NHS
Greater Manchester Mental Health
NHS Foundation Trust

Annual Report and Accounts 2018/19

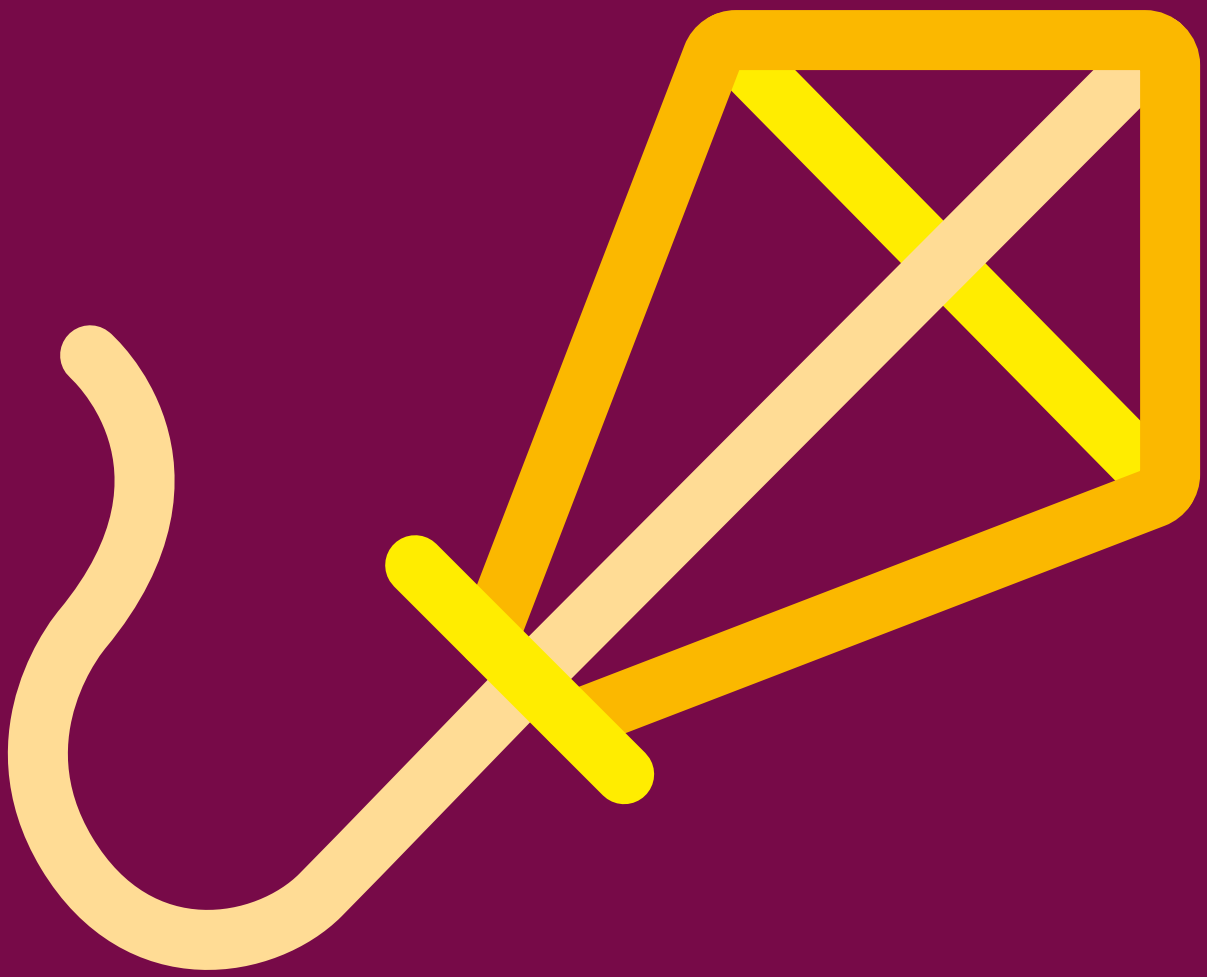
Improving Lives

Greater Manchester Mental Health NHS Foundation Trust

Annual Report and Accounts 2018/19

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

Performance Report



Message from the Chair and Chief Executive

Welcome to our Annual Report for the year ended 31 March 2019. Each year our Annual Report provides opportunity to look back over the last twelve months and reflect on our achievements and challenges, and to also look forwards to the future.

2018/19 has been another busy and successful year for the Trust. Against a backdrop of increasing demand for our services and constraints on funding, our staff have worked hard, showing continued commitment to our vision and values and enthusiasm to improve our services.

Our Financial and Operational Performance

In Neil Thwaite's first year as Chief Executive, we have continued to perform well overall in terms of both operational and financial performance. We have achieved the majority of our Key Performance Indicators (KPIs) and targets. For those areas where we have been more challenged - including IAPT (Improving Access to Psychological Therapies) and Out of Area Placements (OAPs) - we have focused on developing and delivering recovery plans to improve our performance. We have seen these efforts rewarded particularly in relation to OAPs where we have sustained significant reductions in the number of reportable OAPs during the second half of the year.

Rupert Nichols

We delivered an operating surplus of £7.428 million at year-end before impairments and non-cash pension costs. This achievement is notable given the financial challenges presented by our expenditure on OAPs in Manchester early in the year and also on agency staff. As is the case across the NHS, due to a national shortage of skilled professionals and heightened competition to fill vacancies, we have continued to be reliant on agency staffing in some areas to maintain safe staffing levels and standards of care. We are taking forward a number of strategies to improve this position, including the outsourcing of our temporary resourcing services to NHS Professionals with effect from February 2019.

Our year-end financial position has meant that we are able to continue to make investments in improving our services and our estate in future years.

Neil Thwaite

Quality Improvement

We are committed to continuously improving the quality of care for our service users and their families. Our Quality Account 2018/19, which is published alongside this Annual Report, celebrates our quality achievements over the last twelve months.

Since acquiring Manchester Mental Health and Social Care NHS Trust in January 2017, we have taken steps to strengthen our quality assurance mechanisms to support quality improvement. During the last quarter of 2018/19 we held a series of Quality Conversations with staff across the Trust, service users and carers and other key external stakeholders to build on this work and help us to articulate and establish shared ownership of our future quality improvement priorities. We are now working on consolidating the feedback received into a clear Quality Improvement Strategy, supported by agreed improvement methodologies, which we will begin to implement in 2019/20.

Developing our New Long Term Strategy

We have also started work to develop a new long term strategy for the Trust. Aligned with the vision and requirements for mental health set out in the new NHS Long Term Plan, the Five Year Forward View for Mental Health and the Greater Manchester Health and Wellbeing Strategy, our new Strategy will establish our strategic ambitions for the Trust as a whole and for individual service lines. It will also address our ability to grow and adapt to meeting rising population needs, sustain and improve performance and remain innovative, agile and influential at a regional and national level.

Our Long Term Strategy will be enabled by a number of other strategies launched during 2018/19. These include our new Service User Engagement Strategy; Carers, Family and Friends Strategy; Workforce and Organisational Development Strategy; Equality, Diversity and Inclusion Strategy; Spiritual Care Strategy and most recently our Digital Strategy.

Supporting and Growing our Workforce

Staff across the NHS do a difficult job in often very challenging circumstances. Our 2018 Staff Survey results demonstrate this and highlight the need for us to do more to support and improve the experience and satisfaction of our staff at work.

We agreed our new Workforce and Organisational Development Strategy 2018 - 2021 in May 2018. This Strategy sets out actions to address a number of fundamental workforce issues faced by the Trust in four 'High Impact Areas':

1. Supply, Recruitment and Retention
2. Creating an Outstanding Place to Work
3. Transforming our Workforce
4. Outstanding Leadership and Management Development

During 2018/19 we have focused particularly on Supply, Recruitment and Retention. We have continued to grow our apprenticeship programmes and to support people into careers in mental health through our Stepping Forward programme, our Pre-Employment pilot and work experience. We have also increased our number of student nurse placements, recruited our first Trainee Nurse Associate and are leading the work to introduce a guaranteed offer of employment to nursing students that choose to train in Greater Manchester. This is a great start, but there remains significant work to do. Continuing to progress developments in all four High Impact Areas will be a priority over the coming twelve months with a particular focus given to our leadership strategy; employee engagement, reward and recognition; flexible workplaces; staff health and wellbeing; and career development.

Developing New Services

Over the last twelve months, we have continued to innovate and respond to changing needs through new service developments. These include:

Opening Manchester's first ever **Section 136 suite at Park House** on the North Manchester General Hospital site. This suite enables the assessment of individuals detained under Section 136 of the Mental Health Act in a safe and appropriate setting.

Implementing a phased approach to delivering **'Core 24' Liaison Mental Health Services** across our localities as part of a Greater Manchester-wide commitment. Our initial focus has been on Salford and Central Manchester with transformation works planned to commence in Bolton, North Manchester and Wythenshawe in 2019/20 and 2020/21. We have also introduced All Age A&E liaison services in Bolton and Salford, with similar services to follow in our other localities, and have brought our A&E and acute hospital response provision in Manchester together into OneTeam.

Piloting new **High Impact Primary Care (HIPC) Mental Health Teams** in three neighbourhoods within the City of Manchester (Cheetham and Crumpsall, Gorton and Levenshulme, and Wythenshawe).

Commencing roll-out of a **Specialist Perinatal Community Mental Health Team (CMHT)** across the ten Greater Manchester localities in February 2018. The number of women supported by this service has increased steadily over the course of the year and the full service is planned to be operational by April 2021.

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Delivering a new c**ommunity-based Children and Young People's Mental Health Service (CAMHS) in Bolton** in partnership with North West Boroughs Healthcare NHS Foundation Trust.

Introducing additional capacity to enable service users to access care closer to home and reduce our reliance on OAPs. This includes the launch of a new **8-bedded move-on service** (Beech Range) in Levenshulme in partnership with Home Group, one of the UK's largest housing associations. These initiatives have been taken forward as part of our wider 10-Point Plan to reduce OAPs.

Working in partnership with Alternative Futures Group (AFG) to deliver **rehabilitation and recovery services for women with complex needs**, who may otherwise receive care out of the local area, at Honeysuckle Lodge in Bolton.

