trust has subjected to investigation.

During 1 April 2017 to 31 March 2018 859 of GMMH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 191 deaths in the first quarter
- 197 deaths in the second quarter
- 233 deaths in the third quarter
- 238 deaths in the fourth quarter

GMMH is committed to learning from deaths and understands the importance of developing and changing services in line with learning. Learning from deaths fits with the Trust's ethos about putting patients, families and carers at the centre of everything it does. GMMH, in reviewing the care provided to people who have died, can help improve care for all patients by identifying problems associated with poor outcomes, and working to understand how and why these deaths occurred so that meaningful action can be taken. As the table below highlights, out of the 859 deaths, 383 were expected deaths.

Quarter	Unexpected Outpatient	Unexpected Inpatient	Expected Outpatient	Expected Inpatient	Total
1	96	6	88	1	**191**
2	99	1	93	4	**197**
3	133	7	91	2	**233**
4	124	10	91	13	**238**
Total	452 (53%)	24 (3%)	363 (42%)	20 (2%)	**859**

Expected deaths relate to service users who are approaching end of life due to a deterioration in their health condition. As a result, a decision is agreed between healthcare professionals and their relatives to implement the end-of-life care pathway. The majority of these expected deaths (363) were in the community. It is likely that many of the service users, who were placed on an end of life pathway, would have been cared for in an acute trust, a care home, a hospice or in their own home when their death occurred, and this will have been in line with their agreed end of life care pathway.

The remaining 476 deaths were unexpected. The majority of our service users are cared for in the community and the figure of 452 relates to those service user whose death was not anticipated at that time by the healthcare team who were supporting them. In line with the national Guidance, not all unexpected deaths will be deemed to be a serious incident or will be viewed as under suspicious circumstances as a high number of unexpected deaths may occur as a result of an underlying health condition and/or a naturally occurring illness. All unexpected deaths are reviewed individually in line with national Guidance and working closely with our regulators.

It is noted that there was a small increase in deaths during quarter three (October to December 2017) and quarter four (January to March 2018). These deaths occurred during the winter months, and it is not unusual to see an increase in deaths during this period, particularly for older people with underlying physical health problems. When the increase was identified, the GMMH Incident Team undertook a desktop review, which did not identify any specific themes or concerns around care.

There have been some changes regarding the arrangements for reviewing deaths, which are gradually being implemented across NHS organisations. These are currently under review within GMMH in order to determine how they can best be adapted to support investigations within mental health settings.

By 31 March 2018, 0 case record reviews* and 76 investigations have been carried out in relation to 688 of the deaths included above. In 0 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:

Please note that GMMH did not undertake case record reviews during 2017/18. GMMH is currently reviewing the use of the Structured Judgement Review (SJR) Case Note Tool, in conjunction with GM partners to ensure that it is fit for purpose within mental health settings. The intention is for the SJR tool to be implemented during 2018/19 to review specific deaths as appropriate. Further information on the SJR tool is set out in further detail within this Quality Account.

- 24 serious incident root cause analysis investigations, 0 case record reviews in the first quarter
- 15 serious incident root cause analysis investigations, 0 case record reviews in the second quarter
- 22 serious incident root cause analysis Investigations, 0 case record reviews in the third quarter
- 15 serious incident root cause analysis Investigations, 0 case note reviews in the fourth quarter

Zero representing 0% 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**.

**There is no current standardised assessment tool or methodology for Mental Health providers to identify if a death has more likely than not been due to problems in care provided to the patient. There is an ongoing work stream led by NHSI and Humber NHS Foundation Trust in line with the National 'learning from Deaths' Guidance 2017, which intends to define these criteria to assist mental Health providers. GMMH's Medical Director will be supporting the NHSI and Humber working group to address this.

GMMH currently uses Root Cause Analysis as its primary investigatory methodology, in line with the requirements of the National Serious Incident Framework 2015. GMMH calls on the wide range of expertise across its workforce to review incidents following the death of a service user.

All deaths are subject to review through our Executive Serious Untoward Incident Review Panel, which will review investigations, agree recommendations and onward actions and review the Positive Learning Events that take place. Investigations completed for all serious Incidents are submitted to Trust commissioners for their review and approval in accordance with the agreed contractual arrangements and requirements of the NHS England Serious Incident Framework 2015.

Structured Judgement Review Tool (SJR)

In February 2018, following on from recommendations highlighted within the national Learning from Deaths guidance in relation to providers implementing the Structured Judgment case note review tool, our Trust Mortality Review Group commissioned training to a group of clinicians around implementation of the Royal College of Physician SJR tool. The SJR tool will introduce a standardised methodology for reviewing case records of service users, who have died whilst under the care of GMMH.

The primary goal of the SJR tool is to improve healthcare quality through qualitative analysis of health records using a standardised, validated approach linked to quality improvement activity. Training to use the SJR tool was delivered by colleagues from the Humber NHS Foundation Trust, who have been working with the NHS Improvement Team, in adapting the SJR tool and piloting its use specifically for mental health providers. GMMH are keen to implement this method of review to learn from deaths of services users in our care.

In 2016, GMMH developed a quarterly Mortality Review Group, which is chaired by our Medical Director and attended by senior governance and clinical leads from each of our clinical areas. The Mortality Review Group reviews the trusts mortality data and commissions furthers reviews in the form of deep dives into emerging themes relating to deaths. Learning from these reviews is shared trust wide via local quality governance and learning forums.

In September 2018, GMMH developed a GM Provider Mortality Review Group in partnership with Pennine Care Foundation Trust and Northwest Boroughs Partnership NHS Foundation Trust in order to share the wider learning around mental health mortality across the GM footprint.

To improve the health outcomes of people with Learning Disabilities, GMMH supports the national Learning Disabilities Mortality Review (LeDeR) programme and notifies the LeDeR team of all Learning Disability deaths involving one of our service users.

GMMH takes the death of any service user extremely seriously. Carrying out investigations following a service user's death is important to how we learn and improve our clinical services. A thematic analysis of Learning from Investigations was undertaken and highlighted the following themes:

- Record Keeping- Timely and accurate recording
- Clinical Risk assessment- Understanding of risk, formulation, lack of a detailed risk assessment
- Physical health- completion and accurate recording of physical health observations, sharing of physical health concerns with the wider team or with other agencies
- Effective communication between professionals (Internal and external to the Trust during transitions of care
- Carer engagement during care planning or assessment following, recording of the next of kin contact information within the service users records

As part of the Trust annual audit programme, a thematic analysis of themes from Root Cause Analysis Investigations into deaths between 1st April 2017 and 31st August 2018 is currently underway. This will be reported into our Trust Mortality Review Group to enable GMMH to understand the themes identified and possible areas for further review in order to identify where improvements around service user treatment pathways may be required.

Learning from incidents is reinforced at service level through Multi-disciplinary Positive Learning Events. These provide the opportunity for teams to meet to review the investigation findings and to reflect on the incident in a safe and supportive environment and support the implementation of actions identified during the investigation process.
It is the intention that actions identified as a result of all investigations support learning, mitigate future occurrence and reduce the degree of harm and improve the service user and carer experience. Action

plans are recorded on our Risk management System and our Incident Team monitor the progress of the actions within the agreed timescales. The Incident Team provide monthly reports detailing outstanding actions, which are shared with Operational Services.

Others ways we share the learning from incidents are included below:

- Through monthly positive learning Splash Screens and positive learning posters
- Learning and themes identified within the weekly Executive Serious and Untoward Incident (SUI) panel are shared widely across nursing, operational and governance teams.
- Sharing the learning from incidents via NHS Improvement, the NRLS, regional governance leads forums and our commissioning bodies

Deep dives are commissioned by our Mortality Review Group and our Executive Serious Incident Panel to understand any changes in incident reporting and explore emerging patterns and peaks in around incident themes in any of our clinical areas. In 2017/18, the Mortality Review Group commissioned 3 deep dives in directorates where mortality data increased.

In addition, the Post Incident Review panel have commissioned two deep dives. These included a review into deaths where transition in care has been an area of concern and a deep dive into prison deaths. These are currently underway to identify if there are any themes and areas for learning for GMMH to consider.

As a result of learning from investigations conducted in relation to patient deaths at GMMH, the following actions have been taken:

- Record Keeping - The former Greater Manchester West NHS Foundation Trust and Manchester Mental Health and Social Care Trust Clinical Records Management Polices have been harmonised. Our Governance team have now developed a quarterly Good Record Keeping Training programme for all healthcare staff.
- Clinical Risk assessment - An audit into the quality of risk formulation within risk assessments is planned for audit year 2019/2020. From October 2017, clinical risk training has been embedded into induction training, which will include two days training for CAMHS staff.
- In support of the CQUIN for Suicide Prevention, we have trained 100 Team Managers and Ward managers in STORM (Suicide Prevention and Self-harm training) and we are currently exploring a STORM train the trainer approach to train our front line staff to work with service users at risk of self-harm or suicide.
- New staff have access to a clinical risk e-learning package within 6 months of commencement in their role before accessing our mandatory face-to-face Clinical risk training every three years.
- Physical health – Our Manchester district is now using the LESTER tool within Amigos. This tool is a cardio metabolic risk screen and provided to all of our service users at the point of admission and on significant medication change or review. Training has been rolled out to our Manchester district staff on recording the information. The Population health Information (PIT) tool has been improved to include the Lester Tool in addition to clear parameters for clinicians, to highlight any areas for concern. In relation to escalation, the trust has plans to move toward the use of National Early Warning Score 2 Assessment tool across all GMMH Services. Currently the trust has a mixed approach to this, with former GMW services using a modified early warning score and Manchester Services using a National Tool. Moving toward using the National Early Warning Score will ensure that we can consistently use the same tool for recognising a deteriorating patient as our partners in emergency and acute care.
- GMMH has recently invested in a programme to implement the Qrisk3 assessment tool, which is now recognised as a 10-year cardiovascular risk predictor. Plans are in place to integrate this into the electronic patient record and will enable our clinicians to act on a patients cardio vascular risk ensuring that referrals to GP's or into specialist services take place in a timely way.
- Changes to policies include the aligning of both former GMW and MMHSCT policies. This

comprises the Physical Health Care Policy, the Food and Hydration Policy and the Falls Policy. New policies include; Pressure Ulcer Management, The Management of Diabetes and End of Life Policy are in development.
- In addition, new service levels agreements are being negotiated for; podiatry, opticians, dentists, SALT teams and GP's.
- Provision of care - The Transfer to Acute Care Policy is to be reviewed and updated according to practice by the corporate Nursing Team- has been completed and ratified.
- Carers – specific actions have been taken in relation to contact with family and carer as part of care planning or assessment, support to carers and families, and recording of the next of kin contact information. This has included:
    - A refresh of the GMMH Carer strategy which included improving communication with carerso
    - Development of confidentiality guides for staff and carers
    - Service users and carers are invited to take part in the investigation and review of incidents through the application of the Being Open Policy, this provides them with an opportunity to influence the recommendations and action plans to support service improvement and learning:
- Funding has been agreed for a Specialist Bereavement Nurse to provide increased bereavement support and advice for families and carers

It is intended that delivery of these actions will have a positive impact on the service user experience of care and treatment at GMMH. The Trust has robust risk management policies and procedures in place for the identification, management and escalation of identified risk. In addition to these processes, our governance team is currently exploring with our commissioners the use of a standardised Root Cause Analysis (RCA) investigation template for reporting investigations. This includes the use of the 5x5 Risk matrix to help us to identify the likelihood of similar incidents occurring and enabling us to mitigate against any identified future risk.

Zero case record reviews and 21 investigations were completed after 1st April 2018, which related to deaths which took place before the start of the reporting period. As aforementioned, GMMH did not undertake case record reviews during 2017/18. GMMH is currently reviewing the use of the Structured Judgement Review (SJR) Case Note Tool, in conjunction with GM partners to ensure that it is fit for purpose within mental health settings. The intention is for the SJR tool to be implemented during 2018/19 to review specific deaths as appropriate.

Zero representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. As aforementioned, there is no current standardised assessment tool or methodology for mental health providers to identify if a death has more likely than not been due to problems in care provided to the patient.
Zero representing 0% of the patient deaths during 1st April 2016 to 31st March 2017, are judged to be more likely than not to have been due to problems in the care provided to the patient. As above, there is no current standardised assessment tool or methodology for mental health providers to identify if a death has more likely than not been due to problems in care provided to the patient.

2.11 Locally Selected Quality Indicator

For the 2017/18 local data indicator, GMMH has selected complaints information. Our Council of Governors chose this during their February 2018 meeting. For the purposes of this report, the complaints data presented relates to Quarters One, Two and Three of 2017/18, covering the reporting period 1 April 2017 to 31st December 2017.

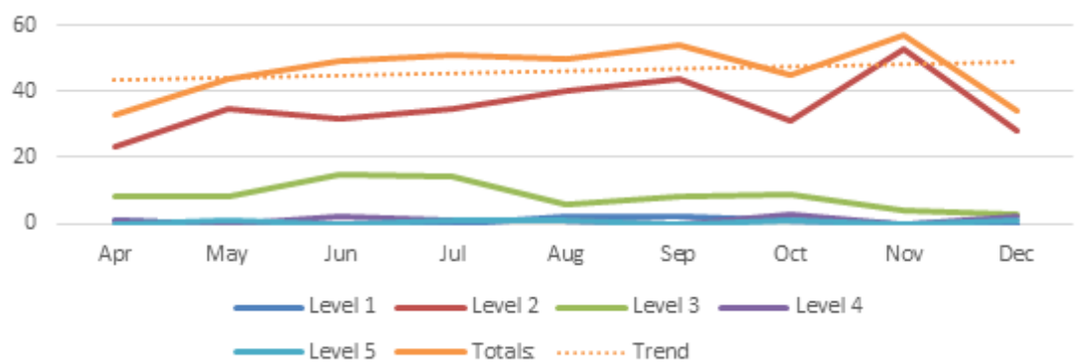
GMMH remains committed to creating a culture that continually learns from complaints and compliments to improve services. The system for managing complaints has been standardised across GMMH following the acquisition of Manchester Mental Health and Social Care Trust.

All complaints are received positively, investigated promptly and responded to within timescales that are agreed with the complainant. Complaints are recorded onto the Trust's DATIX system and reported to the Board of Directors on a monthly basis as part of our Board performance reporting.

Complaints administration was considered by the CQC during their inspection in September. The CQC reported: 'GMMH treated concerns and complaints seriously, investigated them and learned lessons from the results'

During the reporting period, 417 complaints were registered within clinical services. Level Two complaints represent the majority of these making up 77% of all complaints. There were 15 Level Four and Five complaints logged during this period.