Delivering the dual diagnosis component of a **Housing First service** being piloted across Greater Manchester by Great Places Housing Group. The service will provide an integrated care pathway for homeless people with complex health needs.

Proactively sharing learning and innovation across our **older adult services** to improve quality of care. We have also contributed to the delivery of the **Dementia United** programme ambitions across Greater Manchester.

Launching **'Achieve'**, our new integrated drug and alcohol recovery service in Bolton, Salford and Trafford. 'Achieve' is delivered in partnership with a range of providers including The Big Life Group, THOMAS, Great Places Housing Group, Early Break and Salford Royal.

Taking the lead provider role in the development of a pilot **University Student Mental Health Service** for Greater Manchester. The pilot is being funded through a partnership between commissioners and universities across the region.

Working with Our Partners

We recognise the value added through closer collaboration and working differently with partner organisations, both in terms of breaking down barriers between services and enabling the delivery of more care in people's home and local communities. We have continued to be actively involved in driving forward the priorities set out by the Greater Manchester Health and Social Care Partnership and in supporting the implementation of integrated care models across our localities (Bolton, Salford, Trafford and Manchester) during 2018/19 in partnership with health, social care and the Voluntary, Community and Social Enterprise (VCSE) sector. We have also been working hard to deliver schemes that fill the gaps between primary and secondary care in each area. These include piloting High Impact Primary Care (HIPC) Mental Health Teams in three areas in the City of Manchester, introducing Primary Care Mental Health Practitioners in Bolton and Salford and implementing the 'Lambeth Model' (a more responsive front door for mental health service users) in Salford via a multi-agency, multi-disciplinary collaborative.

We are also grasping the opportunity to take on the Lead Provider role for medium and low secure pathways across the Greater Manchester region in line with the New Care Models (NCM) and Establishing Steady State Commissioning (ESSC) programmes. This is with a view to improving the quality and flow of care pathways and also maximising the use of resources through the delegation of some commissioning and budget management functions from NHS England to a local lead. Negotiations have been progressing during 2018/19 and we are planning on introducing the new model in shadow form in 2019/20 with full implementation following in 2020/21.

Working with Our Local Communities

We remain committed to supporting our local communities to increase their resilience to mental health problems, raise awareness, reduce stigma and promote mental wellbeing. Our Manchester Wellbeing Fund (MWF) has continued to go from strength to strength during 2018/19 with 110 local community projects funded across the City since its launch and over 4,000 individuals engaged in schemes supported by the Fund.

We are also lucky to have an enthusiastic and committed Council of Governors who aim to ensure that the views of the local communities they represent are reflected in our strategic priorities and work programmes. Over the course of the year we have welcomed nine new elected governors and three new appointed governors to our Council of Governors. Two of our longer-standing governors also retained their seats on the Council of Governors in our most recent elections. We would like to take this opportunity to formally thank those governors who stepped down during the period for their contributions. This includes our former Lead Governor, Les Allen.

Research and Innovation

In addition to progressing change through partnership working and working with our local communities, we have also continued to focus on delivering improvements through research. Our Research and Innovation service has grown over the last 12 months, achieving financial successes with an excellent NIHR (National Institute for Health Research) grant rate, a growing commercial research portfolio and income from the Greater Manchester Clinical Research Network (GM:CRN) and Health Innovation Manchester (HinM). We have used our funding to support a number of internal research initiatives, including the continuation of our six Research Units focused on psychosis; youth mental health; CAMHS.digital; dementia; complex trauma and resilience; and patient safety. We end the year proud to be identified as the second most research active mental health trust in the country.

Finally, we would like to thank our colleagues on the Board of Directors for their continued support during 2018/19. This includes Kathy Doran, who stepped down from her role as Non-Executive Director in July 2018. We have also been pleased to welcome Helen Dabbs to the Board as Non-Executive Director and Liz Calder as Director of Performance and Strategic Development.

We move into 2019/20 knowing that this will be another challenging year for the Trust and the wider NHS. We are confident that in continuing to support our staff and work closely with our partners, we will be able to deliver our future aspirations. We look forward to updating you on our successes in next year's Annual Report.

Neil Thwaite, Chief Executive
20 May 2019

Rupert Nichols, Chair
20 May 2019

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/Greater Manchester Mental Health).

Overview

This section aims to give readers sufficient information about Greater Manchester Mental Health NHS Foundation Trust (GMMH) to understand our organisation, our purpose, how we performed during the year and any risks to the achievement of our objectives.

About Us

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.

The Trust provides inpatient and community-based mental health care for people living in Bolton, Salford, Trafford and the City of Manchester and a wide range of more specialist mental health and substance misuse services across Greater Manchester, the North West of England and beyond.

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 and 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 focused 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 10 prisons and 2 secure children's homes) and community psychological therapies and perinatal ('mother and baby') mental health services. Our specialist inpatient bed numbers stand at 318.

We employ over 5,400 wte (whole time equivalent) members of staff and deliver services from 143 locations. In a 12-month period we expect to meet the needs of around 53,000 services users.

Our main commissioners during 2018/19 were:

Bolton Clinical Commissioning Group
Salford Clinical Commissioning Group
Salford Royal NHS Foundation Trust (SRFT) via a sub-contract arrangement
Trafford Clinical Commissioning Group
Manchester Clinical Commissioning Group
NHS England
Local authorities in Cumbria, Central Lancashire (until September 2018), 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 aim to provide the best possible clinical care and support to people who use our services. Over the last twelve months we have remained focused on our vision of 'Improved Lives and Optimistic Futures for People Affected by Mental Health and Substance Misuse Problems', which is set out in our current strategy 'Achieving our Vision: 2014/15 – 2018/19' and enabled by the delivery of the following six strategic objectives:

To promote recovery by providing high quality care and delivering excellent outcomes
To work with service users and carers to achieve their goals
To engage in effective partnership working
To invest in our environments
To enable staff to reach their potential and innovate
To achieve sustainable financial strength and be well-governed

Our vision is supported by our values, which were developed collaboratively with staff, people who use our services and other key stakeholders:

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

At our 2018 Annual Members Meeting (AMM), we presented awards to individuals and teams from across the Trust who were felt to have best represented our values during the year. The winners and highly commended in each category were as follows:

We Inspire Hope:

Winner – Kay Darlington, Ward Manager on Mulberry Ward, Park House

Highly Commended – Su Martland, Support, Time and Recovery (STR) Worker in Bolton Early Intervention Team

We Work Together:

Winner – Chapman Barker Unit, Prestwich

Highly Commended – Honeysuckle Lodge, Bolton

We are Open and Honest:

Winner – Bethan Rowe, Community Psychiatric Nurse in North Trafford Community Mental Health Team (CMHT)

Highly Commended – Inpatient Operational Lead at Park House, North Manchester

We Value and Respect

Winner – Thomas Cashin, Social Worker in Manchester Central West CMHT

Highly Commended – Deputy Manager in Bolton Psychological Services

We are Caring and Compassionate

Winner – Katie Horton, Community Psychiatric Nurse in Cromwell House CMHT

Highly Commended – Natalie McFarlane, Social Worker in North Trafford CMHT

We Value and Respect winner

We are Caring and Compassionate winner

Developing our Plans

Each year we follow a well-established process for developing plans to support the achievement of our vision and objectives. Consultation with staff, service users and carers, partner organisations and the Council of Governors is a key part of this process. Examples of key achievements against our 2018/19 plans are provided throughout this Report and in our Quality Account. Further information on our forward plans for 2019/20 can be found in our Operational Plan.

As we reach the end of our current strategic plan, work is underway to develop our new long term strategy for the period 2019/20 to 2023/24. Our new strategy will help us to continue to provide high quality care. It will reflect the changes in our local operating environment and the wider healthcare economy, be guided by stakeholder views and set out a clear direction of travel for individual services within the wider strategic framework provided by our Board of Directors. We are aiming to finalise our new strategy in early summer 2019.

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 and staff. We have also elected to differentiate service users and carers within our membership scheme to ensure their voice is heard. Members vote to elect governors and can also stand for election themselves. The Directors Report on pages 49 to 77 outlines the steps taken to ensure that the Board of Directors and Council of Governors fulfil the requirements of their respective roles.

Our clinical services are structured by network and division. Ten divisional service lines are managed within our three operational networks:

Rehabilitation, IAPT, Bolton and Salford Network:
Bolton
Salford
Rehabilitation and Recovery Services
Improving Access to Psychological Therapies (IAPT)

Trafford, Manchester and Manchester City-wide Network:
North Manchester
Central Manchester and City-wide
South Manchester and Trafford

Specialist Services Network:
NHS England-commissioned Services
Health and Justice
Substance Misuse Services

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 87 to 99 of 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.

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.

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
- Performance against national and local targets and regulatory standards
- Capital investment
- Agency expenditure

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.

Recognising the potential impact of Brexit on the NHS, we have assessed our position in terms of, for example, medicines supplies and contracts in line with guidance issued from the Department of Health and Social Care (DHSC). We have not identified any significant risks at this point in time. We are, however, continuing to take action locally to ensure our readiness. This includes enhancing our emergency preparedness, resilience and response (EPRR) structures and linking into the national Operational Resource Centre (ORC).

Going Concern Disclosure

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

Performance Analysis

We are a well-performing organisation with a good track record of delivering financial, operational and quality targets set by our commissioners, regulators and the government. Performance has been impacted as expected by the acquisition of Manchester Mental Health and Social Care NHS Trust (MMHSCT) on 1 January 2017. We have focused on extending and embedding our robust approach to performance reporting and governance across the combined organisation during 2018/19.

Our performance management framework defines our principles of performance management and sets out how these should be put into practice across the organisation.

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, monthly clinical improvement 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. The Quality Improvement Committee (QIC) 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 supports 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 performance against KPIs is clearly visible at all levels with 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

The NHSI Single Oversight Framework (updated in November 2017) sets out the key national performance requirements. Our key performance indicators and reports reflect these as appropriate.

The following table summarises our performance against our key performance indicators during 2018/19. 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 2018/19 provides more detailed information on our CQUIN schemes and performance against the key mental health targets. As indicated above performance in 2018/19 has been impacted as expected by the acquisition of MMHSCT.

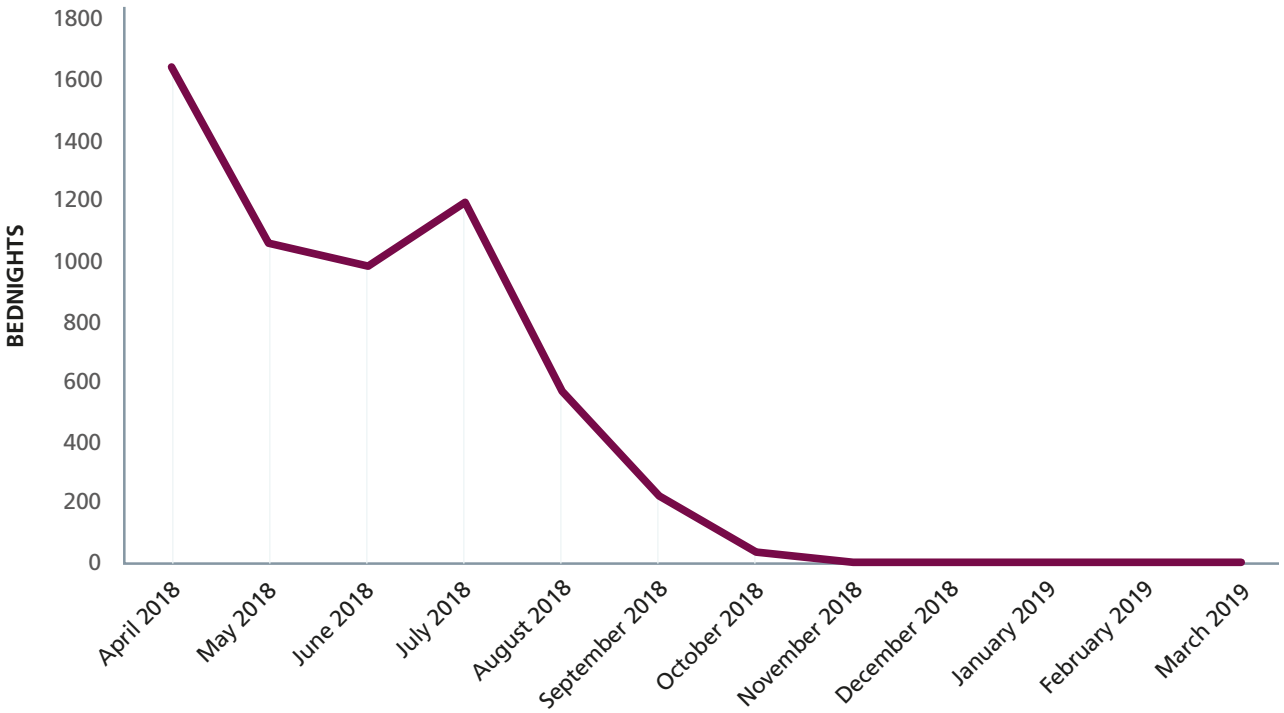
CQC Domain	Source	Indicator	GMMH End Q4
Effectiveness	Single Oversight Framework	Data Quality Maturity Index (DQMI) MHSDS Dataset Score – data completeness	G
	Single Oversight Framework	Reduction in Inappropriate out of area placements for adult mental health services	G
	National CQUIN	Frequent A&E Attenders' Support	G
Safety	Single Oversight Framework	Occurrence of never events	G
	Single Oversight Framework	Admission to adult facilities of patients who are under 16	G
	Single Oversight Framework	CPA 7 day Follow up	G
	Care Quality Commission (CQC)	Registration	G
	National CQUIN	NHS Staff Health and Wellbeing	G
	National CQUIN	Healthy Food - for staff, visitors and patients	G
	National CQUIN	Flu Vaccinations - for frontline clinical staff	G
	National CQUIN	Communication with GPs – improving physical health of those with an SMI (severe mental illness)	G
	National CQUIN	Improving transition from CAMHS	G
	CCG CQUIN (Manchester only)	Suicide Prevention	G
	NHSE CQUIN	Reducing Restrictive Practices - within low and medium secure services	G
	NHSE CQUIN	Discharge and Resettlement - for all specialist mental health inpatient services	G
		Transition from Inpatient CAMHS	G
Responsiveness	Single Oversight Framework	Early Intervention - treatment start within 2 weeks	G
		Cardio-Metabolic Assessment – cardio-metabolic assessment and treatment for people with psychosis is delivered routinely for Inpatient wards, Early Intervention in Psychosis and Community Mental Health services (those on CPA)	A
		IAPT - treated within 6 weeks	R
		IAPT - treated within 18 weeks	R
	National CQUIN	Risky Behaviours - preventing ill health from risky behaviours	G
Caring	Single Oversight Framework	IAPT Recovery – achievement of 50% recovery target	R
	NHS England CQUIN	Development of Recovery Colleges – for medium and low secure patients	G
Well-led	Locally-set	Sickness Rolling 12 Months	R
	Locally-set	Sickness In-Month	R
	Single Oversight Framework	Finance and Use of Resources	A
		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 2018/19, 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 continued during 2018/19. This has included the development of trajectories to clear historical waiting lists and more effective and timely management of new referrals. We are beginning to see improvements in performance as a result of these actions. We 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, which impacts on our recovery rates as these are linked to the delivery of the whole stepped-care IAPT pathway.

A significant challenge at the start of 2018/19 was the achievement of an agreed 33% target reduction in inappropriate reportable Out Of Area Placements (OAPs) bednights. (An inappropriate reportable OAP is where a client has been placed in a provider outside of Greater Manchester (GM) due to no bed availability across the region. This target aims to ensure all service users are placed as close to home as possible promoting access to consistent care, friends, family and local communities and improving recovery potential.) GMMH was one of the highest users of out of area placements nationally at the start of the year, in the main due to the position in Manchester. There has been much improvement work completed in 2018/19. This has included the establishment of a GM OAPs group to lead on this indicator and the delivery of the objectives set out in the GM 10-point plan to reduce OAPs. A GM-wide definition has been agreed and consistently implemented across GM providers. As a Trust, we have established additional inpatient bed arrangements within GM which became operational during August. We have also set-up a GMMH-wide bed bureau/patient flow service, which is operational 24 hours a day. This has improved patient flow and promoted effective use of beds, ensuring access to the right care at the right time in the least restrictive setting.

Reportable OAP Bednights April 2018 to March 2019.



The graph on the previous page demonstrates the collective impact of this work, with the Trust significantly reducing reportable OAP bed nights from 1646 bed nights in April 18 to 5 bed nights in March 2019.

As at the end of March 2019, we had made a reduction of 63% compared to 2017/18 OAPs figures. We are focused on sustaining this reduction in 2019/20 and are also planning further reductions in all OAPs including those within Greater Manchester. Improvement work will include promoting timely discharges and developing alternatives to admissions in collaboration with the whole system including third sector partners and voluntary agency support.

The Data Quality Maturity Index (DQMI) is a new indicator for Trusts reflecting completeness of MHSDS (Mental Health Services Data Set) recording in relation to a number of data quality categories. Our latest published figures are from Quarter 1 2018/19 and show the Trust as achieving above the national target of 95%. New categories have been introduced during the year which have impacted on the performance of all providers. We have implemented new data quality reports to support services in improving recording and are linked into the ongoing national debate in relation to this reporting requirement.

The Finance and Use of Resources metric is shown as 'Amber'. The Trust is achieving an overall score of 3 for the finance ratings. The agency costs in 2018/19 result in a score of 4 against the agency metric and the Trust can therefore only achieve a maximum overall Use of Resources score of 3.

Staff sickness absence has continued to be a challenge during 2018/19, with rolling sickness levels consistently recorded above our locally set target. 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 performance against the national cardio-metabolic CQUIN is also rated as 'Amber' currently. This CQUIN covers the cardio metabolic assessment and treatment for patients with psychoses in inpatient wards, community mental health services and on the Care Programme Approach (CPA) for more than 12 months, and Early Intervention services. It also includes new stretch targets for 2018/19 in relation to reducing weight gain and smoking for those patients in Early Intervention services. The results of the national audit are expected in June 2019, however, internal indicative results indicate the Trust should meet inpatient and community and smoking stretch targets in all areas but may not have met the targets for all Early Intervention teams or the reduction in weight gain stretch targets. Significant progress has been made during 2018/19 from the position in 2017/18 particularly in our Manchester services. An e-learning training package has also been commissioned, implemented and accessed by significant numbers of staff. Additional physical healthcare staff have been recruited. Health improvement coaches have supported services to become smoke free as of October 2018 and we have taken proactive steps to set up new support groups and services.

Our Financial Performance

As demonstrated in our Annual Accounts, we delivered a positive financial position at the end of 2018/19. 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 £5.102 million. Our operating surplus for the year is **£7.428 million** before impairments and non-cash pension costs**.** This difference in performance is due to the impact of asset revaluation and impairment and additional income for meeting the control total of £2.292 million.

Our overall Finance and Use of Resources Rating as at 31 March 2019 is 3 (see 105 for further detail).

Our total Comprehensive income, after movements direct to reserves, is £4.836 million.

The District Valuer undertook a desktop revaluation of our property, plant and equipment in February 2019. Due to the significant impact of desk top movement the resultant revaluation has been reflected in the financial outturn as reported at 31 March 2019.

Income and Expenditure Position

We received a total of £319.3 million income for 2018/19, which represented an increase on our planned income.