Trustwide complaints

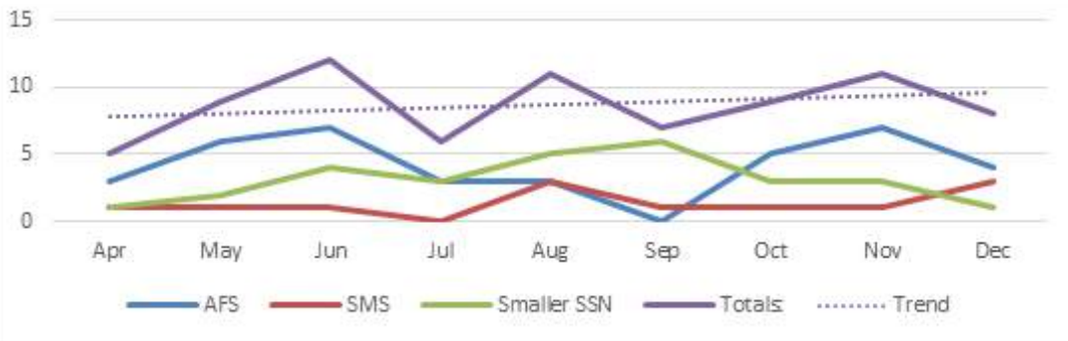


During the reporting period, a total of 339 complaints were logged by district services. Manchester services received the highest number, accounting for 49% of all district complaints. Work is currently underway within GMMH to divide Manchester into three unique sub-divisions, North, Central and South Manchester, to provide consistency with the other divisions.

Divisional service complaints

Within our Specialist Services Network, a total of 78 complaints were received during the reporting period. Our Adult Forensic Services received the highest number, accounting for 49% of all Specialist Service Network complaints.

Specialist Service Network (SSN) complaints



The table below highlights that 209 out of 394 (53%) complaints were upheld or partially upheld compared to 54% for the previous year. Manchester services closed the highest number, accounting for 38% of all closed complaints. Salford had the highest proportion of upheld and partially upheld complaints at 74%. Trafford services had the lowest proportion of upheld and partially upheld complaints (46%).

Complaints closed by Division and outcome

Division	Complaint not upheld	Complaint partially upheld	Complaint upheld	Withdrawn	Total
Bolton	19	27	9	6	61
Manchester	63	50	24	14	150
Salford	17	39	12	2	69
Trafford	20	14	7	5	46
AFS	12	3	8	11	34
SMS	4	1	1	3	9
Smaller SSN	10	11	4	0	25
Total	**144**	**144**	**65**	**41**	**396**

As the table below highlights, after discounting the 39 withdrawn complaints, there were 276 out of 357 closed complaints (77%) that received a response within a timescale that had been agreed between the Trust and the complainant. Bolton services had the highest proportion of complaints responded to within agreed timescales, 54 out of 55 complaints (98%), discounting the six complaints that had been withdrawn.

Complaints closed by Division and outcome

Division	Responded to within agreed timescales	Responded to outside agreed timescales	Withdrawn	Total
Bolton	54	1	6	61
Manchester	84	54	13	151
Salford	63	5	2	70
Trafford	39	2	5	46
AFS	16	8	10	34
SMS	5	1	3	9
Smaller SSN	15	10	0	25
Total	**276**	**81**	**39**	**396**

A full annual report including Quarter Four data (1st January to 31st March 2018) will be available on the GMMH website later this year.

Review of Quality Performance in 2017/18

3.1 Delivery of Quality Improvement Priorities in 2017/18

To support the delivery of our quality improvement priorities, and to make them meaningful and relevant to our local services, GMMH offers an annual Dragon's Den programme. The Dragon's Den programme includes a Quality Innovation Fund that was established to encourage quality improvement at local service level, and to increase the impact of the Quality Improvement Priorities across the breadth of our services.

The fund is promoted annually during April/May when the Quality Improvement Priorities for the forthcoming year are agreed. Any bids into the fund must relate to at least one of these priorities.

All individuals, teams, services and departments that are part of GMMH are able to apply for the fund. Applications are also encouraged from social enterprises, charities, service user and carer groups and third sector organisations that our services may be engaged with.

For 2017/18 there were approximately 130 bids for funds, with 59 of these being successful. Successfully funded projects ranged from stand-up comedy shows and improving access to cardiovascular screening to digital patient stories and a recovery through music project.

We have made significant progress against all of our 2017/18 priorities for improvement. Summaries of our key achievements are detailed in this section. Each achievement reflects the immense commitment of our staff, service users and carers to continually improve quality.

We have provided evidence of our key achievements, with case studies from Dragon's Den funded projects, in the following section.

Priority 1: Service User and Carer Experience – Listening To, Learning From and Acting On Service User and Carer Feedback

Aim: Improving the feedback from a diverse and inclusive range of service users and carers using a broad variety of methods and technologies.

Implementing improvements to services using learning from this feedback and ensuring service users and carers are aware of the changes made.

Progress, Achievements and review against specified improvement measures:

During 2017/18, the CARE Hub has been identified as the single service user and carer experience committee for GMMH. Each division has a Service User Engagement and Experience lead who attends the Service User Engagement and Experience meeting, which reports directly to the CARE Hub. To refresh the Service User Engagement Strategy, there have been a series of consultation workshops held in Manchester services and to date, Manchester service users and carers have agreed with the priorities within the existing strategy.

There have been some additions highlighted by Manchester service users on how we can better differentiate between consultation, engagement and co-production and more emphasis on individual engagement via care planning. The Service User Engagement Strategy action plans are monitored and updated via the CARE hub.

Service User Engagement
Service users and carers continue to be at the heart of the Manchester Transformation Steering group and Clinical Transformation work streams. Additionally, service users and carers have been recruited to participate in Manchester locality meetings to support the allocation of funds as part of the Manchester Wellbeing Fund Programme. This programme aspires to build resilience and networks within the 12 localities in Manchester. Service users and carers are working alongside staff to determine the allocation of funds based on bids received via the programme. Ensuring GMMH is involving service users and carers and truly championing a Co-Production model, the Recovery Academy and service users have co-produced a module on 'Co-Production- Getting It Right'.

Carers, Families and Friends
There have been a number of consultation events for Manchester carers to refresh GMMH's Families and Carers strategy. The Trust Carer Lead has streamlined the Triangle Of Care objectives across Manchester services and all services now have an overarching Carer Lead, Champions allocated for each ward and community base, and action plans in place to ensure GMMH maintains its accredited two stars.

Service User Experience
The CARE Hub continues to explore different methods of eliciting service user and carer stories. Service users continue to share their experiences by supporting the Trust Welcome Day and co-delivering the Recovery Academy prospectus. During 2017/18, a Dragons Den project has delivered a series of digital story workshops.

These have produced eight digital stories covering community resilience, urgent care system, the role of GP and emergency services, medication, follow up post discharge and low and medium secure service user experiences. These stories have further developed the Quality Matters programme and have been shared with staff and the Trust Board. The Carer Lead has worked with a local theatre company to produce three reconstructions based on carer experiences. These videos are being used in staff training to evoke reflective practice surrounding carer experience, confidentiality challenges and communication. There are Trust-wide initiatives in response to responding to service user feedback, and there is a governance process in place where services show case local examples of 'You said, We did' at the Service Engagement and Experience Leads Meeting.

The Quality Matters framework ensures 'You said - We did initiatives' are embedded locally. GMMH's Nursing Strategy has a priority that focuses on learning and improving practice from service user and carer feedback and work related to this is monitored via the GMMH Nurse Leadership Board and CARE Hub.

Systems are in place to capture feedback from Healthwatch, CCG Patient Experience Leads and local service user and carer groups

Volunteers
GMMH is dedicated to diversifying the workforce and supporting those with lived experience to co-deliver services. In 2017/18, the Volunteer Policy was harmonised and ratified. Peer mentorship will be reflected in GMMH's Workforce Strategy and plans are underway to expand peer mentorship across GMMH services. The National Investors in Volunteer Standards is on hold until the extra resource agreed to support the recruitment of volunteers is in post.

Case Study Priority 1: Service User and Carer Experience – Listening To, Learning From and Acting on Service User and Carer Feedback

Stories of my experiences with Psychosis

Ellen Anderson, Assistant Psychologist from the Manchester Early Intervention for Psychosis Service (EIT) approached the Den for £1,000 to produce a book of service user stories, which would be used as a resource to help with normalisation as well as lowering the stigma often associated with psychosis. The purpose was to also educate others on what it is like to live with psychosis, and enable a deeper understanding of the condition.

The Dragons were keen to fund this project as it clearly demonstrated that service user experience and feedback had directly contributed to the need for the book. Ellen noted that through the current peer support group, she had witnessed the benefits of sharing stories amongst service users. This is mutual, as sharing and opening up about their stories benefitted those speaking, as well as those listening.

The book responds to service user feedback, in that not enough is known about others with similar experiences. This could help service users from the start of their journey with the Early Intervention Service by informing them of others' stories.

The book has been produced and was launched formally in November 2017, and involved several of the 500 service users currently working with Manchester's Early Intervention Service, by way of painting, writing, drawing, collage and even rap.

John Sainsbury, the Manchester Early Intervention Service Manager, said: "The idea behind the book was service users saying 'We've had difficult times, but through hope and resilience we found a way through, and if there's a way of sharing our stories to give others hope, then here it is'.

"Hope is one of the underpinning philosophies of the Early Intervention Service and that is illustrated in this book. It will touch a lot of people and stand the test of time as a way for people to see that hope can help them through the low points."

Ellen also commented: "Although psychosis can have a huge impact on somebody's life, recovery is possible. There are many people who have an episode of psychosis and fully recover to their original level of functioning.

"The purpose of this book is to allow people to realise that there are others going through similar experiences to themselves, most of whom have inspiring messages to share.

"The book was created to give people an opportunity to hear about psychosis from the perspectives of those with lived experience."

Priority 2 Recovery: Promoting Recovery – Improving Outcomes through the Delivery of Recovery Focussed, Positive and Safe Services.

Aim: To improve outcomes through the delivery of recovery focussed safe, positive services across inpatient and community services.

Progress, Achievements and review against specified improvement measures:

During 2017/18, we continued with our efforts to reduce restrictive practice including levels of prone restraint and seclusion use across the organisation. As part of our work, we undertook a deep dive audit into our Positive and Safe practice across GMMH. The aim of this deep dive was to provide some robust intelligence in terms of our good practice, and to identify any areas for improvement. The deep dive audit confirmed that the prone technique was the least often used method of restraint accounting for 11% of all GMMH incidents. This is lower than the NHS Benchmarking data score of 15%. However, use of prone restraint is above the average national weighted population scores for both older adult and adult acute wards. Further work is ongoing to understand why this is and to take any additional steps to reduce this further.

The Positive and Safe deep dive audit also confirmed that seclusion was used as part of a fifth of all violence and aggression incidents. The majority of incidents took place on our Hayeswater ward, which is a Therapeutically Enhanced Medium Secure Service (TEMSS) for women.

There is no comparable NHS Benchmarking data but some comparisons can be drawn with the TEMSS and some of the high secure wards at Rampton hospital in Retford. The audit highlighted that some service users required long-term segregation and a very high level of clinical input and support. Whilst the seclusion policy is followed when service users are segregated, their care is often in an Intensive Nursing Suite with a re-integration plan.

More generally, the use of prone restraint and seclusion is monitored by the Positive and Safe group, which commissions assurance, reports from ward managers where monthly use of restraint and seclusion is highest. These are reviewed by the Positive and Safe team, which provides additional ward level support in strengthening local Safewards interventions as well as reviewing the management of aggression and violence with individual service users where this may be indicated.

During the year, the Trust wide Safewards lead has continued to monitor implementation of the ten Safewards modules across all inpatient settings. A specific Task and Finish group focusing on implementation in Manchester services continues to meet and this has led to a further reduction in blanket rules, strengthening of positive support planning and collaborative debriefs following incidents of aggression or violence.

A system of RAG rating is used to enable the Positive and Safe team and ward and network managers to monitor and strengthen the use of Safewards in their respective areas. In the last quarter, this has included sharing Trustwide learning in relation to the 'calm down methods', 'reassurance', 'mutual help meetings', 'talk down' and 'soft words' modules.

Work is ongoing to Incorporate Safewards into Trust wide training programmes, and ensure the Prevention and Management of Violence and Aggression (PMVA) training and Safewards are closely integrated. The Safewards Lead Nurse is working more closely with the Positive and Safe trainers and the 5-day training course for new starters remains under review. Further steps are planned during 2018/19 to further integrate the Positive and Safe team within the wider Central Nursing Team.

We have also continued to roll out specific PMVA training for staff working with younger people, older people and deaf people. The CAMHS training group monitors training provided across the CAMHS wards. The two-day CAMHS induction training is held quarterly and includes verbal de-

escalation strategies and the CAMHS specific training package produced by the Positive and Safe group last year.

A rolling programme of Older Adults training is in place, which compliments the five-day training course for all new starters. A rolling programme of PMVA training for deaf people is also in place, which compliments the five-day training course for all new starters. All three service specific training programmes will be reviewed early in 2018/19 to ensure fidelity with the Positive and Safe strategy.

During 2017/18, GMMH has further developed service specific feedback surveys and ensured they include Patient Reported Experience Measures (PREMs). There is a program in place to ensure these surveys are uploaded to the existing Friends and Family kiosks that are in all community surveys and inpatient reception areas.

We have embedded a number of Patient Reported Outcomes Measures (PROMs) in services such as Improving Access to Psychological Therapies (IAPT), Substance Misuse, Early Intervention and Adult Forensic. Clinician Reported Outcomes Measures (CROMs) are used (Health of Nation Outcome Scales- HoNOS) in GMMH community mental health services. The Recovery Star is an engagement/PROM that was introduced in GMMH a number of years ago and a small number of services continue to use the tool (mainly Home Based Treatment (HBT) and Rehab services). GMMH has purchased additional Recovery Star licenses and invested in a Train the Trainer programme to support the rollout of training. There is an implementation plan to rollout the Recovery Star across all district acute admission wards.

GMMH has re-established the Care Programme Approach (CPA) meeting and work is underway to harmonise the policy. CPA leads have been identified in all divisions and Terms of Reference have been finalised.

Our Recovery Academy launched its tenth prospectus in 2017/18. There are 56 courses running across GMMH's footprint including North, South and Central Manchester. A Recovery Academy campus has been explored at HMP Hindley, however this had to be discontinued due to factors related to the threatened closure of Hindley. Hindley will now remain open, however, resources are yet to be identified to continue with this work. There had been discussions with HMP Haverigg, however GMMH recently lost the contract to provide services, and therefore this has not been pursued. Ongoing discussions are taking place with the Service Manager for Health and Justice.

The research into the effectiveness of the Recovery Academy is now complete and demonstrates that Recovery Academy courses significantly improved recovery, wellbeing, internalised stigma and social interaction anxiety amongst individuals with lived experience. Exploratory dose effect analyses revealed high doses of courses attended at the Recovery Academy significantly reduced social interaction anxiety amongst individuals with lived experience.

The research concludes that the Recovery Academy effectively supports the recovery and wellbeing of individuals with lived experience of mental health difficulties and can promote resilience to recovery barriers such as internalised stigma. There is a need for further exploration into the influence of Recovery Colleges upon health professionals and family members in order to establish mechanisms for change within these populations.