	For the Year to 31 March 2019		
	Plan	Actual	Variance
	£000's	£000's	£000's
Clinical Income	267,181	280,211	13,030
Other Income	32,039	39,075	7,036
Total Income	**299,220**	**319,286**	**20,066**
Operating Expenditure	(283,718)	(298,592)	(14,874)
EBITDA	**15,502**	**20,694**	**5,192**
Depreciation	(7,524)	(7,558)	(34)
Interest Receivable	132	163	31
Interest Expense	(105)	(109)	(4)
Public Dividend Capital	(5,713)	(5,886)	(173)
Profit/(Loss) on disposal of assets		(12)	(12)
Surplus/(Deficit) before Other Non-Operating Expenses	**2,292**	**7,292**	**5,000**
Other Non-Operating Income/Expenses			
Impairment Losses (Reversals) net (on non PFI assets)		(2,190)	(2,190)
Net Surplus/(Deficit)	**2,292**	**5,102**	**2,810**
Elements of Comprehensive Income	(15)	(266)	(251)
Comprehensive Income	**2,277**	**4,836**	**2,559**

The table below confirms our normalised operating performance:

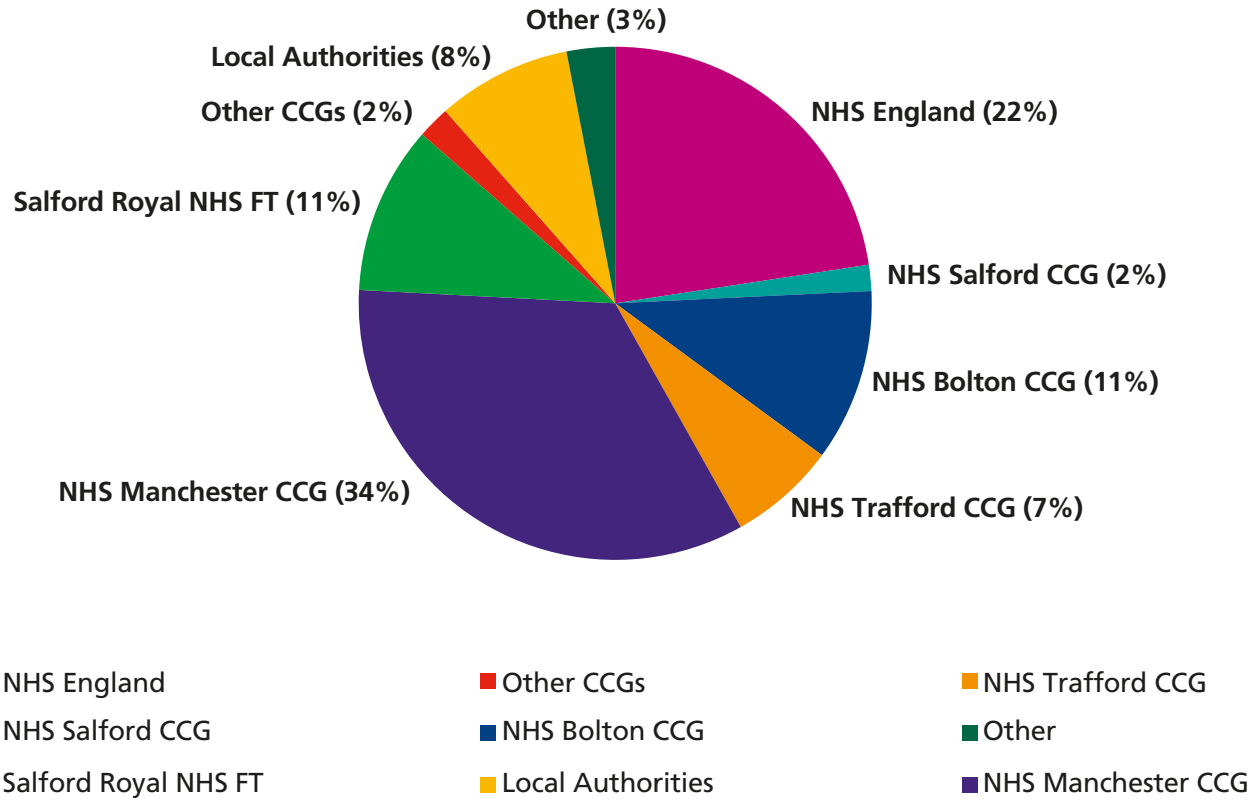
Financial Performance for the year	£'000
Surplus/(deficit) for the year from continuing operations	5,102
Impairments following revaluation of PPE	2,190
Reversal of non-cash SOFP pension	136
Operating Surplus for the year	**7,428**

The majority of our £319.2 million income received related to patient care (£280.2 million). This can be broken down by commissioner as follows:

	NHS England	NHS Salford CCG	NHS Bolton CCG	NHS Trafford CCG	NHS MCR	SRFT*	Other CCGs	Local Authorities	Other	Total
Income (£'000s)	63,309	4,606	30,381	18,993	95,199	29,008	5,732	24,790	8,192	280,211

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, part of SRFT, from 1 July 2017. With effect from 1 April 2019, responsibility for commissioning mental health services for Salford will transfer back to NHS Salford CCG under an alliance model.

Patient Care Income By Commissioner April 2018-March 2019



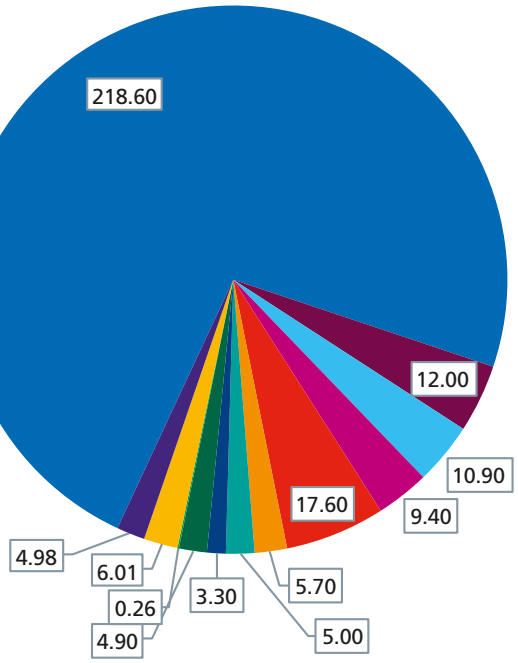
We received £39.1 million other income for non-patient care services, with the majority (£15.8 million) coming from Health Education England (HEE) to support education and training. In addition, we received income of £4.9 million to support research and development, £6.7 million Sustainability and Transformation funding, £6.1 million transition and transformation funding to support the embedding of Manchester mental health services and £5.6m other income.

Our Expenditure in 2018/19 totalled £308.4 million and can be analysed as follows:

Operating Expenses	Expenditure (£'000s)
Staff Costs	218,554
Premises & Transport	11,998
Supplies and Services - Clinical and General	10,869
Purchase of Healthcare from NHS Bodies	9,396
Purchase of Healthcare from Non NHS Bodies	17,571
Other	5,739
Drug Costs	5,002
Establishment	3,300
Research and Development Costs	4,902
Redundancy	264
Rentals under Operating leases	6,017
Training, Courses and Conferences	4,980
Total Operating Expenditure	**298,592**
Depreciation	7,558
Impairments of Property, Plant and Equipment	2,190
Loss on disposal of land and buildings	12
Grand Total	**308,352**

The largest item of expenditure relates to staff costs at £218.6 million or 70.9% of operating expenses. A desktop revaluation of our estate was carried out as at 31 March 2019. This valuation resulted in impairments due to a downward revaluation of £2,190k.

Operating Expenditure Year Ended 31st March 2019



- Staff Costs
- Premises & Transport
- Purchase of Healthcare from NHS Bodies
- Purchase of Healthcare from Non NHS Bodies
- Drug Costs
- Establishment
- Redundancy
- Rentals under Operating leases
- Research and Development Costs
- Supplies and Services – Clinical and General
- Training, Courses and Conferences
- Other

Capital Investment

We have continued to invest in the development and improvement of our estate (patient and non-patient facilities) in 2018/19. We invested a total of £9.98 million across the year. Key capital developments have included a new purpose-built pharmacy on our Prestwich site, the provision of the new patient administration system for the Manchester Services the provision of 5 additional beds on our TEMMS unit at Edenfield, the provision of a S136 suite at Park House and the refurbishment of the Harpurhey Well Being Centre to house IAPT and community based services. We have also invested capital in our IT infrastructure, 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 2019 (£'000's)
IM&T Expenditure (including the implementation of Paris in Manchester)	2,339
Pharmacy at Prestwich site	1429
Knowsley Suite refurbishment - Nursing and Governance	777
MMHSCT Acquisition Backlog Maintenance & Environmental Improvements	511
TEMMS Unit, Edenfield - Additional 5 beds	497
Harpurhey Wellbeing Centre	453
Environment Improvement Works (First Impressions)	387
Manchester services – S136 suite	348
John Denmark Unit (JDU) - INS	325
Hawthorn House - Development of Bolton Rehabilitation and Recovery Service	311
Keswick, Edenfield extension to replace Conservatory day space	264
Decentralisation of boilers	223
Other Specific Schemes less Than £200k	965
Ligature Audit Schemes	145
Backlog Maintenance Schemes	79
Statutory Schemes	173
Energy Improvement Scheme	21
Minor Schemes	358
Vehicle replacements	67
Corporate Overheads	303
Total	**9,975**

Liquidity and Short Term Investments

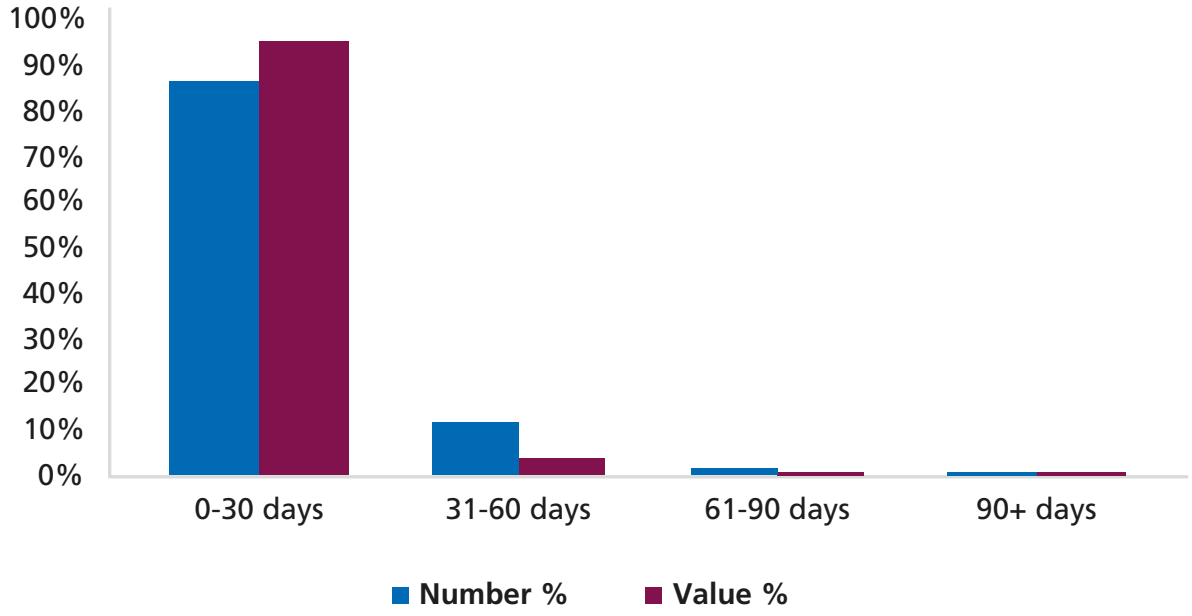
As at 31 March 2019, our cash balance stood at £29.6 million, with interest receivable of £0.1 million being reinvested in the delivery of services.