During 2017/18, we continued to tackle the social stigma associated with mental health and addiction by celebrating our service user's achievements annually as part of National Volunteer Week and the Festival of Learning in June.

The Recovery Academy prospectus includes a course on Tackling Stigma, and the key messages from this course are included in the Trust Welcome Day for new staff and volunteers. Resources from the national reducing stigma campaign led by Time to Change are also included in the Trust Welcome Day to encourage participants to think about how we can challenge the stigma that exists amongst communities but also

within health and social care services. The work of the Recovery Academy, Service User Engagement Scheme and Peer Mentor Project was celebrated at the Trust Annual Members Meeting with the Mayor of Greater Manchester present.

GMMH has celebrated the achievements of the Volunteer Peer Mentor project in Early Intervention Services which was a 12 month funded project commissioned by Health Education England. In January 2017, 16 Volunteer Peer Mentors were recruited, and at the end of the project, 11 had completed their training and are working within teams across Bolton, Salford and Trafford. This now means there are Volunteer Peer Mentors well established in Substance Misuse Services, Early Intervention teams and in wards at the Moorside Unit in Trafford. Plans are in place to support this work moving forward so that we can expand roles across all inpatients services and Community Mental Health Teams (CMHTs)

Case Study Priority 2: Promoting Recovery – Improving Outcomes through the Delivery of Recovery Focussed, Positive and Safe Services

Building competency to deliver mindfulness-based interventions

The Dragon's Den fund does not only support projects once, but often if something has proven successful, the fund is there to provide further support to ensure the initiative can go from strength to strength. This was the case when Dr Rory Allott, Clinical Psychologist in Trafford' Early Intervention Team and Dr Charlotte Morris, from Community Mental Health Services in Bolton approached the Den for almost £10,000 to continue to support the delivery of mindfulness across the Trust.

In 2015, the Dragons provided funding to establish competent mindfulness teachers across the Trust's footprint. The intention was to meet the high demand for mindfulness expressed by both staff and services users. Its impact on recovery, which is a Quality Account priority, has been independently verified many times by researchers and the National Institute of Clinical Effectiveness. The bid was supported by Trevor Cunningham – a former service user - who participated in and more recently co-facilitated the Recovery Academy courses. His personal testimony of the benefits of mindfulness strengthened the bid.

Ten people completed a year-long pathway delivered by the University of Bangor which led to a teacher-training certificate in Mindfulness Cognitive Behavioural Therapy. This has allowed the Trust's Recovery Academy to expand their mindfulness courses and give access to mindfulness for 80 staff, service users and carers, each term. Evaluation of these groups show that they improve wellbeing and are positively received. Course recipients have said "Mindfulness helped me to make sure I focus on my life values" and "It provided me with protected time out of a busy life to reflect on self and develop personally."

Furthermore, these mindfulness teachers have extended their delivery into clinical services, increasing the psychological offer in community mental health teams, early intervention and inpatient areas. To sustain this success and ensure the resilience of the teachers in their own personal mindfulness practice, it is vital they attend regular supervision. The Dragons were happy to support follow-up monthly supervisions for the group of mindfulness teachers. They have also funded further training for two of the original cohort of mindfulness teachers to become supervisors recognised by the UK mindfulness network.

Dr Allott and Dr Morris' bid has futureproofed an extremely valuable resource by offering support and guidance to the teachers, who in turn are helping to increase the offer of effective psychological interventions across the GMMH footprint.

Priority 3: Enhancing Quality of Life of People with Dementia and Older People with Functional Illness

Aim: To improve experiences of older people with mental health problems

Progress, Achievements and review against specified improvement measures:

During 2017/18, we continued to set high standards, and delivered a range of improvement activities across GMMH to enhance the quality of life for people with dementia and older people with functional illness.

We agreed to undertake a process of sharing our strengths and learning from good practice as a high priority across the four districts of Bolton, Salford, Trafford and Manchester. To initiate this, we held an older adult's inpatient effective practice sharing day during April 2017.

Front line clinical staff and managers from a wide range of disciplines attended this event. The day focussed on sharing good practice and challenges within the inpatient services across all areas. GMMH also hosted a Greater Manchester wide inpatient older adult conference in order to support the spread and scale of quality innovation across our dementia and older adult services.

We successfully adapted the focus and membership of our older adult steering group. This has enabled the full participation of our colleagues from Manchester services. We reviewed the remit of the group to ensure that it reflected the changes in both organisational and management structures that took place throughout the year. This group has met regularly during 2017/18.

The Older Adult steering group has robust membership and representation from all areas of GMMH and ensures that learning is discussed and disseminated across the breadth of our services and professional groups. Each meeting has a theme for discussion, which supports shared learning. Themes have included physical health and shared learning from the Royal College of Psychiatry accreditation processes.

Throughout the year, we have facilitated a range of joint education and training sessions, which were identified within the effective practice-sharing day. The training sessions are delivered each month and are promoted across all older adult services. Examples have included our Frontotemporal Dementia, Rapid Tranquillisation and Covert Medication joint education sessions.

We have also hosted practice development sessions within older adult services; this has included a full day pain and dementia workshop hosted by our Practice Development Team at Woodlands. Older adult services have participated in the GMMH 'Quality Matters' programme during 2017/18. Quality Matters is a quality improvement tool, it provides a strategic framework, offering ward to Board level assurance that our services are safe, positive and effective. It is also an effective way to identify good practice, and for sharing strengths across inpatient services.

Older adult services have reviewed and refined the application of both the Mental Capacity Act and the Mental Health Act during the year. An audit was completed across GMMH services on the correct use of T2/T3 forms for our service users who are detained under the Mental Health Act. This audit included capacity assessment recording for service users. An action plan was completed following this audit to improve practice, and a regular programme of re-audit and quality improvement has been agreed. Representatives from older adult services regularly attend the Mental Health Act and Mental Capacity Act Compliance Committee.

We have also strived to ensure that we continue to meet the needs and preferences of older adults from black, minority ethnic and other protected characteristic groups. The Memory Assessment and Treatment Service in Bolton was successful in a bid for transformation funding for new posts to work on improving networks and access to services for our more diverse communities.

Ongoing developments also include a proposal for a new project involving cascade training on dementia within the Asian community. The overall aim of the project is to enable the reduction of health inequality in dementia diagnosis and treatment through the reduction of stigma in the British Asian community of Manchester. We also produced new information about religious beliefs at the end of life, and disseminated this across our services.

Another area of improvement within this priority was to improve transition, reduce risk and promote seamless care between services. This included transition between general adult services and older adult services, memory assessment services and community mental health teams, acute hospitals and inpatient services, and inter-district transitions. To support this activity, the Older Adult Steering Group reviewed the Transfer to Acute Care Policy to ensure that it adequately met our expectations, and disseminated this across our services. A further plan is currently being developed to look at the other transitions from and more widely into older adult services.

During 2017/18, we have reviewed the information we provide with the aim of providing high quality, clear and easy to understand information about all aspects of care including therapies, medication therapies and aftercare placements.

The services now use standardised medication leaflets, which can be downloaded from the 'Choice and Medication' website that GMMH subscribes to. This information is available different languages and formats. We have also ensured that information reviews are fully considered as part of ongoing service development within our older adult services going forward.

Case Study Priority 3: Enhancing Quality of Life of People with Dementia and Older People with Functional Illness

Mobile interactive floor projection

Innovation in supporting people living with dementia and older people with functional illness is improving all the time. There are many examples of digital-based treatments that have helped individuals reconnect with memories and activities, which make them happy and can lead to positive experiences for both the individual, their carers and families.

for those reasons, the Dragons were happy to support a mobile interactive floor projection for older adults at Woodlands Hospital, which provides later life inpatient care. It encourages service users who lead active lives to maintain their healthy lifestyle while in hospital.

The system has many features such as projecting a river or leaves onto the floor, which then move when hands or feet are pressed against them. There is also a football pitch where a ball can be 'kicked' into the goal and a pond to walk through which makes the fish swim. Service Users can also enjoy the quiz setting, where they have to step on the correct answer. If there are service users whose physical restrictions means they are unable to take part in the activities, they can still enjoy watching the moving projections on a table top screen.

The system has been used for a few months on all three wards at Woodlands and the service users are enjoying it. On Hazelwood ward there have been improvements in service users mobility when using the projection and it is providing great sensory stimulation and activity on the more organic wards too.

This system provides real-time multi-sensory experiences and is an incredibly powerful tool. It engages patients in a variety of applications, ranging from relaxing sensory cause and effect, games, learning and educational themes. It will undoubtedly enhance the quality of life for people with dementia and older people with functional illness, which is why the Dragons had no hesitation in supporting this bid.

Priority 4: Physical Health – Improve Assessment and Treatment and Promote Health Improvement

Aim: Improve assessment and treatment of physical health conditions across inpatient and community services to reduce the risks associated for service users, and promote health improvement.

Progress, Achievements and review against specified improvement measures:

Throughout 2017/18, we have continued to improve our assessment and treatment of physical health conditions across inpatient and community services to reduce associated risk and promote health improvement across our range of services at GMMH. We have now incorporated the Trust physical health care monitoring tool (PHIT) with QRisk2 to help improve cardiac risk monitoring. The Trust has invested in the procurement of the QRisk2, ten-year cardiovascular indicator and intends to incorporate this into the electronic patient record. This risk tool has been superseded during the year by the QRisk3, which now makes specific allowances for patients who are prescribed antipsychotic medication.

We have strengthened our obesity care pathways and continues to develop a weight management service. The Trust is currently in discussion with ABL who are a weight management service provider. We are negotiating the development and delivery of a weight management-training programme that will assist the workforce with improving the care of patients who require support regarding weight gain. We have also successfully recruited a Band 5 dietician who commenced employment in March 2018.

We have ensured compliance with Hospital Food Standards to encourage service users to make healthier food choices and are now fully compliant with Hospital Food Standards across all areas with the exceptions of Laureate House and Park House. High level discussions and menu amendments are being worked on to achieve this in conjunction with the host trusts and SLA providers In addition to this, we have reviewed our external contracts for hospital food provision and have increased our internal capacity to deliver this. An example of this is Trafford services who historically had their food provided by an acute trust but this is now completed and delivered by Trust catering services, giving us greater control over the quality of the meals our patients receive.

We have worked hard during the year to improve end of life care/palliative care and bereavement support for service users and carers. The Trust has a dedicated group of professionals which meet regularly to improve the quality of end of life care in GMMH services. Guidelines for practice have been developed and relationships have been formed with the Bereavement Service at Salford Royal Hospital. The Trust has recently advertised for a Bereavement Nurse and recruitment is ongoing.

We have provided motivational interviewing training to offer staff the necessary skills to support service users to make lifestyle changes associated with risk behaviours. We continue to provide training for brief interventions associated with risky behaviours such as smoking and excessive alcohol consumption. At the present time, we have trained 411 staff and have dedicated nurse champions in each of our services to lead this area of work.

We have appointed a Quality Improvement Lead Nurse who oversees the implementation of the nationally mandated Service Development Improvement Plan for smoke free premises, and have invested into the implementation of an internal smoking cessation service. Bespoke training for smoking cessation within mental health will be developed, to ensure appropriate delivery of interventions for our patient group.

We continued to provide enhanced physical skills training for our nursing workforce. We have commissioned a number of educational programmes from our local higher education providers and deliver these on a regular basis. We also are in the process of expanding the essential skills training available for our nursing support workers.

We have worked to reduce the harm associated with falls through the development of a falls prevention e-learning package and ‘falls prevention care bundle’ that will be delivered in high risk areas. The falls care

bundle has been embedded within the Trust falls policy and this is in the process of being included within a falls prevention e-learning package. We have also implemented a speech and language therapy service for our specialist services. Our early focus has been within Child and Adolescent Mental Health Services (CAMHS). However, we are currently in the process of reviewing the resources available within our forensic services to ensure that this is used in the most appropriate way.

During the year, we have also ensured access to necessary physical healthcare assessment and monitoring equipment across GMMH. New equipment has been invested into our community teams in Manchester. We have also continued to work with our commissioners to strengthen communication with GPs to reflect physical health priorities.

Case Study Priority 4: Physical Health – Improve Assessment and Treatment and Promote Health Improvement

Healthy mind, healthy body

GMMH is proud to host one of only three national mental health and deafness centres in the UK. One in seven people with hearing issues will suffer from a mental illness as well, and our John-Denmark Unit (JDU) provides inpatient and community care for those living with deafness and mental health issues.

By listening to feedback during weekly community meetings and weekly patient forums, patients asked if it would be possible to have exercise equipment on site. Many patients wish to engage in exercise in order to activate natural endorphins and improve their mood and feelings of wellbeing. Others have felt this would be a useful activity for evenings and weekends, while others believed it would alleviate some of their symptoms such as restless legs and muscle cramps.

Whilst the unit does not have internal spaces to accommodate a gym, there are paved areas within the large garden area where outdoor equipment could be used, similar to park gyms, which promote healthy living for all.

One of the groups that the Occupational Therapy team currently facilitates is based on the Five Ways to Wellbeing – Connect, Be Active, Take Notice, Keep Learning and Give. The introduction of outdoor equipment would assist patients in achieving all these aims for example, connecting with their environment and their fellow patients; being active on the equipment; noticing the beauty of the garden as they exercise and giving back to the unit by encouraging other patients to take part.

With the Dragons' support, JDU have purchased a bicycle and an elliptical cross trainer. These will be situated in the main JDU garden and can be accessed by both male and female patients, allowing them to take part in exercise, in attractive, outdoor surroundings. This facility at the JDU truly promotes health improvement.

Priority 5: Reducing the Number of Service Users Placed Outside of the Local Area for Care and Treatment

Aim: Ensure effective use of the local health and social care system to reduce the need for out of area placements (OAPs) and promote 'place based care'.

Progress, Achievements and review against specified improvement measures:

In the last 12 months GMMH have had a dedicated, focussed work stream on OAPs and patient flow. This commenced with the acquisition of Manchester services in January 2017 and led to the appointment of the Strategic Lead for Patient Flow to further support this work.

Over the last 12 months a deep dive was commissioned, sponsored by the Executive Team, to investigate, interrogate, synthesis, analyse and report on a wide range of data in relation to patient flow within the acute care pathway. As a result, all GMMH divisions now focus on the fidelity of the Acute Care Pathway and patient flow within the inpatient services via their Senior Leadership Team meetings, as well as within the Trust-wide and local Bed Management Meetings.

In addition to all the work currently undertaken by GMMH to create acute and PICU inpatient capacity and reduce the use of Out of Area Placements (OAP's), a Trust-wide Patient Flow Group, chaired by the Executive Director of Operations for GMMH, and attended by senior leaders and clinicians from all GMMH divisions has been established.

This group also links to the new Greater Manchester wide OAPs group, chaired by the Executive Director of Operations from GMMH and with the Executive Director of Operations for Pennine Care NHS Foundation Trust acting as Deputy Chair. There is also representation from all Greater Manchester CCGs and supported by the Greater Manchester Combined Authority (GMCA). All activities follow a Ten-Point Plan to eliminate OAPs.

Point 1: Create whole system collaboration on the objective of eliminating OAPS with every provider and commissioner (health and social care) having executive sign up to the plan. This has been achieved as described above by establishing a GMCA supported, Greater Manchester (GM) wide forum chaired by Executive leadership from providers, including clinicians and representatives of all CCGs. A provider forum has also been established with other providers of GM mental health services. GMMH's own group is multi-disciplinary.

Point 2: Agree a GM definition of an OAP and a trajectory that will eliminate the need for OAPS. This definition has now been agreed and supported by the GM Adult Mental Health Board and discussed with NHSE. Agreement of this will then enable the development of a realistic trajectory for the elimination or reduction of all GM OAPs by 2020.

Point 3: Agree a data set that demonstrates elements of patient flow (inpatient and community) across GM and introduce regular data and monitoring systems. Work has been ongoing within the Trust to produce a suite of reports that enable the demonstration of patient flow within all services. This includes weekly reports on OAPs per division, activity on admission and discharges per division, length of stay per division as well as finance information that helps identify costly placements and priority repatriations.

GM wide work is ongoing with Business Intelligence leads at GMCA to develop information and data sets to support the work required to monitor OAPs both outside and inside GM and a range of other fields to aid the development of actions to support patient flow.

Point 4: Agree and implement GM standards that achieve fidelity of an effective Acute Care Pathway including decision to admit protocols and discharge planning. Both the local and GM wide work programmes contain an action to develop standards that support the effective management of service users

within the Acute Care Pathway. This includes the expectations of practice for a Care Co-ordinator, regardless of the place their service user is admitted, as well as monitoring and ensuring all agreed standards for fidelity to the pathway are met.

These include increased visits if becoming unwell, medical review, robust gate keeping processes, admission and discharge rights. To support timely discharge and create capacity GMMH have undertaken a review of the existing daily service user's reviews, board rounds and ward rounds including documentation used. During March 2018, an audit will be taking place on some elements of the Acute Care Pathway.

Point 5: Agree standards with all NHS providers for bed management and create a GM Bed Bureau that includes real time data. Work is ongoing locally for options within GMMH that will interface with GM wide solutions to bed management when agreed. This will include an IT infrastructure to support real time data and reporting processes to support requirements. GMMH also has a system in place to ensure that all inpatient resources across the Trust are reviewed before an OAP is authorised. The Strategic Lead for Patient Flow has developed guidance for on call managers regarding patient flow and the use of an OAP, which includes an escalation process to ensure that no service user is placed in an OAP unnecessarily

Point 6: Respond to the findings of the Crisis Concordat work to understand the current response to crisis care and what is required to fill any gaps. Greater Manchester Police (GMP) is leading this work, and the GMMH Trust Wide Patient Flow forum is linked into the work stream via Associate Director membership. This enables GM level Crisis Care Concordat work to feed locally into the GMMH group. This has directly supported a range of initiatives including exploration of the use of crisis beds in Manchester and re-provision of pathways for access in Bolton. This work will also feature on the work plan for the GM Wide OAPs group.

Point 7: Establish the availability of adequate housing, including specialist supported housing and how specialist care packages are agreed and develop collaborative proposals across Greater Manchester to fill these gaps. The local GMMH forum is exploring Community Sustainability Models that include crisis beds (as outlined above) and supported housing options that release capacity in the acute bed base. The Greater Manchester wide OAPs forum will also look at developing proposals for Greater Manchester wide solutions to some specialist placements required within the Greater Manchester economy.

There is a focus on service users with a length of stay (LoS) over 150 days across the Trust's adult and older adult wards including PICU. A review was undertaken to identify themes and barriers to discharge. This is being progressed via professionals meetings and case conferences for complex cases with all key stakeholders involved in the service users care, including GMP, Housing, Local Authority (LA) and Learning Disability professionals (or others) as required to progress discharge for these service users.

GMMH, CCG's, the City Council and Local Authorities continue to work closely as part of the Section 75 agreements, to streamline funding processes. GMMH are continuing to work closely with other providers to develop appropriate pathways and flow. GMMH are also reviewing the Rehabilitation pathway, and have already identified clear discharge pathways for current service users in rehabilitation beds. These are in the process of being progressed to discharge to create additional capacity within the rehabilitation services.

This will increase availability of specialist rehabilitation beds for those service users identified as clinically appropriate for rehabilitation and support the reduction of out of area placements. The Bolton directorate have progressed the development of Honeysuckle Lodge, which is a specialist locked rehabilitation facility for females, which officially opened on 10 May 2018.

Point 8: Continue to learn from others and share the Greater Manchester experience. In order to optimise learning from good practice models elsewhere in the country a dedicated element of the work plan is to review the models of good practice elsewhere and take the learning points into the actions for both forums. Visits have already been made to Manchester Royal Infirmary and Cheshire and Wirral Partnership regarding their bed management systems and making contact with trusts that have demonstrated good practice in this area such as Bradford and Sheffield.

Point 9: Evaluate the effectiveness of the Greater Manchester plan and the impacts on service users, their friends and family. The Greater Manchester Providers will be specifically considering service user and carer participation in relation to best practice standards. A process of evaluation underpins both forums and is essential to the effectiveness of the pathways developed. This includes the development of protocols and standards that support the access of families and carers to their loved ones should they be placed out of their home area.

Point 10: To establish the costs of OAPS and develop systems to reduce this. GMMH have the overall management responsibility of the cost of all OAPs in the Manchester Services. In order to optimise this GMMH have opened 2 wards, in the last 12 months, within its own bed base. These wards are in Salford and Prestwich, and offer both male and female provision for service users who previously would have been placed in expensive OAPs outside the Greater Manchester footprint.

The GMMH Trust Wide Patient Flow Group is working to develop finance information that supports the current data in order to be able to manage and plan a reduction within this. Conversations are also underway with other GMMH CCG colleagues for a similar risk share for the management of OAPs costs. The Greater Manchester wide forum will also look to ways of effectively managing the costs of OAPs with a view to an overall GM reduction. GMMH Trust Board recognises that the management of OAPs is one of its top priorities and as such the above actions have been developed to enable robust operational management whilst ensuring a high quality of care is delivered to the service users and their families under the care of GMMH services and ultimately across GM.

Case Study Priority 5: Reducing the Number of Service Users Placed Outside of the Local Area for Care and Treatment

Exercise referral scheme

One of the main priorities across the Trust is to reduce the number of people going out of their local area for care and treatment. One of the bids has recognised this issue from the author's experience of working in an Accident and Emergency department (A&E).

Will Reekie, a Mental Health Liaison Nurse, saw that many people who required a hospital admission found their mental health deteriorating and risk increasing because they did not meet the threshold for community or home-based mental health treatment, were experiencing long weighting times to access IAPT. Left to their own devices, their condition worsens and was not addressed until they presented to A&E having harmed themselves or reporting symptoms which require admission.

Will has devised a scheme that could potentially fill this void. He felt that if people were helped sooner they would not deteriorate and admissions will decrease, reducing waiting times and potentially the amount of referrals. In turn, this would ease the pressure on beds and reduce out of area admissions and inappropriate waits in medical beds.

Will is a runner and four years ago, he joined a running club where he noticed the emphasis on inclusivity and providing a safe environment for people to enjoy exercise with others. He has also observed how running and being a member of such a supportive community has impacted so positively on other's people mental health.

Within A&E, Will sees high-functioning individuals who need support in managing their stress, but are unable to access help. They may not want or need medication and many are reluctant to engage in talking therapy. Will often talks to them about making healthy lifestyle choices, but most do not have the motivation to apply these changes without support. Depression and anxiety co-exist with low self-esteem, social isolation, a lack of confidence and poor motivation; but with the appropriate support most people within this cohort are capable of adopting healthy lifestyle choices and engaging in exercise.

With the Dragons' support, Will has begun a running group, incorporating the NHS Couch to 5K app (an evidence-based approach for non-runners to begin running, three times a week with the aim of achieving a 5K run). The group offers no specific mental health intervention, but are facilitated by experienced mental health practitioners to promote a positive environment and encourage informal discussion and support for participant's mental health needs.

BBC North West filmed one of the group's sessions in January, talking to Will and the group participant about their experience so far, and the impact the group has had on their mental health. One of the participants told the BBC that: "The exercise is definitely part of therapy, I would see it as part of treatment".

Another said "This encourages you to make those steps, especially if there's a sense that the NHS is involved".

Priority 6: Further Improve the Effectiveness of Improving Access to Psychological Therapy (IAPT) Services Across the GMMH Footprint.

Aim: To understand the determinants of effective treatment and use this learning to improve the effectiveness of all our services

Progress, Achievements and review against specified improvement measures:

Over the course of the year, we have continued to analyse the variation in effectiveness both within and between our IAPT services. The table that follows shows recovery figures by year (current year to date: to January 2018) and an average for the ten Clinical Commissioning Groups (full pathway) in the relevant Index of Multiple Deprivation (IMD) determined decile (2015-2016) for comparison.

GMMH Salford and Manchester figures are Step 3 only, .i.e. part of the Clinical Commissioning Group pathway. Recovery for the Step 2 and 3 combined services shows 57.0% (of a year-end estimated 3,448 people completing therapy). Recovery for the two Step 3 only services, combined, shows 30.4% met the recovery criterion (of a year-end estimated 4,517 people completing therapy). The overall Trust recovery figure is 49.1% of the estimated 7,964 people completing therapy, within the four services.

Recovery %	IMD Decile	2015-16	2016-17	2017-18
Bolton	46.1	43.5	52.8	58.8
Manchester	41.7	20.4	21.6	23.7
Salford	43.1	39.9	41.1	44.1
Trafford	47.8	53.5	54.9	55.5

All services show continued improvement on previous years. Both Bolton and Trafford are compliant with a 50% expectation, and show significantly better recovery than comparable Clinical Commissioning Group areas. Salford (Step 3 only) have achieved better recovery than comparable Clinical Commissioning Group pathways (Step 2 and 3 combined).

Manchester continue to show significantly lower recovery than comparable Clinical Commissioning Group areas. Three services with explicit performance expectations, broken down to practitioner level, show considerably better effectiveness than the service without such individual goals. Next year we will seek to develop the performance dashboards, to practitioner level, available all services to aid engagement to meaningful performance goals and hold to account.

During 2017/18, we have ensured that our pathways have been redesigned to be accessible, acceptable and optimally effective in respect of local population and national targets. The IAPT pathway has been redesigned and an integrated Manchester Psychological Therapy Service launched in the Central, North and South localities of the city.

A new patient clinical management information system (PCMIS) has been implemented in Manchester during October to December 2017 and will be live in the other districts from April 2018. Alongside an enhanced leadership structure in Manchester, with performance expectations being held explicitly to account, conditions are in place to enable improved needs-led performance over the coming year.

We have worked hard throughout the year to improve the clinical effectiveness of our service delivery by demonstrating 60% reliable improvement across all localities. Reliable Improvement (RI) data for year to date show compliance for three services. This is highlighted in the table below:

Reliable Improvement %	IMD Decile	2016-17	2017-18
Bolton	62.9	65.4	71.7
Manchester	59.2	48.6	49.5
Salford	60.4	61.1	63.2%
Trafford	62.7	70.1	69.3

The combined RI for the two Step 2 and 3 integrated services shows 77.3% (of a year-end estimated 3,448 people completing therapy). Combined RI for the Step 3 only services, shows 54.0% (of a year-end estimated 4,517 people completing therapy).

Therefore, the overall Trust recovery figure is 63.4% of the estimated 7,965 people completing therapy, within the four services. RI is used to indicate a reduction in recorded level of distress, which is too large to be explained by random variation, i.e. is indicative of meaningful positive change.

We have continued to reduce waiting times for IAPT services to meet national targets for 75% of patients to be seen within six weeks, and 95% of patients in 18 weeks. The two tables, below, show Bolton and Trafford maintaining compliance with six and 18-week access targets.

Both Manchester and Salford showing gradual improvement towards independent compliance. Meaning 661 more people accessed the Salford service within 18 weeks, than last year; 487 more accessed within six weeks. In Manchester, 496 more people accessed within 18 weeks; 267 more within six weeks.

75% within 6 weeks	2015-16	2016-17	2017-18
Bolton	92.4	87.8	80.8
Manchester	25.0	21.0	30.2
Salford	53.3	54.3	61.0
Trafford	83.8	83.4	88.3
95% within 18 weeks	2015-16	2016-17	2017-18
Bolton	100.0	99.9	99.8
Manchester	57.2	69.2	86.7
Salford	88.6	92.6	93.3
Trafford	97.8	98.0	98.4

Throughout 2017/18 we have supported the development of service models in localities with commissioners for delivery of integrated IAPT services. The North Manchester Long Term Conditions (LTC) Pilot has been implemented and is delivering care to people with co-morbid LTC and common mental health problems.

The service model will form the basis of developments in Central and South Manchester. Similar service models, capable of meeting the needs of this population, in the other boroughs we serve, are reliant on funding being finalised from commissioning colleagues.

Case Studies Priority 6: Further Improve the Effectiveness of Improving Access to Psychological Therapy (IAPT) Services across the GMMH Footprint

Visual graphic toolkit for low intensity CBT intervention

Michael Safranek, a Psychological Wellbeing Practitioner approached the Dragons for funding to address a situation he came across in the Working Well Talking Therapies Service. Michael helps to deliver Cognitive Behavioural Therapy (CBT), which often entails the use of workbooks and diaries that require a basic level of literacy. This can cause problems for people who do not speak English as their first language, or have dyslexia or other literacy difficulties. These groups of people found it difficult to access CBT and may have lower recovery rates, inappropriate treatments or require longer and higher step courses of treatment. They may even drop out of treatment or decline a referral if their literacy issues caused them concern.

Many CBT interventions are behavioural and it is possible to illustrate these without the use of text, providing a universal resource that can be used regardless of the literacy levels or language spoken by the service user. It would also save clinicians time searching for translated materials or adapting treatment. Michael identified resources to produce CBT materials using as few words as possible and wherever possible, would be wordless. This will reduce reading requirements and the need for translation. Worksheets and booklets would be used in therapy sessions with a therapist to discuss them and explain what the images refer to. They would also serve as a reminder of key points outside of sessions.

Research has found that using text and images results in significantly higher scores in memory tests compared to participants who were given the same information in a text-only format. Given that CBT is a learning model, the use of materials which helps that learning process should be a priority – one that the Dragons were happy to support – particularly as it aimed to help more people to access this kind of therapy.

3.2 Performance against Quality Indicators Selected

This section of our Quality Account provides an overview of quality as demonstrated by a range of indicators.

The indicators cover the three domains of quality (experience, effectiveness and safety). Please note that data for 2016/17 relates only to the former Greater Manchester West Mental Health Foundation Trust. GMMH is a significantly larger organisation following the acquisition of MMHSCT during 2016/17, and this will be a contributory factor for any variance in the data reported. For the Patient Led Assessment of the Care Environment (PLACE) and Community Mental Health Survey scores, please also note that there were changes to the data collection and reporting systems from 2016/17 onwards.