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 2019 is 86.38% in terms of number of invoices paid within 30 days and 95.14% by value of invoice. We have positive relationships with our suppliers and have not been required to pay any interest accrued by virtue of failing to pay invoices within the 30-day period.

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 2018/19.

Preparation of our Accounts

We have prepared our annual accounts for 2018/19 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 78 onwards.

Future Financial Strategy

The financial year 2018/19 has seen the consolidation and transformation of services following the acquisition of MMHSCT in January 2017. The next few years will prove to be a significant challenge as we continue 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 circa 1% compounds this pressure. For the Trust, this equates to an estimated recurrent savings requirement of £3m. We have an excellent track record of making all required efficiencies and have agreed plans to address this agenda without compromising service quality in 2019/20.

Our financial strategy for 2019/20 aligns with the national planning guidance and commissioners' strategic intentions. It is focused on achieving long-term financial sustainability for the organisation whilst continuing to deliver key financial targets and effectively managing financial risks. Our financial objective is to deliver a financially stable organisation for the financial year 2019/20, whilst managing patient demand and acuity and ensuring the safety and quality of service provision within the resources we receive.

Our overall financial objectives for 2019/20 are to:

Meet our Control Total as set by NHS Improvement;

Report a Use of Resources (UoR) score of 2/3 for 2019/20;

Maintain our overall margin of average earnings before interest, tax, depreciation and amortisation (EBITDA). (EBITDA is used as a measure of operating efficiency and underlying financial sustainability);

Maintain cash balances to support future working capital requirements;

Deliver cost improvement plans (CIPs) in line with national requirements;

Reduce our spending on agency and contract staff;

Reduce reliance on Out of Area Placements (OAPs) and the overall cost of OAPs to the Trust; and

Be a financially stable and sustainable organisation.

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; and

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 Mental Health Investment Standard (MHIS), the ongoing transformation of services to meet the continued growth in both demand and acuity, the continuing impact of the devolution of health and social care in Greater Manchester and any tendering activity in substance misuse 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

In July 2018 we launched our refreshed Service User Engagement Strategy following further consultation with service users and staff from across Manchester services. Sixty people attended the event including staff, service users, commissioners, Healthwatch and the voluntary sector. In it we made our commitment to collaborative care; improving our services based on feedback from our service users; co-producing and co-developing our services with our service users so that they are more responsive to local needs; and co-delivering our services with people with lived experience.

As a result, the number of service users and carers providing valuable support to service development across the organisation has grown significantly during the reporting period. In 2017/18, 622 service users and carers were involved in meetings, away days, inspections, quality initiatives, recruiting staff, and delivering training, compared to 1,197 for 2018/19. Our commitment to widening participation through our Service User and Carer Engagement Scheme is stronger than ever and the development of the Trust's Equality, Diversity and Inclusion Strategy has strengthened our links with voluntary sector and community based organisations. As we look forward to the next 12 months we are committed to increasing the number of people we engage with whom have protected characteristics, ensuring that we meet the diverse needs of the individuals who use our services and the communities we serve.

As a direct result of feedback from our Manchester service users, we have strengthened our governance structures to include a role within the CAREhub for a person with lived experience to connect with all of the different service user groups across the Trust footprint. This will ensure that their experiences and feedback reach the CAREhub (of which the Trust's Chief Executive is now a member). Their role – *Service User and Carer Engagement Coordinator* - will also connect groups with one another so they can share information, ideas and learning.

January 2019 saw the launch of the new NHS Long Term Plan. The commitment to volunteering and peer mentorship previously set out in the NHS Five Year Forward View has been taken forward with a commitment to double the number of volunteers working in the NHS within 3 years. In 2018/19 alone we have met this challenge within our own organisation with 111 active volunteers and 117 in recruitment. 30% of those roles are volunteer peer mentors, who will use their lived experience to support and mentor others in their journey of recovery. In July 2018 the Lancet reported the impact of peer mentoring in mental health, showing a reduction in the use of crisis services and hospital admissions for people who were offered self-help interventions alongside a peer mentor.

Our Recovery Academy continues to grow and we launched our twelfth prospectus on 1 October 2018. 213 training programmes were delivered in 2018/19. The student population has grown to just over 6,400 with 49% of those registered with us as service users or carers. A bank of 96 trainers support the delivery of each prospectus, 28 of whom are people with lived experience, co-producing and co-facilitating our courses alongside our dedicated clinical staff.

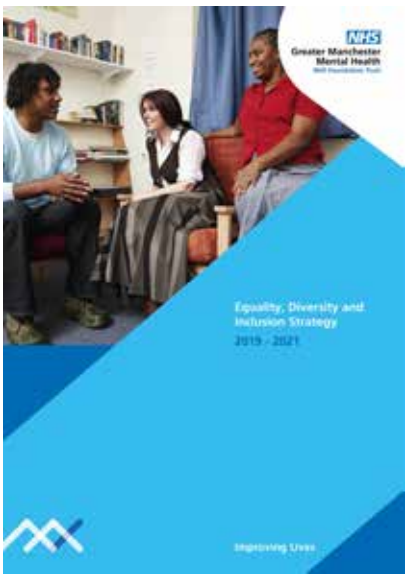
Our research into the impact of the Recovery Academy is still to be published but results show self- reported recovery progression increased for service users who attended courses compared to those that did not attend any courses. Decreased social interaction anxiety for students that did attend was reported alongside an increased sense of wellbeing. Students with lived experience also reported decreased levels of internalised stigma, which actually increased for those that did not attend, and we know that often it is this internal stigma that stops people from accessing help in the first place. Finally, there was a significant association between course attendance and paid/self-employment with the odds 4.57 times higher for people who had attended courses compared to those that hadn't.

Specifically in relation to our carers, we have strengthened our commitment to them by refreshing and relaunching our Carers, Family and Friends Strategy. Following consultation with over 250 carers across the Trust footprint we have identified five priority areas as follows:

Identifying carers in the first place and ensuring they get the information they need to support them in their vital role
Involving carers in their loved ones care
Communicating with carers so they remain engaged
Supporting carers in their own right so that their health remains as important as their loved ones
Improving identification of young carers within the context of our safeguarding commitments

It has been an exciting 12 months and we thank all of our service users, carers, staff and partner organisations for their continued hard work and support. We look forward to the next 12 months working alongside all of them to improve the services we provide, and empowering the communities we serve.

Equality



The Equality, Diversity and Inclusion (EDI) agenda has continued to evolve across the organisation during 2018/19. We have been working closely with staff, service users, carers and stakeholders to realise a personalised, fair and diverse health and social care system.
We have strengthened our regional EDI networks and established relationships with the LGBT Foundation and the Caribbean African Health Network.

Consulting on and developing our new three-year Equality, Diversity and Inclusion strategy has been a key focus for us this year. Our Strategy is built around the four goals stipulated by the Equality Delivery System for the NHS (EDS2) and we have committed to delivering the following priorities:

- Improving service user access and experience of GMMH services
- Better health outcomes
- Representative and supported workforce
- Inclusive leadership
- Culture change and mainstreaming EDI

Progress against our EDI Strategy will be monitored at our Trust-wide Equality and Diversity Committee and Workforce Equality meeting.

We have also consulted on and launched our new Spiritual Care Strategy 2019 – 2021 in April 2019. The Strategy is the outcome of a twelve-month collaboration between our Chaplaincy and Spiritual Care Team, service users, staff and carers. It identifies spiritual care as an integral component in helping us to understand, treat and promote recovery from mental ill health. Although our Chaplaincy and Spiritual Care Team are focused on delivering and facilitating spiritual and religious care to service users, staff and carers across the Trust, spiritual care is also an important dimension in the holistic assessment of a service user's needs by our frontline professionals. Our Spiritual Care Strategy sets out six key priorities for the future:

Sharing our vision statement on spirituality
Promoting our Spiritual Care and Recovery Course at the Recovery Academy
Establishing a Spiritual Care hub
Initiating a multi-disciplinary network of staff committed to implementing spiritual care
Increasing the diversity of faiths and non-faiths in the Chaplaincy Team
Continuing to build good relations with all faith/non-faith groups across Greater Manchester

During 2018/19, we have celebrated a number of achievements related to equality and diversity. These include:

Provision of a mental health and homeless team in Manchester
Development of an inclusive staff network that runs a quarterly networking event and leadership programme
Development of an organisational Autism Strategy
Taking an instrumental role in the development of the Greater Manchester Carer Toolkit for employees
Development of a gender identity co-produced session at the Recovery Academy
Ensuring our care plans are personalised and reflect service users' holistic needs
Introduction of Accessible Information Standard (AIS) training and system changes to reflect AIS annual review requirements
Diversifying our staff recruitment channels and service user engagement schemes

Equality Strategy Launch

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 2018/19, we continued to address all of our local equality and diversity objectives. We have, however, continued to face challenges in the recording of protected characteristics and have incorporated this issue as a key objective in our new EDI Strategy for 2019 to 2021.