Patient Experience	2016-17*	2017/18	Comments
PLACE inspections - The assessment evaluates cleanliness, condition/ appearance, privacy and dignity and food.	92.45%	93.10%	Source: Figure taken from PLACE formal assessment inspection results published by NHS Digital
Complaints – total number of complaints received per 10,000 recorded service user contacts	7.7	8.8	Source: PARIS and Datix (As of Dec 2017)
Compliments – total number of compliments received per 10,000 recorded service user contacts	14.7	13.4	Source: PARIS and Datix (As ofDec 2017)
Clinical Effectiveness	2016-17*	2017/2018	Comments
Community Mental Health Survey - % of responses that rated the services received from our Trust as good, very good or excellent	Score - 66.9%	Score - 69.3%	Source: CQC (Community Survey 2017 Results, Q40, Rank 7-10 as % of Ranks 0-10)
Friends and Family Test – Service users – % of Service users who responded as "Extremely Likely" or "Likely".	86.7%	75.8%	Source: Friends and Family Service Users Submission to Unify (as of Dec 2017)
Total staff sickness absence (%) – rolling 12-month position	5.5%	5.9%	Average sickness rate for Mental Health / Learning Disability Trusts in the North West is 6.8% Source: Board Performance Report (January 2018) via Electronic Staff Record (ESR)
Safety	2016-17*	2017/2018	Comments
Degree of harm incurred by service users in incidents reported to the National Patient Safety Agency - % of all incidents reported that resulted in no obvious harm	78.3%	78.3%	Source: Datix (As at Dec 2017)

Safety	2016-17*	2017/2018	Comments
% of all patient safety incidents that resulted in severe harm or deathin no obvious harm	0.4%	1.5%	Further information on this indicator can be found in Section 2.10.7 of this Quality Account Source: Datix (As at Dec 2017)
Number of under 18s admitted to our adult mental health inpatient wards	4	10	Source: Board Performance Report (Dec 2017) figures only Apr – Dec 17

3.3 Performance against Key National Priorities

We always work hard to deliver all relevant national priorities and targets. Our performance against the mental health indicators set out by the Department of Health in 'Everyone Counts: Planning for Patients 2015/16 – 2018/19' and by NHS Improvement (NHSI) in the Single Oversight Framework are summarised here. We are registered with Monitor, the regulatory body for foundation trusts and have consistently achieved all required targets and standards for continued registration. The Single Oversight Framework introduced in October by the NHSI replaces the Monitor Governance and Financial Risk ratings. We are currently rated at Level 3 (month 11) for the Finance and Use of Resources metric.

Similarly, we are registered with CQC without conditions, complying with all regulations. We have established robust mechanisms for monitoring compliance against all the outcomes detailed in the CQC Compliance Guidance to provide ongoing registration assurances. We are compliant with the NHS Quality Risk Management Litigation Authority Standards.

Patient Experience	Target	2016-17*	2017/18	Comments
Early Intervention in Psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	>=50.0%	85.1%	74.3%	Updated as per March Board Report
Ensure that cardio metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:				
a) inpatient wards	90% for 2017/18	94% (data identified from final CQUIN activity report)	Data not yet available**	For 2015/16, this audit only included inpatient services The 2017/18 data is not available at the time of writing this report. Please see the note below.
b) Early Intervention in Psychosis services	90% for 2017/18	62% (data identified from final CQUIN activity report)	Data not yet available**	The 2017/18 data is not available at the time of writing this report. Please see the note below.
c) Community Mental Health services (people on care programme approach)	65% for 2017/18	65% for 2017/18	Data not yet available**	The 2017/18 data is not available at the time of writing this report. Please see the note below.
a) proportion of people completing treatment who move to recovery (from IAPT dataset)	>=50.0%	46.3%	41.2%	Updated as per March Board Report

Patient Experience	Target	2016-17*	2017/18	Comments
b) waiting time to begin treatment (from IAPT minimum dataset): i. within six weeks of referral	>=75.0%	72.4%	61.8%	Updated as per March Board Report
b) waiting time to begin treatment (from IAPT minimum dataset): ii. within 18 weeks of referral	>=95.0%	95.0%	93.7%	Updated as per March Board Report
Care programme approach (CPA) follow-up: proportion of discharges from hospital followed up within seven days	>=95.0%	98.3%	96.5%	Updated as per March Board Report Of the 1,595 discharges from our adult services during 2017/2018, 1,539 were followed up within seven days.
Admissions to adult facilities of patients under 16 years old		0	0	
Inappropriate out-of-area placements for adult mental health services****		N/A	242*****	The figure has been calculated as follows: • 110 inappropriate OAPs in January (complete) • 67 inappropriate OAPs in February (complete) • 65 inappropriate OAPs in March

* This data relates to the former GMW Trust only
** Please note that GMMH scores for 2017/18 will be provided as part of the National Clinical Audit of Psychosis report, published by the Royal College of Psychiatrists. The report is expected to be published by 30 June 2018
*** Please note that GMMH scores for 2017/18 will be provided as part of the National Early Intervention in Psychosis report, published by the Royal College of Psychiatry. The report is expected to be published by 30 June 2018
****As this indicator has only been in the Single Oversight Framework from November 2017, mental health NHS foundation trusts are only required to report performance in the quality report for Quarter 4 (1 January 2018 to 31 March 2018).

With regard to out of area placements (OAPs), the Trust Board recognises that the management of OAPs is one of its top priorities. GMMH has agreed a range of actions to enable robust operational management, whilst ensuring a high quality of care is delivered to service users and their families under the care of GMMH services and ultimately across GM. All activities follow the Ten-Point Plan, as detailed within Section 3.1 of this Quality Account.

A recovery plan has been put in place to address each of the areas highlighted above, where performance falls below the required target.

Priorities for Quality Improvement in 2018/19

This section of the Quality Account sets out our priorities for improvement that we intend to deliver during 2018/19. These priorities were identified as part of an engagement and consultation process, which involved staff, service users, carers, our Governors, Healthwatch colleagues from Bolton, Manchester, Salford and Trafford, and other external stakeholders. We also took into account some key themes and issues that have been identified during the year by our Quality Governance Committee, and reflected on the findings from our recent CQC inspection report.

4.1 Consultation feedback

Our discussions around potential Quality Improvement Priorities commenced at the beginning of January 2018. This started with a four way Healthwatch meeting where a range of themes was suggested. The themes included important issues such as care planning, carer feedback, the Mental Health Act, medications, spiritual care homelessness, access to care, physical health, recovery, dementia and transfers of care, among many others.

These suggestions were explored further during discussions with our stakeholders throughout January to March 2018. It was felt that both IAPT, and out of area placements could be discontinued, as both would continue to be subject to rigorous performance management, therefore maintaining a high profile. There was a consistent view throughout this time suggesting that we should maintain the four remaining priorities from 2017/18. It was unanimously agreed that we had made excellent progress against each of these, but our stakeholders also felt that we should maintain our focus by adding in some new stretches and improvement measures. As a result of this engagement, it was decided that the four priorities we would maintain were to include:

- Listening to, Learning From and Acting on Service User and Carer Feedback
- Enhancing the Quality of Life of People with Dementia and Older People with Functional Illness
- Improving Outcomes through the Delivery of Recovery Focussed, Positive and Safe Services
- Improve Physical Health Assessment and Treatment and Promote Health Improvement

During March and early April 2018, we identified leads for each of the six themes. The leads consulted with operational and clinical colleagues at key meetings, and developed each theme into an improvement priority with an agreed aim, and a set of SMART improvement measures so that robust monitoring can take place. Our monitoring arrangements are set out in Section 4.3 of this Quality Account.

4.2 Improvement Priorities 18/19

The Quality Improvement Priorities for Greater Manchester Mental Health NHS Foundation Trust during 2018/19 include the following:

Priority 1 - Service User and Carer Experience	
Quality domain	Service User Experience and Effectiveness
Priority for Improvement	Delivering Service Improvements by Listening to and Learning from Service User and Carer Feedback
Aim	We will strengthen how the organisation listens and responds to service user and carer feedback, ensuring that any innovative learning is shared. We will continue to expand the CARE Hub and ensure related outcomes triangulate with quality improvements initiatives.
Improvement measures	In 2018 /19 we will: • Relaunch and deliver our refreshed Service User and Carer Engagement Strategy 2018-2021. • Utilise national guidance and further develop the different levels of service user and carer participation across the organisation. • Relaunch and deliver our refreshed Family and Carers Strategy 2018-2021 • Launch the 'Hidden Carers Campaign', which aims to identify hidden carers regionally and signpost those to the right support. • Establish support networks for staff who have a caring role. • Develop pathways to strengthen connections between user and carer groups and the CARE Hub, establishing qualitative feedback and relating this to the organisations quality improvement work. • Support user and carer groups to develop peer and national networks • Develop a programme of eliciting service user and carer stories; utilising these stories to support staff morale, establish learning and identify and evaluate service improvements. • Increase the number of peer mentors in services and further expand these roles in areas such as Community Mental Health Teams. • Relaunch the volunteer policy and benchmark the Trust against the National Investors in Volunteer Standards . • Strengthen how the organisation learns from complaints, service user and carer feedback and engagement activity. Introduce learning conversations and initiatives such as seven-minute briefings. • Work with Organisational Development to explore the training needs of staff emerging from themes and trends identified by the CARE Hub, ensuring any related training is co-designed and co-delivered with service users and carers. • Co-produce a spiritual wellbeing strategy with service users and carers. • Co-produce an equality and diversity strategy with service users and carers. • Establish engagement networks with service users and carers with protected characteristics. • Triangulate data and information including incidents and service user safety with the CARE Hub activity and outcomes.

Priority 2 – Recovery Focussed, Positive and Safe Services	
Quality domain	Effectiveness, Safety and Service User Experience
Priority for Improvement	Promoting Recovery and Improving Outcomes through the Delivery of Positive and Safe Care.
Aim	To improve outcomes through the implementation of a Safewards strategy, and delivery of recovery focussed, positive and safe care across our inpatient wards
Improvement measures	In 2018 /19 we will: • Develop and implement a Safewards strategy to clearly articulate our approach to reducing restrictive interventions across GMMH and embed into our service training and development programmes. • Incorporate Safewards into Trust-wide training programmes including PMVA training, and ensure that this provides guidance for de-escalation, post-incident debriefs, care plans, risk management plans and management of self-harm. • Include principles of trauma informed care into our PMVA training. • Explore through the Trust CareHub, the relationship between patient reported satisfaction and use of restraint, using the outcomes to review practice. • Produce a Safewards 'Big Book of Best Practice' to share innovation and influence the ongoing development of the Positive and Safe programme . • Ensure that we review our Positive and Safe ward dashboards to prioritise areas that may benefit from dedicated support including implementation of Safewards modules, and continue to promote effective use of dashboards within inpatient services to embed learning and enable benchmarking. • Continue to identify our highest reporters of restrictive interventions with service leads at the Positive and Safe forum, supporting a culture of positive leadership and professional practice, which keeps people safe, promotes recovery and provides assurance that we apply the least restrictive principles in the delivery of care. • Identify a virtual team with expertise around both Safewards and Positive and Safe activity to support implementation and maintenance of approaches. • Monitor the use of restrictive interventions with a specific focus on gender, age and ethnicity. • Undertake a re-audit of our positive and safe approach across GMMH to support ongoing quality improvement and delivery of recovery focussed, positive and safe services.

Priority 3 - Dementia and Older People	
Quality domain	Effectiveness, Safety and Service User Experience
Priority for Improvement	Enhancing the Quality of Life for People with Dementia and Older People with Functional Illness
Aim	Improve experiences of older people with mental health problems.
Improvement measures	In 2018 /19 we will: • Facilitate effective practice sharing days for Continuing Professional Development and use these to encourage shared learning across the districts. • Ensure that dementia and older adult services are engaged in a range of quality improvement initiatives. and that good practice, quality innovation and service improvement is reported at each of the district Senior Leadership Teams. • Continue to review and refine the application of the Mental Capacity Act and Mental Health Act to ensure competency in undertaking robust capacity assessments, and in appropriate use of Deprivation of Liberty Safeguards. • Ensure that we identify and respect the needs of Black and Minority Ethnic groups and other protected characteristic communities across our older adult services. • Continue to take steps to improve transition between services, to reduce risk and promote seamless care. This includes transition between general adult services and older adult services, Memory Assessment services and Community Mental Health Teams, acute hospital and inpatient services, and inter-district or Trust transitions. • Commence project work to inform older adult teams on the use of intra venous fluids within our wards, including the development of clear staff guidance. • Review the NICE guidance for dementia to map our services against stringent national quality standards, taking steps to address any areas where our services fall short of the required quality standards. • Ensure that learning from wards that have been accredited by the Royal College of Psychiatrists is applied across all older adult inpatient services, and that support is provided to the older adult wards that are currently preparing for service accreditation. • Undertake a review of the defined pathways for older adults with emotionally unstable personality disorder to ensure clear alignment with the GMMH Personality Disorder Strategy. • Fully engage with the GM Dementia United strategy and work programme.

Priority 4 – Improve Physical Health Assessment and Treatment and Promote Health Improvement	
Quality domain	Safety and Effectiveness
Priority for Improvement	Supporting Improvements in our Service Users' Physical Health, including Improving Assessment and Treatment and in Positive Health Promotion
Aim	To refine our systems and ensure that we continue to improve the assessment and treatment of physical health conditions, and to promote innovative health improvement approaches including signposting our service users to relevant services
Improvement measures	In 2018 /19 we will: • Develop a strategy to clearly articulate the Trusts commitment to physical health and wellbeing. • Improve the care provided to diabetic patients through the delivery of care bundles, building on progress that has been made. • Review the service level agreement for podiatry services to ensure that it is appropriate for our service user population. • Complete a review of the tissue viability service level agreements to ensure that it meets the needs of our service user population. • Continue the review of the end of life care provision across GMMH services, building on progress that has been made to date. • Enhance the skills of the nursing workforce in order to reduce the need for transfers of care in our older adult services. We will start to address this in 2018/19 by training our older adult nurses around the use of IV fluid for rehydration. • Implement a consistent approach to Early Warning Score monitoring which is in line with National Guidelines. • Develop a standardised approach to the delivery of cardio metabolic risk training across the organisation. • Implement a smoking cessation service that will support our service users and staff to reduce the harms associated with smoking behaviour. • Develop, deliver and evaluate a weight management intervention to support our service users in Early Intervention Teams. • Develop a mobile application which supports our service users to manage their own physical healthcare.

Priority 5 - The Development of a Personality Disorder Strategy and Framework	
Quality domain	Effectiveness, Safety and Service User Experience
Priority for Improvement	Delivering Service Improvement by Producing a Framework to Inform our Approach to Service Users with Personality Problems either as their primary diagnosis or as an important aspect of a complex clinical presentation
Aim	Improving the clinical effectiveness of all Trust services and practitioners working with service users of all ages with personality problems
Improvement measures	In 2018 /19 we will: • Work with the relevant department to undertake a survey using the Personality Disorder Institute's Knowledge and Skills Questionnaire (PD-KASQ) on the knowledge, attitudes and skills of practitioners in services across GMMH in relation to personality disorder. • Work with Organisational Development and the Recovery Academy to create a highly visible personality disorder learning stream from existing courses and use these as a basis for the development of new and helpful courses to support practitioners and service users. • Work with the Organisational Development to increase the number of Knowledge and Understanding Framework (KUF) training courses and trainers, and the attendance of practitioners on courses scheduled. • With the assistance of the Communications team, develop a website to support and promote the current work (containing news and resources for people with personality disorders and the practitioners working with them) and examine options for making use of social media to support this endeavour. • Undertake a review of clinical supervision data for services across the Trust, and develop clear guidance for clinical supervision aimed at practitioners working with people with personality disorder. • Via the CAREHub, support the ongoing development of service user networks and support groups that enable clients with personality problems to express their opinions of services, provide feedback on their experiences and make suggestions for improvements. • Support cost neutral training and supervision initiatives across the Trust for specialist interventions for people with personality problems that fit with the objectives of this framework, with particular attention to Structured Clinical Management. • Explore the viability of having service users in a position to choose from at least two options where a specialist intervention for personality disorder is recommended. • Work with the Paris team to develop a formulation tile, which can be used as a basis for generating formulation-based interventions for service users, ensuring that all interactions are underpinned by an understanding of the person and the difficulties they encounter. • Identify how eligibility criteria for CMHTs and IAPT services supports the care of people with personality problems, and explore any barriers to how this support is currently accessed. • Map where people with personality problems can access support in the event that they are not eligible for access to mainstream Trust secondary mental health services and work on ways of improving access.

Priority 6 – Improving the Quality and Effectiveness of Service User Care Plans	
Quality domain	Effectiveness, Safety and Service User Experience
Priority for Improvement	Improving the Quality and Effectiveness of Service User Care Plans
Aim	To ensure that there is effective engagement and collaboration with service users and carers in the development of personalised care plans, and that service users and their carers are aware of their rights and responsibilities in relation to care planning.

Improvement measures	In 2018 /19 we will:
	• Develop a steering group with involvement from service users, carers and professionals to drive quality improvements around our care planning approaches.
	• Review our CPA policy and procedures to ensure that there is effective engagement and collaboration with service users and carers producing personalised care plans.
	• Identify the training needs of staff and co-design (with service users and carers) a care-planning training programme for delivery to staff with care planning responsibilities.
	• Deliver care planning training to all new preceptorship nurses, and ensure that effective monitoring is in place.
	• Deliver a bi-annual Trust-wide audit around care planning to share good practice and local innovation, identifying ward or service areas where quality improvement may be required.
	• Develop systems for promoting good practice, including the 'learning conversations' model to share innovation around effective care planning, and ensure that GMMH interventions reflect NICE guidance and best practice.
	• Review our CPA documentation and ensure that our care planning information is service user and carer friendly.
	• Develop care planning guidance and provide resources on the Trust website to support effective care-planning, and specifically ensure that our approaches
	  • Meet professional, GMMH and national standards.
	  • Outline the aims, actions and responsibilities of effective assessment and care planning
	  • Take account of recovery focussed outcomes and goal setting
	  • Build in regular opportunities for review
	  • Take adequate consideration of risk management
	  • Are accessible, clear and understandable to everyone involved in the care planning process
	• Develop a care planning charter that is service user and carer led to clarify rights, responsibilities and expectations in relation to care planning.
	• Through application of NHS Improvement guidance, work towards developing a culture where service user and carer involvement with care-plans is considered an 'always event'.
	• Ensure that effective Care Planning is factored into Trust wide training programmes including PMVA and Safewards training, emphasising the need to update care plans following PMVA incidents.
	• Strengthen our range of tools and increase the current opportunities to optimize individual recovery, ensuring that there is ongoing appraisal and

monitoring at the CAREHub.

- Embed care-planning standards within the Quality Matters Metrics framework and monitor improvements.
- Ensure that Care Planning standards are explored during Quality Matters Walkaround visits to wards and services, and that thematic learning is shared at the Trust's Quality Governance Committee.
- Ensure that effective and robust care planning takes place during both internal and external transitions, and that staff take account of wider physical health, social care needs, and other areas important to our services users including employment, where appropriate.
- Review the February 2018 CQC report to draw out specific recommendations relating to care planning, and ensure these are acted on throughout 2018/19.

4.3 Monitoring our Quality Improvement Priorities

These Quality Improvement Priorities will be subject to robust monitoring during 2018/19. Each Improvement Lead will be required to produce a quarterly progress report, which will be monitored at our CQUIN and Quality Measures meeting, before being reported to our Quality Governance Committee, and received at our Trust Board. The Dragon's Den initiative will continue to support our ambition that the Quality Improvement Priorities remain meaningful and relevant for our local services. Through the programme, we will welcome bids from across the breadth of our services that will improve quality for our service users and their families, and ensure that they are linked to at least one of these priorities. We will continue to ensure that service users and carers are involved in supporting our decisions around bids that are funded through the Dragon's Den process, and will provide further detail on what we have done this in next year's Quality Account.

This Quality Account provides an overarching picture of some of the work we have done and will do in the future as part of a much wider comprehensive quality agenda. This ensures that our services are provided to the highest possible quality standards and continue to meet changing needs in a person centred way.

Please feel free to contact us if you would like to know more about any of the priorities for 18/19 or any other quality improvement activity taking place at the Trust.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Annex

Annex 1 - Feedback from Key Stakeholders

Feedback from NHS Bolton CCG on behalf of Bolton, Salford and Trafford Clinical Commissioning Groups

Bolton CCG has coordinated this response on behalf of the commissioning organisations involved in the multilateral contract who collectively welcome the opportunity to comment on the 2017/18 Quality Account.

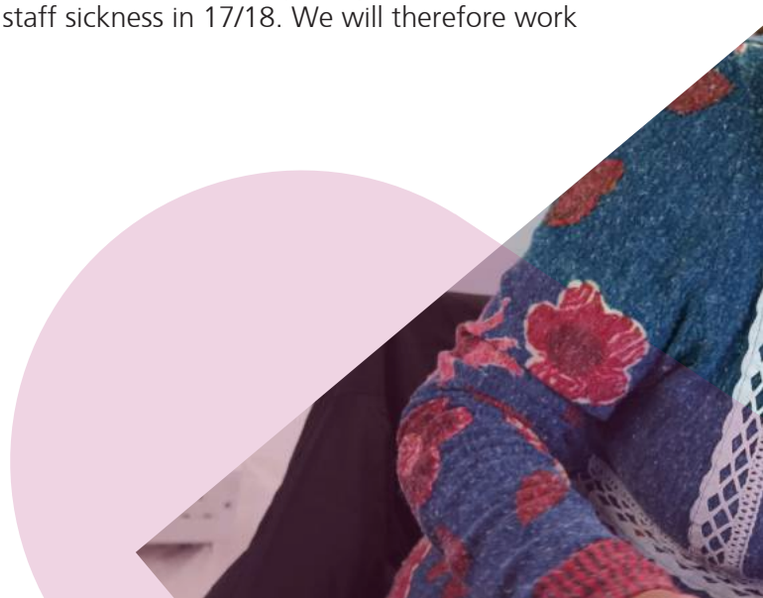
The CCG's have once again worked closely with GMMHFT in 2017/18 to gain assurance that the Trust has provided safe, effective and patient focussed services. A collaborative and clinically led governance process continues to monitor quality and the content of this account is consistent with the information shared throughout the year.

We have made comments in previous years that the Account's scale and format is not ideal for a public facing document, and due to a lack of distinct measures, it isn't always clear whether the priorities have been met and whether the actions undertaken have led to the desired outcomes. Unfortunately our comments haven't led to the desired change as the Account is presented in line with previous years.

We are pleased with the continued progress on the acquisition, further service developments such as CAMHS, the CQC's overall 'Good' rating, and we are assured that areas requiring improvement, specifically around safety, are being addressed.

The Account again provides examples of innovation, accolades, and extensive engagement with service users, and we are also pleased that the Trust achieved 100% of the CQUIN schemes, which were developed collaboratively to improve the quality of services. We would like to see examples of meaningful collaboration with primary care in next year's Account.

We noted last year that staff health, wellbeing and support wasn't continued as a priority within the account and unfortunately there has been no progress in improving staff sickness in 17/18. We will therefore work



closely with GMMH in 18/19 to ensure this important measure retains to focus necessary to lead to improvement.

In reviewing performance against last year's priorities we again note the extensive feedback provided in the Account, especially the case studies and evidence of service user involvement where appropriate. As stated earlier it is difficult to know whether the priorities have been met and we expect that, in not having 'Out of Area Placements' and 'IAPT effectiveness' as priorities this year, we do not lose a focus on these as they remain key priorities for the CCG's who will be holding GMMH to account for their delivery.

We again support the improvement priorities for 18/19 which have been developed in line with the views of multiple stakeholders, and we are particularly pleased to see the 2 new priorities which focus on personality disorders and care plans. We would like the Trust to be able to clearly identify in next year's account whether they have achieved these priorities and specifically what actions led to the success.

In summary the Account describes an organisation that is able to deliver services to a high standard, is innovative and patient focussed. We look forward to working with the Trust in 18/19 to not only support achievement of the priorities but to further develop the delivery of mental health services in line with Bolton, Salford and Trafford's Locality Plans whilst ensuring service users continue to receive safe and effective care locally.

Dr Jane Bradford - Clinical Director for Governance and Safety

Michael Robinson - Associate Director for Governance and Safety

Feedback from Manchester Health and Care Commissioning on behalf of NHS Manchester Clinical Commissioning Group and Manchester City Council Social Care services

We would like to thank Greater Manchester Mental Health NHS Foundation Trust (GMMH) for the excellent progress made in improving services for patients, following the acquisition of Manchester Mental Health Services in January 2017.

Manchester Health and Care Commissioning (MHCC) is committed to supporting the Trust to achieve the ambitions set out in its transformational programme. This includes ensuring the necessary financial investment to deliver the improvements, including the requirements set out in the Five Year Forward View are in place.

MHCC has reviewed the content of the 2017/18 Quality Account and believe it is a fair and accurate reflection of the services provided by the Trust. The Quality Account demonstrates the continued progress in the implementation of a transformational programme of improvement for patient, carers and families in the City of Manchester.

On the 22nd of May 2017 a suicide bomber detonated an improvised device at the Manchester Arena. The bomb killed twenty-two people including many children. Over one hundred were physically injured and many more suffered psychological and emotional trauma. The Manchester Arena attack was the deadliest in the UK since the London bombings on 7th July 2005.
Paramedics treated many walking wounded in the city centre. Hospitals in Greater Manchester treated people with serious injuries, transported by the Ambulance Service, whilst others made their way to hospitals across the wider region. Mental health trusts provided vital psychological support to victims and families in the aftermath of this event.

MHCC would like to commend the response from GMMH in relation to this tragedy.

Significant progress has been made during the year in key priority work streams. These include improving access to psychological therapies (IAPT), reducing out of area placements, redesign of the urgent care, acute care and rehabilitation pathways as well improved community engagement. For example, under the urgent care pathway redesign, the development of the dedicated Section 136 suite at Park House, is well underway and due for completion in June 2018. Investment has also been provided from Greater Manchester Health and Social Care Partnership, to develop new service models across Mental Health Liaison Services for all ages and Perinatal Services.

Further improvement work is to be undertaken within future years, which will identify opportunities to maximise efficiencies, value for money, and improved patient pathways.

The Care Quality Commission (CQC) inspected GMMH from September to December 2017 and published its report in February 2018. The overall rating of the Trust was ‘good’, with the service rated as:

- Outstanding for the service being well led, and
- Good for the service being responsive; caring and effective.
- Requires Improvement for the service being safe, and the CQC have outlined the actions the Trust should take to help improve this rating.

The inspection team were struck by how well the leadership team at GMMH had brought the Manchester services into the trust and improved them. The Trust has developed an action plan to address the areas for improvement, and MHCC will closely monitor progress against the plan and provide any support necessary.

MHCC acknowledges, within the Quality Account, the areas of good practice already within the Manchester services. This includes the ongoing GMMH work programme to address staff sickness and the recognition

of the importance of having an engaged, motivated and healthy workforce in the delivery of high quality care, and the impact of staff absence on remaining staff.

Of particular note is the progress made in implementation of the Research and Innovation Strategy designed to ensure research informs and improves clinical services by dissemination and translation into clinical practice and adoption of innovations.

Also the Trust continues to develop strong working relationships with other providers, such as Pennine Care Foundation Trust and North West Boroughs Partnership Foundation Trust. A good example of partnership working between trusts' is the GM Provider Mortality Review. This work will facilitate wider learning across GM to support improvements in clinical services.

The Trust has also taken a lead role in the development of a GM wide plan to reduce the number of service users placed out of area, by improving the effectiveness of local health and social care systems and acute care pathways. As this is a particular area of concern for Manchester, the Transformation Programme has laid the foundations for improvements to reduce the number of out of area placements. It is acknowledged that the Trust has made progress in repatriating significant numbers of patients back to local services and put in place systems to improve appropriate patient flow, but this area remains a challenge whilst other developments are underway to reduce demand on beds.

The Trust is also working hard to improve access to psychological therapies (IAPT) for patients with depression or anxiety. A key aspect of the IAPT improvement programme is to deliver a more integrated pathway for patients. Much of this work has been implemented this year and over the next few months we envisage to see improvements in relation to more people accessing treatment, reducing waiting times, and improving recovery rates for those that have completed treatment.

Progress made regarding the inclusion of Manchester services into the Service User CARE Hub is also welcomed. The CARE Hub proactively seeks feedback from servicer users, carers, staff, and volunteers to improve the quality of care.

MHCC also commends the staff members and teams in the Trust for the respective accolades awarded to them at individual and team levels for their work at GMMH.

In 2017/18, MHCC staff undertook the first quality walk around at the inpatient mental health unit based in Wythenshawe Hospital. The walk around proved positive and the findings highlighted positive patient experience, supportive and caring staff and effective leadership.

As the Local Care Organisation (LCO) in Manchester develops, GMMH as a key partner is contributing to that development. GMMH are engaged in the development of the governance organisational form of the LCO, as well as involvement in the LCO Neighbourhood Team Models, and working groups such as Urgent Care and High Impact Primary Care.

We support the proposed quality improvement priorities for 2018/19 of:

- Improving service user and carer experience and to deliver service improvements by listening to and learning from service user and carer feedback;
- Promoting recovery and improving outcomes through the delivery of positive and safe care through the implementation of a Safewards strategy, and delivery of recovery focussed, positive and safe care across inpatient wards;
- Enhancing the quality of life for people with dementia and older people with functional illness;
- Supporting improvements in the service users' physical health, including improving assessment and treatment and positive health promotion;
- Developing a Personality Disorder Strategy and Framework to improve the clinical effectiveness of

all Trust services and practitioners working with service users of all ages with personality problems, and
- Ensuring the effective engagement and collaboration with service users and carers in developing personalised care plans, and ensuring that service users and their carer's are aware of their rights and responsibilities in relation to care planning

As Manchester is a diverse city, MHCC support the continued focus on promoting equality of access to these services and the outcomes for all service users from all equality groups. However, the Equality Impact Assessment could be more comprehensive in order to fully assess the impact on all protected characteristics.