Pathways into Employment and Apprenticeships

2018/19 has seen significant progress made with regard to pathways into employment and apprenticeships. As a registered Apprenticeship Training Provider with the Education and Skills Funding Agency (ESFA RoATP), we draw down funding directly from the Apprenticeship Levy. We have seen a significant increase in the number of our staff taking up Apprenticeship opportunities this year, as well as an increase in services recruiting into roles specifically developed to support someone into an Apprenticeship opportunity. As at March 2019, 4.2% of our workforce were engaged in an Apprenticeship programme, which is in excess of the Public Sector statutory target of 2.3%.

Our internally delivered Apprenticeship portfolio has continued to grow during 2018/19. We currently have 211 colleagues on 36 different Apprenticeship programme pathways and levels. We have continued to provide apprenticeships in Health and Social Care, Business Administration and Customer Service. To support our aspiring leaders we have also introduced an Apprenticeship in Leadership and Management (ILM) at Level 3 to complement our existing ILM Level 5 Apprenticeship programme. Our dedicated Functional Skills Tutor supports learners in the achievement of maths and english qualifications. Our internal Apprenticeships are now entirely based on the new Apprenticeship standards and facilitate the stretch and challenge of learners via service improvement projects to support Cost Improvement Programmes (CIPs).

We were again delighted to have our Matrix Accreditation renewed in 2018/19. The Matrix standard is a quality assurance framework that measures the career education, information, advice and guidance given to learners engaged in our Apprenticeship programmes. In November 2019 we hosted our first OFSTED Support and Monitoring visit and achieved an excellent outcome. OFSTED judged us as having made significant progress in all three judgement areas of the visit. To date, we are the only NHS Trust in the UK to achieve this outcome. We continue to demonstrate strong financial management of our Apprenticeship Levy and have taken further steps to strengthen our partnerships with local training providers. This has enabled a number of our staff to access more specialist programmes such as the Trainee Nurse Associate Programme (TNA).

We have continued to grow our offer to the local community to take part in different levels of work experience within the Trust, which as a result has seen this become a route of employment for some of those who have been on a placement with us. During 2018 we commenced a Cadet programme in partnership with Bolton College whereby Level 3 Healthcare Students have been able to undertake the practical elements of their qualification on some of our inpatient wards.

Finally, in October 2018 we celebrated our Apprentice of the Year Award at our Annual Members Meeting. We hosted two awards for Clinical and Non Clinical Apprentices. We could not be prouder of our winners Heather Parkinson (Clinical) and Phil Denman (Non Clinical) who have achieved so much in their learning journeys whilst making vital contributions to our services and service users. In March 2019 we celebrated National Apprenticeship Week for the third year running and, with the support of our Communications Team, embarked on a successful social media campaign raising awareness of the vast array of Apprenticeship opportunities available to our colleagues.

Homelessness

Homelessness has become an increasingly significant problem across the country in recent years. We are working on the development of a Trust-wide response focused on preventing service users from becoming homelessness and improving access to mental health services for people who are homeless. The links between homelessness and mental health are clear in that mental health problems can be both a cause and a consequence of homelessness. It is also clear that no single agency can tackle this problem effectively and mobilisation of cross-sector partnership working is required to deliver change.

For GMMH the problem is most acute around the city of Manchester. We established a Mental Health and Homelessness Operational Group in November 2017, which brings together clinical services with key housing agencies and community projects. The group reports into homelessness partnership structures and is integral to the homelessness and health action plan.

Key developments have included the expansion of our dedicated mental health and homelessness team and the reorganisation of the homelessness pathway across community and inpatient mental health services so that homeless people are identified sooner and offered appropriate support. We have also established an IAPT clinic at The Booth Centre which enables greater access to psychological therapies for homeless people and ‘buzz’, our health and wellbeing service, provides dedicated physical and mental wellbeing support at key homeless venues. We are also delivering a mental health training programme for housing staff and are leading on a programme to establish Psychologically Informed Environments (PIEs) in key homeless services. This approach is supported by national homelessness Trailblazer funding and in October 2018 we delivered a very successful conference in central Manchester highlighting national best practice in psychological approaches for homeless people.

We have also responded to the new statutory duties created by the Homelessness Reduction Act, have systems in place to identify people being treated in our in-patient settings who are either homeless or at risk of homelessness, and have established extra capacity to provide housing advice and support.

Sustainability

During 2018/19, 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. In late 2019, we were delighted to be able to donate furniture through 'Warp It' to the Kori Project, which helps to educate, empower and improve the health of women and girls in Taiama in the Kori district of Sierra Leone. We have also donated ink cartridges to a local foodbank and our used pallets to Sow the City, enabling our service users to engage in gardening activities.

Through 'Warp It' our waste avoided to landfill Kgs has increased by 4,463kgs compared to 2017/2018 figures. Our CO_2 (KG) Emissions avoided have also increased by 3,602kgs from 2017/2018.

Efficiencies realised through 'Warp It' in 2018/2019:

CO_2 Saved (KG)	Cars off the Road	Waste Avoided (KG)	Trees Planted Equivalent	Total Savings
27,905	4	10,960	18	£59,654

Total efficiencies realised since the introduction of 'Warp It' in 2015/16:

CO_2 Saved (KG)	Cars off the Road	Waste Avoided (KG)	Trees Planted Equivalent	Total Savings
76,183	4	24,688	104	£174,930

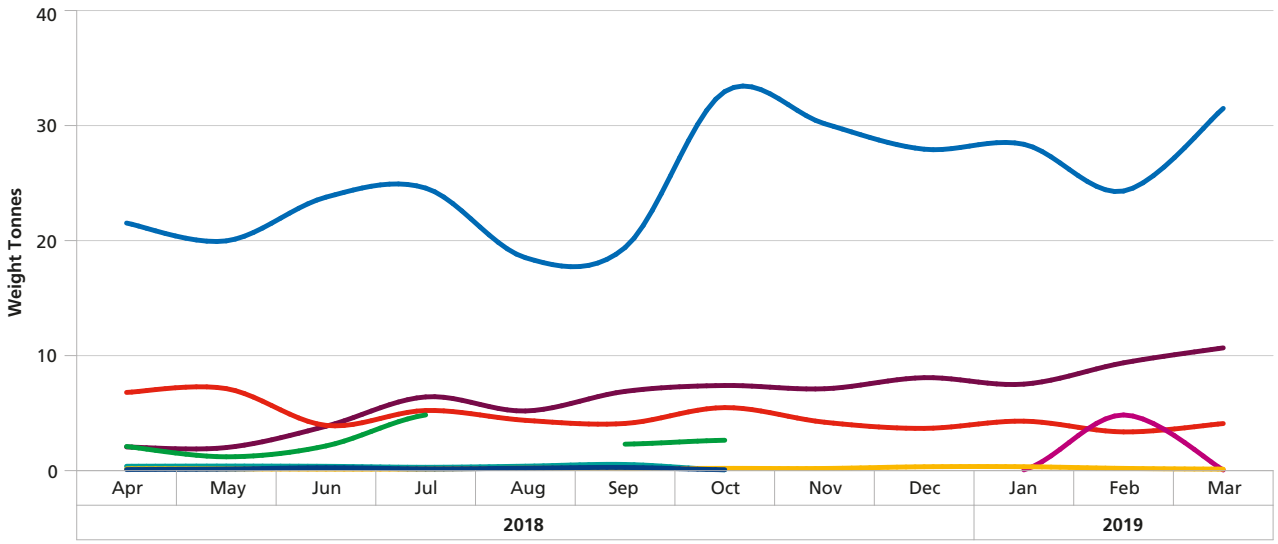
As part of our long-term sustainability commitment plan we have recruited a Sustainability Manager to oversee and manage all GMMH Sustainability activity. Other current examples of good practice include:

- Minimising pollution from vehicles through, for example, 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;
- Promotion of cycle to work schemes and the provision of changing rooms, showers and cycle racks/pods in a number of areas;
- Working with our Domestic and Dry Mixed Recycling collection provider to provide more waste streams across our organisation. This has included increased segregation of waste at our Recycling Yard at Prestwich to allow better wood recycling along with cardboard and general waste;
- Introduction of a Metal Skip - we receive a rebate of 70% of any profit made from selling the metal on;
- Action plans to reduce the number of office bins in corporate workspaces and create centralised recycling areas which will be more convenient for our Domestic staff;
- The use of clear waste bags as opposed to the black household ones still in use in many trusts;
- Segregation of spent coffee grounds from the hot beverage machines at both The Curve and Waterdale Restaurants for recycling into carbon-neutral advanced biofuels; and
- Exploring Food disposal routes with Anaerobic Digestion plants.

The following analysis provides an overview of our recycling performance in 2018/19. The total % recyclable is an 8.72% improvement on the 2017/18 position.