We are looking forward to continuing the close working relationship with the Trust in the coming year to further transform services and ensure that we continue our relentless focus on patient quality and safety in everything we do.

Please note MHCC is not responsible for verifying data contained within the Quality Account/Annual Report; that is not part of these contractual or performance monitoring processes.

Ian Williamson,
Chief Accountable Officer, Manchester Health and Care Commissioning
May 2018.

Feedback from HealthWatch, one narrative provided on behalf of HealthWatch Bolton, Manchester, Salford and Trafford

Re: Greater Manchester Mental Health Quality Account 2017/18

The Greater Manchester network of Healthwatch have reviewed the GMMH Quality Account for 2017/18 and find that it is a fair reflection of the services provided by the Trust.

Firstly, we have very much welcomed the ongoing involvement of the four main Healthwatch associated with the Trust, namely, Bolton, Salford, Trafford and Manchester. This has enabled us to feed in patient and carer views throughout the year to complement the work undertaken by the Trust.

Overall, GMMH seems to have performed well in 2017/18, given the challenge of integrating services into the Trust. This is evidenced by improvements in involving service users in research and a high proportion of follow-ups for recently discharged patients. The report also correctly identifies several areas in need of improvement, such as out of area placements, for which a comprehensive 10-point plan has been devised, as well as more widespread and timely access to psychological therapies (IAPT).

There is much to commend the Trust's achievements during the year under review, not least the positive CQC ratings. The outstanding rating for leadership is apparent in practice and a similar rating for substance misuse services is commendable. We hope that next year the Trust can achieve a 'good' (or better rating) for safety based on the plans the Trust is currently implementing.
The number of accolades is also commendable, and it is good to see individuals' achievements being recognised in this way.

We were encouraged to see the continued improvement in 7-day follow up and particularly in follow up phone calls to the most vulnerable within the first two or three days following discharge. We think it particularly important to follow up those people who are of no fixed abode or who may be single and have no visible means of support.

The emphasis on physical health, housing and employment are all good. We do feel that it would be useful to monitor the no-smoking initiative not only among service users but also staff.

As we now have borough figures for suicides, it would be useful to have a similar breakdown of the number of deaths. We were encouraged to see the investment in a bereavement nurse and would like the Trust to keep this under review. We recognise that there is no current standardised assessment tool for deaths in service nationally.

We are pleased to affirm the priorities within the Quality Account, particularly in relation to people with a personality disorder and out of area placements. We acknowledge good service user and carer involvement in the Trust's work.

We have a few specific areas that we would wish to highlight which may benefit from further focus:

- Strategies to address workforce shortages, particularly in relation to IAPT. As identified, Manchester has a particularly poor record for IAPT metrics (recovery, reliable improvement, waiting time) compared to surrounding boroughs, causing GMMH to miss a few national targets
- We would like to see complaints and compliments analysed by demographic indicators with focus on the protected characteristics and type of service.
- As well as looking at length of stay at 50 and 150 days, we would like to see figures for those who remain in the Trust for longer periods and some of the efforts that have been made to effect discharge e.g., to nursing homes.

- We commend the approach to crisis responses and to rehabilitation, although we still feel that nursing care on an ongoing basis for those not able to benefit from rehabilitation across the GM footprint would be useful.
- Quality of appraisal improvements and understand the broad experience of employment within the Trust would be key areas to identify staff strengths and weaknesses and may help to ameliorate sickness levels.
- Continuing training in relation to PARIS so that partners can be assured about quality of information.

We would like to take this opportunity again to recognise the efforts the Trust has made to continue to involve Healthwatch in developing its priorities and we hope that our contribution has been helpful.

We look forward to working with the Trust during 2018/19.

Yours sincerely,

Delana Lawson, Chief Officer
Healthwatch Salford

And on behalf of Healthwatch Bolton, Healthwatch Trafford and Healthwatch Manchester

Feedback from the Manchester and Salford Health Scrutiny Committees

Health and Adults Scrutiny Panel – Salford City Council

Our work with Greater Manchester Mental Health NHS Foundation Trust over the past 12 months has provided an ongoing demonstration by the Trust to provide outstanding services to the people of the city and Greater Manchester. The delivery of these standards shows the clear commitment of the Trust to its staff, patients and visitors.

The Panel note the organisational challenges which have been successfully met by the Trust and offer congratulations regarding the recent Care Quality Commission (CQC) inspection and report.

The Panel would like to offer congratulations and thanks to all employees of the Trust, without whose endless dedication and professionalism, the achievements and improvements would not be possible.

We look forward to further progressing our partnership work with the Trust in 2018 / 2019.

Councillor Margaret Morris, MBE
Chair of the Health and Adults Scrutiny Panel
Salford City Council

Manchester City Council Health Scrutiny Committee

11 May 2018

Dear Greater Manchester Mental Health NHS Foundation Trust,

Manchester City Council Health Scrutiny Committee - Response to Greater Manchester Mental Health NHS Foundation Trust Quality Account 2017/18

As Chair of Manchester City Council's Health Scrutiny Committee I would like to thank you for the opportunity to comment on your Trust's Draft Quality Accounts for 2017/18. Copies of the draft were circulated to members of the Committee for comment and, in response, we would like to submit the following remarks for inclusion your final published version.

Firstly, we would like to congratulate you on achieving a Care Quality Commission rating of 'Good' for the Trust as a whole and a rating of 'Outstanding' for leadership and management and substance misuse services. Manchester City Council's Health Scrutiny Committee felt that this was a clear sign that your governance arrangements are robust and effective and that there is a commitment to provide the best possible service for your patients, their friends, relatives and carers. We were also encouraged to see that specific actions are to be developed in response to aspects of the inspection findings where a need for further progress was highlighted.

We noted throughout the Account a consistent theme of the Trust's commitment to create positive experiences of care across the breadth of services. There was a clear focus on responding to service user feedback and the impact of this was supported by good levels of engagement for the Friends and Family Tests and that the resulting feedback was so positive. We also welcomed the frequent reference to carers throughout the Account. It is clear that that their voice is heard and their views are consulted upon and we agree that this is a very important aspect in the delivery of care. We were pleased to note the introduction of targeted interventions that will allow you to reflect on and continue to improve patient outcomes in an effective way. We felt that initiatives you have developed to improve both the quality and the impact of local services through the Dragon's Den and the Quality Innovation Fund were innovative and patient-focussed. In addition, we felt that the

case studies described in your Review of Quality Performance section provided clear evidence that service user experience remains at the heart of delivery.

We particularly welcomed the targeted work undertaken by the Trust to improve access to psychological therapies and reduce the number of service users that are placed outside of the local area to receive care. As you are aware, the Committee has a keen interest in this matter as we acknowledge that this is a particular concern for patients, their families and carers. We remain optimistic that recent and ongoing changes to performance monitoring and leadership will provide good oversight of the Pathway and will help to overcome the underlying barriers to improve the delivery of those services in Manchester.

We looked at the Trust's performance against National Priorities and whilst it was clear that not all targets had yet been fully met, we noted that some of the datasets were incomplete in that the year-end data was not available at the time of publication. We felt that the Trust seemed well placed to either meet or exceed all of its targets and wish to congratulate you on that.

With regard to the six improvement priorities identified for the forthcoming year the Committee welcomes these and is particularly pleased to note that staff, service users carers, governors and HealthWatch were involved in their development. We saw these as firm commitments that would provide a good benchmark to allow progress to be monitored and assessed in future years.

The Committee welcomed this document as a positive draft Quality Account with evidence included such that chronological and organisational comparisons may be made. We felt that overall the Quality Account is very positive and reflects the successful operation of an organisation that serves many service users and patients in an efficient and compassionate manner.

Yours sincerely,

Councillor John Farrell
Chair of the Health Scrutiny Committee

Annex 2 - Independent Auditor's Assurance Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Greater Manchester Mental Health NHS Foundation Trust to perform an independent assurance engagement in respect of Greater Manchester Mental Health NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- 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
- 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 auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18*.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 22 May 2018;
- feedback from governors, dated 12 February 2018;
- feedback from local Healthwatch organisations, dated 18 May 2018;
- feedback from Overview and Scrutiny Committee, dated 11 May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated November 2017;

- the national staff survey, dated March 2018;
- Care Quality Commission Inspection, dated 23 February 2018
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated March 2018; and
- any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Greater Manchester Mental Health NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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 Greater Manchester Mental Health 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 indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change

over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Greater Manchester Mental Health NHS Foundation Trust.

Conclusion

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
One St Peter's Square
Manchester
M2 3AE

23 May 2018

Annex 3 - Statement of Directors' Responsibilities in Respect of the Quality Account

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 review:

- The content of the Quality Report to ensure it meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report so that it is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to March 2018
    - Papers relating to quality reported to the board over the period April 2017 to March 2018
    - Feedback from Manchester Health and Care Commissioning received on 21st May 2018
    - Feedback from Bolton, Salford and Trafford Clinical Commissioning Groups (CCG's) received on 22nd May 2018
    - Feedback from governors received on 12th February 2018
    - Feedback from local Healthwatch organisations received on 18th May 2018
    - Feedback from Manchester Health Scrutiny Committee received on 11th May 2018
    - Feedback from Salford City Council Health and Adults Scrutiny Panel received on 26th April 2018
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31st May 2017
    - The 2017 National Patient Survey published November 2017.
    - The 2017 National Staff Survey published March 2018.
    - The Head of Internal Audit's annual opinion of the Trust's control environment provided in March 2018
    - CQC inspection report dated 23rd February 2018
    - The Quality Report ensuring it presents a balanced picture of the NHS foundation trust's performance over the period covered
    - The performance information reported in the Quality Report is reliable and accurate
    - There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
    - The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
    - The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

Greater Manchester Mental Health NHS Foundation Trust
By order of the board:

Rupert Nichols, Chair

Neil Thwaite, Chief Executive

Annex 4 - Equality Impact Assessment

Consideration		Yes/No	Comments
1	Does the Quality Account affect a group with a protected characteristic less or more favourably than another on the basis of: • Age • Disability • Gender Re-assignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race • Religion of Belief • Sex • Sexual Orientation	No No No No No No No No No	The Quality Account contains a priority that relates specifically to older adults including people with dementia. The nature of the priority and any associated activity will not result in this protected group being treated more favourable however. The proposed activity will focus on shared learning and good practice.
2	Has the Quality Account taken into consideration any privacy and dignity or same sex accommodation requirements that may be relevant?	Yes	This was taken into account as part of the planning and production of the Quality Account. No specific issues have been identified throughout the production stages of this Quality Account.
3	Is there any evidence that some groups are affected differently?	Not Applicable	There is no evidence that any groups are adversely affected as a result of the Quality Account. Monitoring and consideration will remain ongoing.
4	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	Not Applicable	No valid, legal or justifiable discrimination has been identified throughout the production of this Quality Account.
5	Is the impact of the Quality Account likely to be negative?	No	The impact of the Quality Account is not likely to be negative.
6	If so, can the impact be avoided?	Not Applicable	This does not apply as no negative impact has been identified
7	What alternatives are there to achieving the Quality Account without impact?	Not Applicable	This does not apply as no negative impact has been identified
8	Can we reduce the impact by taking a different action?	Not Applicable	This does not apply as no negative impact has been identified

Annex 5 - Local Clinical Audits Reviewed in 2017/18

Trust Clinical Audits	
Advancing Quality / Commission For Quality And Innovation (Cquin) /Key Performance Indicator Audits	
1	CQUIN Improving Dementia Care: Memory Assessment and Treatment Service Team audit of case notes for carers views
2	Collaboration with Primary Care Clinicians
3	CPA Risk Assessment/Risk Management Plans
4	Reception and Secondary Screening – HMP Manchester and HMP Buckley Hall
5	Thematic Review – Audit of RCA Reviews following a Serious Untoward Incident
6	Transitions out of Children's and Young Peoples Mental Health Services
7	Suicide Prevention Questionnaire to Staff
8	Lessons learned – System and process of good practice/lessons learned
9	Audit of the Duty of Candour/Being Open
10	Positive and Safe – Deep Dive Audit of Datix Incidents
11	NICE Self-Harm Quality Standards
12	Annual Ligature Audit
Patient Experience/Safety Audits, Health and Safety Audits	
13	Improving Dementia Care MATS Patient care and Experience
14	Audit of Antipsychotic Prescribing for People with Dementia at Point of Discharge
15	Questionnaire to Carers of Patients with Dementia
16	Questionnaire to Carers of functional Older Adults
17	Infection Prevention Hand Hygiene Audit
18	Audit – Carer Survey (within Adult Services)
19	MDT Record Keeping
20	Record Keeping – HMP Buckley Hall and HMP Manchester
21	Accuracy of Service User Data
Mental Capacity/Mental Health Act Audits	
22	Mental Capacity Act
23	Consent to Treatment
24	Patient's Rights
Medicines Management Audits	
25	Antibiotic Prescribing
26	Depots in the Community

27	PRN Prescribing
28	Antipsychotic Prescribing for Patients with Schizophrenia

Directorate Specific Audits	
Bolton	
29	Directorate Specific Audits
30	Clinical audit on discharge letters to HP following an outpatient clinic appointment with Bolton Assessment Services (BAS) (496) by Dr F Uzair, Dr R Ashraf, Dr F Alam
31	An audit of the documented Assessment of Capacity to Consent to Treatment (512) by Dr M Miller
Re-audits	
32	Compliance with the Stepped Care Model of Psychological Interventions within the Community Mental Health Team (no.460) by Hannah Gaffney (Trainee Clinical Psychologist, under supervision from Dr Joanne Bennett (Clinical Psychologist)
Salford	
33	Audit of Long Acting Antipsychotic Depot Prescribing in Later Life Psychiatry Service (468) by Dr Rodwan Husein, Dr R Ahmed, Dr R Lepcha
34	Compliance of Informal Admissions with Trust's Acute Care Pathway (no:473) by Dr Yamnini Vadali (CT3 Trainee) and Dr Saba Nazir (Consultant Psychiatrist)
35	Braeburn House Recovery Star Clinical Audit (490) by Jelena Jovanoska (Assistant Psychologist) & Dr Jonathan Mitchell
36	Section 5(2) outcome in Meadowbrook Unit in 2016 (503) – by Dr Saba Nazir, Consultant Psychiatrist and Dr Nazir Ahmad, SHO Home Based Treatment team
37	Audit of Shared Care Protocol for prescribing atypical antipsychotics in Salford directorate-Ramsgate House (522) by Dr Swanand Patwardhan
Re-audits	
38	High dose antipsychotic medication prescribing for inpatients at Meadowbrook (510) by Dr Kailyn Soo (ST5) and Dr David Hughes
39	High dose antipsychotic medication prescribing for inpatients at Meadowbrook (510) by Dr Kailyn Soo (ST5) and Dr David Hughes
40	High dose antipsychotic medication prescribing for inpatients at Meadowbrook (510) by Dr Kailyn Soo (ST5) and Dr David Hughes
41	Retrospective audit of completion of IPE and PHIT form of new patients admitted in Salford Directorate (585) by Dr Khalid Kareen, Dr Anthony Baynham
Trafford	
42	Driver and Vehicle Licensing Agency (DVLA) guidance within the patient population of the Trafford Home Based Treatment Team (462) by Dr S Khan & A Rahdhay
43	To establish the working pattern of night time Junior Doctors in Middle Grade Tier/ST Doctors (471) by Dr Hena Rahman (Speciality Doctor)
44	Shared Care Protocol for Atypicals in Trafford (493) by Dr S Krishnamurthy
45	A 18 Month Review of an ADHD clinic against NICE Guidelines (439) by Dr Chris Henderson and Dr Cherry Lewin