	Total 2018/2019
Total Tonnage Collected	466.169
Non-Recyclable Tonnage	380.599
Recyclable Tonnage	85.670
% Recyclable	**18.36%**

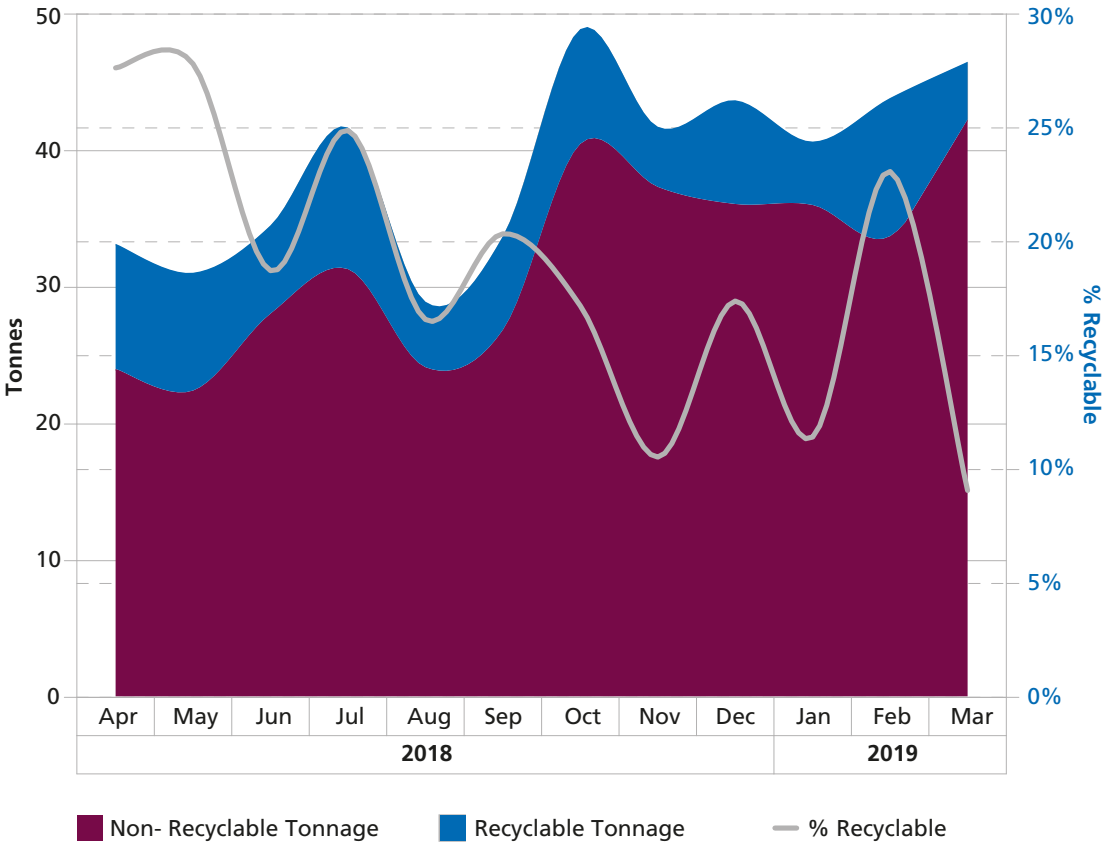
Tonnage by Contracted Material Type



Waste Type

- General Waste for RDF Production IC
- General waste Wet - with organics
- Dry Mixed Recycling IC
- Wood General IC
- None Entered
- Mixed Metals IC
- General Non-Hazardous Waste IC
- General Mixed Recyclables IC
- Cardboard OCC 90/10 IC

Recyclables Analysis



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 energy usage in year. This has led to a decrease in our CO_2 emissions and the amount of carbon used.

Overall Trust Performance	2017/18	2018/19
Giga joules per 100m^3 (Gj/100m$^{3)}$	41.34	35.26
Tonnes of CO_2 (Tonne/CO_2)	6,442.58	5,416.17
Tonnes of Carbon	2,439.27	1,563.06

As demonstrated above, an overall reduction of 6.28 Gj /100m^3 in energy usage has led to a reduction of 1,026.41 tonnes of CO_2 and 876.21 tonnes of carbon in year. *(Date Source – mandatory Estates Return Information Collection (ERIC)).*

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 2018/19, 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.

Research and Innovation

Our Research & Innovation (R&I) Service has continued to develop over the last 12 months strengthening infrastructure within the R&I Office, the Research Delivery team and the Research Units. The service has been fully funded by external research income including National Institute for Health Research (NIHR) grant successes leading to Research Capability Funding (RCF), a growing commercial research portfolio and income from the NIHR Greater Manchester Clinical Research Network (GM:CRN) and Health Innovation Manchester (HinM).

Our R&I Strategy was finalised in December 2017 and progress has been made throughout 2018/19 against all six key aims particularly in relation to our Research Units. Our strategic aims are to:

- 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 2018/19 for all active grants awarded to GMMH was £3,397,447. There has also been a number of new NIHR grant successes within the last 12 months which will run over the next three to five years. Areas of focus include prevention of suicide in prisons, improving prediction of psychosis and the development and trial of a culturally-adapted family intervention. Our six Research Units are proving to be a great asset with grant successes, new service user researchers, service user/experts by experience groups established, industry links and continued academic and clinical collaboration. In 2018/19 there has been over 100 active projects with more than 1,500 participants recruited to date including service users, carers and staff. Research Events have included showcasing Research Unit progress as well as a joint event with the Nursing Academy to strengthen research across the nursing workforce.

Further investment has been made by the R&I Service in the Research Units for 2019/20 with an expectation that they will continue to align themselves with clinical services, act on service user priorities and generate research income. Investment has also been made to support nursing research, fellowship applications and growing areas such as substance misuse.

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 on our DATIX system and reported to the Board of Directors on a monthly basis as part of the Board Performance Report.

Learning from complaints is triangulated with other service user experience data and reviewed at our CAREHub. There are different methods to disseminate learning from complaints, positive learning events, seven-minute briefings and various other communication strategies. In a recent audit, Mersey Internal Audit Agency provided an opinion of 'Substantial Assurance' that there is a good system of internal control designed to manage complaints and that controls are generally being applied consistently.

We received 852 complaints during the reporting period. The following table breaks these complaints down by service area and provides a comparative position against 2016/17 and 2017/18 complaints data for all the services that now make up GMMH.

	2017/18	2018/19
Bolton	87	110
Manchester	235	343
Salford	101	124
Specialist Services	103	207
Trafford	63	68
Totals:	**589**	**852**

The increasing trajectory in terms of numbers of complaints received cuts across all of our services. The increase in specialist services can be contributed to the addition of new services, including prison health services and Child and Adolescent Mental Health Services (CAMHS) during the period. Analysis of the increase in Manchester has not identified any recurring themes and may be linked with ongoing service redesign.

312 improvement actions have been identified across the organisation as an outcome of complaints received in 2018/19. Of these, 146 actions had been completed by the end of March 2019 with the remaining 166 improvements still in progress.

Examples of service improvements during 2018/19 include:

The introduction of robust procedures for secondary mental health services referring service users to psychological services;

Improved information for relatives and carers about inpatient services and amendments to our Mental Health Act information;

Following communication breakdown when service users are transferred between care settings, our Operational Managers in Manchester have developed a briefing sheet along with guidance to ensure that the right level of information is handed over;

Improved carer awareness and training in services where there have been carer-related complaints; and

Changes to various trust training programmes and policies to reflect and share learning.

Significant Events Post 1 April 2019

There have been no significant events since 1 April 2019, 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
20 May 2019

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 2018 to 31 March 2019.

The Directors' Report should be read alongside the Performance Report, Quality Account and Annual Governance Statement.

Following our most recent core service with well-led inspection by the Care Quality Commission (CQC), the CQC awarded an 'Outstanding' rating for well-led (leadership) in February 2018. In awarding this rating, the CQC highlighted:

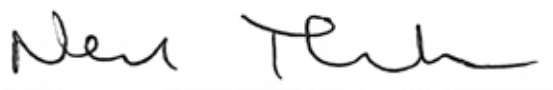
- The leadership team's effective oversight of the risks and challenges facing the trust
- The maintenance of a strong clinical and financial performance during and subsequent to the acquisition
- The trust's effective approach to partnership working
- The well-established and thorough systems for investigating 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

We have continued to progress delivery of the action plan developed following our last well-led assessment during 2018/19. No material inconsistencies have been identified between the outcomes of that assessment and our own current evaluation of the organisation's performance and system of internal control as set out in this Annual Report. We have received notification that the CQC will complete its next planned inspection of the Trust during the first half of 2019/20 and are actively preparing for this.

Statement as to Disclosure to Auditors

All Directors have confirmed that the Annual Report and Accounts for 2018/19, 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 unaware and that they have taken all the steps that they ought to have taken as a director 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 26 onwards.



Neil Thwaite, Chief Executive (by order of the Board)

Date: 20 May 2019

Our Governance Arrangements

We work hard 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 and experience in finance, strategy, business development, the law and the third sector. 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 focused 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 68. 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 statutory duties, through attendance at Council of Governors' meetings and the Annual Members' Meeting. 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 70 onwards for further detail on the activities of our Council of Governors during 2018/19.

Our Board of Directors

There have been no significant changes to the portfolios of executive members of the Board of Directors since 1 April 2018. Neil Thwaite acted as Interim Chief Executive from 1 April 2018 and took on the role substantively following Council of Governors approval of his appointment on 9 April 2018. Andrew Maloney's portfolio expanded in January 2019 to include the role of Deputy Chief Executive.

Liz Calder joined the Board of Directors in February 2019 as Director of Performance and Strategic Development. Prior to Liz Calder's appointment, Mary Lee (Associate Director of Development and Performance) acted up into this position, as Acting Director of Development and Performance, from May 2018.

Helen Dabbs joined the Board as a Non-Executive Director in September 2018 following Kathy Doran's retirement in July 2018.

The substantive members of our Board of Directors at the end of 2018/19 were:

Non-Executive Directors

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 sectors. 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.

Non-Executive Directors

Anthony Bell

Non-Executive Director (current terms ends July 2021)

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 that 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.

Helen Dabbs

Non-Executive Director (current term ends September 2021)

Helen is recently retired. Prior to retirement, Helen most recently worked at executive level at NHS Improvement (NHSI) North (2015 to 2018) as Regional Nurse Director and Delivery and Improvement Director, where she had oversight of the safety, quality and financial sustainability of provider trusts and also supported trusts with their quality improvement agendas. Helen joined NHSI from Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) where she held progressive roles including Director of Mental Health (2002 to 2005), Director of Operations (2005 to 2008), Acting Chief Executive Officer (2008 to 2009) and Deputy CEO/Director of Nursing and Partnerships (2009 to 2015). During her time at RDaSH, Helen also held a number of additional roles including Specialist/Clinical Advisor to CHI/Healthcare Commission/Care Quality Commission (CQC) and National Taskforce Advisor to the Better Care Fund.

Helen's early career began with clinical nursing posts (general and mental health) (1984 to 1991), prior to progression to senior management roles in provider organisations (1991 to 2002). Helen holds professional dual registration as a nurse.

Helen is a member of the Quality Improvement Committee.

Non-Executive Directors

Stephen Dalton

Non-Executive Director and Vice Chair
(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. He currently leads Chief Executive Development groups at a national level.