Re-audits	
46	Shared Care Protocol for Atypicals in Trafford (492) by Dr S Krishnamurthy
47	High dose of Antipsychotic Medication prescribing for Community Patients (499) by Dr Kailyn Soo (ST5)
Manchester	
48	Survey of structured psychological interventions being delivered on Mother and Baby units in the UK (528) by Dr Anja Wittowska, Charlotte Garette
49	Assessing compliance with ward round standards on Laurel Ward (529) by Z Bhatti
50	Lipid monitoring in patients taking antipsychotics, and the use of the QRISK2 score to identify and manage cardiovascular risk to these patients as per NICE guidance on Redwood Ward (530) by Dr Ishrat Ahmed, Dr Paul Wilson
51	Survey of Psychological support for partners being delivered on Mother and Baby Units in the UK (531) by Beth Turner, Charlotte Garrett, Anja Wittowska
52	Audit of referrals to step 4 psychology by ethnicity at Gaskell House and Laureate House (532) by Dr Amy Squire
53	Prescribing Sodium Valproate to Women of Childbearing Age - Community Audit (533) by Dr Ipshita Mukherjee
54	Capacity and Consent to Treatment Documentation on Blake Ward (536) by Mahesh Gopakumar
55	Discharge Communication to GP when discharged from North Manchester Mental Health Home Treatment Team (537) by Dr Helen Johnson
56	Service Evaluation of the population of MCI patients in Memory Assessment Service (538) by Dr Clare Smith
57	72 Hours On SAFIRE An Audit of The Assessment Process (539) by Dr Neil Crossley
58	The Availability and Suitability of Equipment for Physical Health Assess Inpatients North Manchester General Hospital (540) by Dr Lucy Conor, Dr Kathleen Serracino-Inglott
59	Compliance of South Manchester Home Treatment multi-disciplinary team meeting documentation guidance (541) by Dr M Omair Husain
60	The copying of GP letters to patients in the Later Life Community Mental Health Team East (542) by Dr Eleanor Swift
61	Monitoring of physical health in patients on Antipsychotics at Anson Road Rehabilitation Unit as recommended by NICE (543) by Dr Sikti Pal, Dr Samira Malik
62	Physical health assessment with a diagnosis of psychosis or schizophrenia within 7 days of admission to Bronte ward (545) by Phoebe Jackson
63	An assessment of adherence to local shared care protocol when monitoring physical health of patients on Clozapine Treatment at Park House (546) by Dr Upeksha Nanayakkara, Dr Alfred Cheung, Dr Peter Parker
64	Psychiatric review within 7 days of discharge from Maple Ward (547) by A Singh
65	Factors affecting discharge from out-patient services and waiting time for new referrals at Laureate House (548) by Dr Hannah Goldup
66	Smoking Cessation in the North Mersey Community Mental Health Team (553) by Dr A Matrunola, Dr A Wormall
67	Antipsychotic polypharmacy and high-dose antipsychotic prescribing in acute psychiatric inpatients admitted to Park House (554) by Dr J Scaria, Dr J Clark, Dr J Thompson

68	Service Evaluation of South Manchester Memory Assessment Service (563) by Dr C Cole, Dr S Lennon
69	Evaluating participant experience of a compassion focussed therapy course within primary care (565) by Sandra Castle, Alison Dixon, Lorraine Lowe
70	Waiting times and provision of post-diagnostic information in the North Manchester Memory Assessment Service (571) by Barbara Chavunduka, Jillian Geary, Louise Mahon
Re-audits	
71	Good Practice in Junior Doctor Handover at Laureate House (534) by Dr K Wilson
72	Audit of polypharmacy and metabolic parameters monitoring of patients on high dose antipsychotic therapy in the community (535) by Dr S Patwardhan
73	Compliance of South Manchester Home Treatment team with DVLA guidance regarding Fitness to Drive (544) by Dr C Redmond
74	Audit of Discharge Communication to General Practitioner when discharged from North Manchester Mental Health Home Treatment Team (549) by Dr H Johnson
75	Good practice in Junior Doctor handover at Park House (559) by Dr A Dierckx, Dr M Manzoor
76	Driving and Dementia (560) by Dr J Ratcliffe, Dr W McPartland, Dr O Wilkinson
77	Monitoring Electrocardiograms (ECGs) in patients on antipsychotic medications admitted in a psychiatric ward: a standard based audit. ECG recording during admission period on Redwood ward from (564) by Dr R Dasi, Dr A Elaswed
78	Audit on current practice of high dose antipsychotic prescription in an adult psychiatric ward (566) by Dr H Zamani, Dr R Dane, Dr E Kaye
78	Audit on current practice of high dose antipsychotic prescription in an adult psychiatric ward (566) by Dr H Zamani, Dr R Dane, Dr E Kaye
79	Polypharmacy above AIMS limit prescribing and physical health monitoring in general adult patients (567) by Dr H Zamani, Dr R Dane, Dr E Kaye
80	What is the anticholinergic burden from prescribed medications for adult and elderly inpatients at a mental health trust (574) by Joan Miller, Madeline Coldwell – Supervised by Dr Richard Keers, Karen Bennett and Joanne Nguyen
81	Views of Staff Toward Involving Pharmacy Teams in the Administration of Medicines in a Mental Health Hospital (575) by Joan Miller
Specialist Network Services	
Adult Forensic Services	
82	Prescribing practices for long acting injectable antipsychotics (498) by Dr Siobhan Reilly, Andrew McDonald
83	Dental Hygiene and Dental Assessment in patients with mental health conditions (501) by Dr Taslim Kamath, Dr M Rahman
84	Quality of Medical Recommendations for detention under MHA at AFS (502) by Dr Andrew Porter
85	Standards of care for patients with a diagnosis of Diabetes (518) by Dr Kathleen Serracino-Inglott, Dr Niamh Sweeney, Dr Hany El-Metal
86	Monitoring of lithium at GMMH Low Secure Women's services (520) by Dr Sana Sohail, Dr Mukta Bahugana
Re-audits	

87	Use of IM Olanzapine in Adult Forensic Services (475) by Dr Pushpindr Sindhu, Dr Yamini Vadali, Dr F Bashir
Mental Health & Deafness (John Denmark Unit)	
88	Violence and aggression in a UK open Acute Mental Health Deafness Unit (500) by Dr Neel Halder, Dr Sodi Mann, Kate Hall
Pharmacy	
89	Valporate Audit (451) by Onagh Boyle
Substance Misuse Services	
90	Actioning and recording of Safeguarding process within Discover (426) by Mags O Neil, Heather Thornley, Damien Bradley and Gill Heaton
91	Audit of deaths at SMS services (463) by Mags O Neil, Karen Nicoll, Patrick Horgan, Richard Rodgers, Jonathan Dewhurst
92	Alcohol related deaths at SMS Services (465) by Mags O Neil
93	Substance misuse related deaths at SMS (466) by Mags O Neil
94	Prescribing Benzodiazepines at AIM Trafford (480) Dr Tracey Myton, Dr Sher Ahmed
95	Admissions to Chapman Barker Unit (481) by Dr Patrick Horgan
96	Hepatitis C Testing and Hepatitis B Vaccination in North Cumbria (489) by Dr Patrick Horgan
97	ECG monitoring in high dose methadone prescribing at UNITY (511) by Dr Patrick Horgan, Dr Rachel Garth
98	Prescribed Medication Audit at Achieve Salford (519) by Haitham Nadeem, Dr Alex Shaw
99	Clients with no documentary evidence of Blood Borne Virus Screening at Unity Barrow (506) by Dr Patrick Horgan and Dr R Ahmad
100	Clients with no documentary evidence of Blood Borne Virus Screening at Unity Barrow (506) by Dr Patrick Horgan and Dr R Ahmad
101	Pabrinex prescriptions at CBU compared to NICE and local guidelines (479) by Dr Rebecca lee, Dr Deepti Kongnolikar, Dr H Chaudhry, Dr S Ahmed
102	Atypical Opiate Prescriptions at AIM Trafford (556) by Molly Chabata

Annex 6 - Glossary of Terms

A&E	Accident and Emergency hospital services
AC	Accreditation Committee
AIMS	Accreditation for Inpatient Mental Health Services
AMIGOS	Former Manchester Mental Health and Social Care Trust current clinical patient record system
AQuA	Advancing Quality Alliance
ARMS	At Risk Mental State
BD	Bipolar Disorder
BMI	Body Mass Index
BNF	British National Formulary
BP	Blood Pressure
CAARMS	Comprehensive Assessment of at Risk Mental States
CAMHS	Child and Adolescent Mental Health Services
Care Co-ordinator	The professional who, irrespective of their ordinary professional role, has responsibility for co-ordinating care, keeping in touch with the service user, and ensuring the care plan is delivered and reviewed as required.
CARE Hub	The CARE Hub was created in 2014 to support the Trust to develop a coordinated approach to Service User and Carer feedback and engagement. The CARE Hub is a virtual network to engage with Service Users, Carers and Volunteers in a number of different ways. CARE stands for Compassionate and Recovery Focussed Every Time.
Carer	An individual who provides or intends to provide support to someone with a mental health problem. A carer may be a relative, partner, friend or neighbour, and may or may not live with the person cared for.
CBT	Cognitive Behavioural Therapy
CBU	Chapman Barker Unit, specialist service for those with substance misuse needs on the Prestwich site
CCGs	Clinical Commissioning Groups - groups of GPs are responsible for designing and commissioning local health services
Clinical Guideline	CG
CMHT	Community Mental Health Team
Clinical Guideline	Care Programme Approach - a framework for assessing service users' needs, planning ways to meet needs and checking that needs are being met.
CQC	The Care Quality Commission is the independent regulator of all health and adult social care in England and has responsibility for protecting the rights of individuals detained under the Mental Health Act.
CQUIN	Commissioning for Quality and Innovation framework, which allows commissioners to link income to the achievement of quality improvement goals
CRN:GM	Clinical Research Network: Greater Manchester

CROM	Clinician Reported Outcome Measures
DATIX	The Trust's Integrated Risk Management Software
DH	Department of Health
DNAR	Do not attempt resuscitation
ECG	Electrocardiography
EDIE	Early detection and intervention evaluation for people at risk of psychosis
e-GFR	Estimated Glomerular Filtration Rate
EI	Early Intervention
EIP	Early Intervention in Psychosis
EQUIP	'Enhancing the quality of user involved care planning in mental health services'. A collaborative project between the University of Manchester, University of Nottingham, Nottinghamshire Healthcare NHS Trust and Greater Manchester Mental Health NHS Foundation Trust to examine ways to improve user and carer involvement in care planning in mental health services.
FFT	Friends and Family Test
GM	Greater Manchester
GMMH	Greater Manchester Mental Health NHS Foundation Trust
GMP	Greater Manchester Police
GMW	Greater Manchester West Mental Health NHS Foundation Trust
GP	General Practitioner
HAELO	Innovation and Improvement Science Centre in Salford
HBT	Home Based Treatment
Healthwatch	Healthwatch is an independent consumer champion. It was created to listen and gather the public and patient's experiences of using local health and social care services. Local HealthWatches were set up in every local authority area to help put patients and the public at the heart of service delivery and improvement across the NHS and care services.
HEE	Health Education England
HMP	Her Majesty's Prison
HoNOS	Health of Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
IAPT	Improving Access to Psychological Therapies: National programme aiming to improve access to evidence-based talking therapies in the NHS through an expansion of the psychological therapy workforce and supporting services.
ICO	Integrated Care Organisation
iESE	Improvement and Efficiency Social Enterprise
IM	Intra-muscular
JDR	Join Dementia Research
JDU	John Denmark Unit - Inpatient unit for deaf mental health services on the Prestwich site

Junction 17	Inpatient unit for child and adolescent mental health services on the Prestwich site
KPI	Key Performance Indicator
KPMG	Professional Service Company and Auditors
LeDeR	Learning Disabilities Mortality Review
Lester Tool	Downloadable resource used in a range of healthcare settings to improve screening and to ensure a person's physical and mental health conditions are jointly addressed providing a systematic framework for screening and recommendations for treatment and support.
LGBTQI	Umbrella term for people who identify as Lesbian, Gay, Bisexual, Transsexual. The "Q" stands for those who are questioning or in a state of flux with their gender and/or sexual identity.
LQAF	Library Quality Assurance Framework
MATS	Memory Assessment Services
MBU	Mother and Baby Unit
MDT	Multi-Disciplinary Team
MH	Mental Health
MIAA	Mersey Internal Audit Agency
MMHSCT	Manchester Mental Health and Social Care Trust
Monitor	The independent regulator of NHS Foundation Trusts
MSK	Musculoskeletal
NCI	National Confidential Inquiry
NCISH	National Confidential Inquiry into Suicide and Homicide
NG	NICE Guidelines
NHS	National Health Service
NIAG	NICE Implementation and Audit Group
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research: The NIHR commissions and funds a range of NHS and social care research programmes
NRLS	National Reporting and Learning System
NWAS	North West Ambulance Service
OPS	Operations
PAM Assist	People Asset Management Assistance
PARIS	PARIS: GMMH current electronic patient record system
PbR	Payment by Results
PCFT	Pennine Care NHS Foundation Trust
PCMIS	Clinical information system used in Manchester
PHIT	Physical Health Improvement Tool used in PARIS
PICU	Psychiatric Intensive Care Unit

PLACE	Patient-Led Assessments of the Care Environment
PLAN	Psychiatric Liaison Accreditation Network
PMVA	Prevention and Management of Violence and Aggression
PREM	Patient Reported Experience Measures
PRN	Pro Re Natum (as the need arises)
PROM	Patient Reported Outcome Measures
PRU	Psychosis Research Unit
PSI's	Psychological Interventions
QGC	Quality Governance Committee
QPR	Questionnaire about Process of Recovery
R&D	Research and Development
R&I	Research and Innovation
RAG	Red Amber Green

Contact Us

For more detail about the information contained in this Quality Account, please contact:

Patrick Cahoon
Head of Quality Improvement

Greater Manchester Mental Health NHS Foundation Trust
Harrop House
Bury New Road
Prestwich
Manchester M25 3BL
Telephone: 0161 357 1793
E-mail: patrick.cahoon@gmmh.nhs.uk