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 has been Chair of GMMH's Quality Improvement Committee since Kathy Doran's retirement and is also a member of the Charitable Funds Committee.

Non-Executive Directors

Andrea Harrison (née 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 CBE

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.

Executive Directors

Neil Thwaite

Chief Executive

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.

Liz Calder

Director of Performance and Strategic Development (from February 2019)

Liz joined GMMH in 2019 from the Northern Care Alliance NHS Group, where she held the post of Deputy Director of Strategy and Planning and provided strategic leadership and support to key programmes of work. Since joining the NHS as a Graduate Management Trainee in 1994 Liz has worked in senior roles across the North West of England including commissioning, community, acute and tertiary organisations. As an Economics graduate with an MA from University of Manchester Liz has extensive experience in strategic change, significant transactions, service developments, contracting, tenders, planning and operational management. Recent roles have included working with partners to establish the first Integrated Care Organisation in the country and the national proton therapy service at The Christie.

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 and offers 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.

Executive Directors

Andrew Maloney

Director of Human Resources
and Deputy Chief Executive

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 capital, estates and facilities (CEF) and corporate affairs. Andrew was also appointed as the Trust's Deputy Chief Executive in early 2019.

Andrew undertakes two national roles as an NHS Employers representative on the Social Partnership Forum and the NHS Staff Council.

Deborah Partington

Director of Operations

Deborah began her NHS career over 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 of the operational management of all clinical services.

Meetings of the Board of Directors

During 2018/19, the Board of Directors met formally on 9 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 not less than two executive directors, of which one must be the Chief Executive or Deputy Chief Executive, and not 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 2018/19 Board meetings.

	Name	Number of Meetings Attended	Number of Meetings the Director could have Attended
Non-Executive Directors	**Rupert Nichols,** Chair	9	9
	Anthony Bell, Non-Executive Director	8	9
	Helen Dabbs, Non-Executive Director	6	6
	Stephen Dalton, Non-Executive Director	8	9
	Kathy Doran, Non-Executive Director	3	3
	Julie Jarman, Non-Executive Director	9	9
	Andrea Harrison , Non-Executive Director	8	9
	Pauleen Lane, Non-Executive Director	8	9
Executive Directors	**Neil Thwaite,** Chief Executive	9	9
	Liz Calder, Director of Performance and Strategic Development	2	2
	Chris Daly, Medical Director	8	9
	Gill Green, Director of Nursing and Governance	9	9
	Ismail Hafeji, Director of Finance and IM&T	9	9
	Andrew Maloney, Director of HR and Deputy Chief Executive	9	9
	Deborah Partington, Director of Operations	9	9

Mary Lee attended all Board of Directors meetings held during the period May 2018 to January 2019 in her capacity as Acting Director of Development and Performance, with the exception of the October 2018 meeting.

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, whilst the Chair's performance is appraised by the Senior Independent Director. The Chief Executive appraises individual executive director performance. The appraisal process is competency-based, targeted towards the specific requirements of individual roles and includes self- and peer-assessment. The Nominations Committee of the Council of Governors receive a report on the outcomes of the Chair and non-executive director appraisal process and this is, in turn, considered at a full meeting of the Council of Governors. The Remuneration and Terms of Service Committee are briefed on the outcomes of the Chief Executive and executive director appraisal process. Objectives and personal development plans for the upcoming year are agreed through the appraisal process.

Board development activity during the reporting period followed a formal schedule and commenced in June 2018. Development activities have focused on the digital agenda, quality improvement, equality and diversity, the new NHS Long Term Plan and the development of GMMH's new strategy, cyber security, inquests, Mental Health Act (MHA) Reform and corporate criminal liability. All Board members participated in a collective review of Board effectiveness, facilitated by Impact Consulting Ltd., in December 2018. (Impact Consulting Ltd. have no other connection to the Trust). Improvements agreed as an outcome of this review included mechanisms for increasing non-executive director involvement in key strategic initiatives at an earlier stage.

All individual Board members have completed an annual self-assessment 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 also continued to evaluate the effectiveness of Board meetings at the end of each meeting with feedback reviewed at the subsequent meeting and informing future Board development activity.

Board Committee Structures

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

A. Audit Committee

B. Quality Improvement Committee (formerly 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 Chairs' reports 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 anti-fraud arrangements in place.

The Audit Committee Terms of Reference were subject to an annual review in September 2018.

Committee Membership and Meetings

The Audit Committee has been chaired throughout the year by a non-executive director. 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 2019 was as follows:

Andrea Harrison (née Knott), Committee Chair

Anthony Bell, Committee Vice-Chair

Pauleen Lane, Committee Member

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 Deputy Chief Executive 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 2018/19 and the table below shows each member's attendance.

Name	Number of Audit Committee Meetings Attended	Number of Meetings the Director could have Attended
Anthony Bell, Committee Member and Vice-Chair	5	6
Andrea Harrison, 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 2018/19. Right of access to the Committee Chair for internal audit, external audit and counter-fraud has also been maintained throughout the year.

Audit Committee Effectiveness

The Audit Committee completed its annual review of effectiveness in February 2019. This review was informed by self-assessments completed by Audit Committee members and also considered performance against the Committee's agreed objectives for 2018/19. The outcomes of the review were positive overall, with a number of actions for improvement identified and being progressed.

Assurance - Internal Audit

Our internal audit function has continued to be provided by Mersey Internal Audit Agency (MIAA) during 2018/19. Our Team at MIAA consists of an Engagement Lead and Engagement Manager.

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 2018/19 was agreed by the Audit Committee in February 2018 and reflected the risk assessment, assurance requirements and strategic objectives of the enlarged organisation. The plan was reviewed during the year and amended as appropriate to reflect current and changing priorities. The plan was delivered within the agreed reporting timescales. The Audit Committee received reports on 12 internal audits completed during the reporting period, of which 10 received a 'Substantial Assurance' opinion, 1 received a 'Moderate Assurance' opinion and 1 received a 'Limited Assurance' opinion. 56 recommendations were raised as part of the reviews. The 'Limited Assurance' opinion followed completion of a Quality Spot Checks audit. Corporate thematic recommendations emerging from this audit have subsequently been taken forward in addition to the agreed actions for individual wards.

The Committee has secured assurance on progress with 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 2018/19 in April 2019. 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 2018/19, we spent £151,820 on internal audit, of which £32,780 related to anti-fraud services.

Assurance - External Audit

External audit services have continued to be provided by KPMG LLP during 2018/19. KPMG's current contract term as our external auditors commenced in December 2016 following appointment by the Council of Governors.

KPMG have continued to present technical updates to the Audit Committee on accounting, business and regulatory matters that are relevant to our organisation and the wider healthcare sector during 2018/19. The effectiveness of KPMG's services has been judged on the basis of the quality of their audit provision, level of challenge, timeliness of reporting and communication and engagement. In February 2019, KPMG made the case to the Audit Committee on their independence and compliance with applicable technical and ethical standards.

On 4 February 2019, the Audit Committee considered and approved the 'External Audit Plan for 2018/19', including the proposed materiality levels and financial risk assessment.

We incurred external audit fees of £78,696k in 2018/19 for statutory audit services, comprising external audit fees of £64,790 and Quality Account fees of £13,906. No non-audit services were commissioned from KPMG.

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 February 2018 and informed by national and regional risk areas, GMMH-identified strategic risks, management requests, national standards and best practice.

The Audit Committee received regular reports on the progress and outcomes of anti-fraud work during the period, in addition to briefings on 'live' anti-fraud investigations to enable more timely action. As a result of this, the Committee requested deep dives into two areas during 2018/19 – estates maintenance and verification of bank and agency shifts – where concerns had been raised. The Committee sought further action and assurance from the management team from both a fraud and staffing perspective in both areas. We completed our annual self-assessment against the NHS Counter Fraud Authority's Standards for Providers in late 2018/19.

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.

On the basis of the information received by the Audit Committee, the 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 2018/19, we spent £32,780 on anti-fraud services.

Audit Committee Review of Financial Statements, Operations and Compliance

On 29 April 2019, the Audit Committee reviewed a summary of the Trust's performance based on the annual accounts for the period 1 April 2018 to 31 March 2019. The Committee noted any variations from performance in 2017/18 including the explanations provided for this. Management brought to the Committee's attention significant movements in the accounts over the period.

Compliance with financial reporting standards
Areas requiring significant judgements in applying accounting policies
Any changes to accounting policies during the year
Whether the accounts offer a fair reflection of the Trust's performance

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

The Committee considered the significant audit risks identified in relation to the financial statements, including the recognition of NHS income and deferred income, the valuation of land and building assets, the valuation of the Local Government Pension Scheme (LGPS) liability, the recognition of expenditure and management override of controls. 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 represent a true position of the Trust's finances.

Audit Committee Review of Annual Governance Statement

At its meeting on 29 April 2019, the Audit Committee reviewed the draft Annual Governance Statement for 2018/19. The statement was judged consistent with the Audit Committee's view on the organisation's system of internal control.

B. Quality Improvement Committee (formerly Quality Governance Committee)

Working on behalf of the Board of Directors, the Quality Improvement Committee aims to ensure that our organisational culture supports and encourages staff to deliver quality improvements, share learning and report harm and errors. The Committee ensures that quality goals and outcomes are effectively consulted, communicated and understand from 'Board to Ward to Board' and tracks performance against agreed quality priorities, requiring action to be taken on any sub-standard performance. With the agreement of the Board, the Committee's name was changed from the Quality Governance Committee to the Quality Improvement Committee in late 2018/19 to better reflect the Committee's increased focus on quality improvement and its role in overseeing delivery of the Trust's emerging new Quality Improvement Strategy from 2019/20 onwards.

The Board of Director members of the Quality Improvement Committee as at 31 March 2019 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 2018/19 to ensure appropriate representation from across the Trust's services. The Terms of Reference for the Quality Improvement Committee were reviewed in February and March 2019.

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

	Name	Number of Quality Improvement Committee Meetings Attended	Number of Meetings the Director could have Attended
Non-Executive Directors	**Helen Dabbs,** Committee Member	5	6
	Kathy Doran, Committee Chair until July 2018	2	3
	Julie Jarman, Committee Member and Committee Chair from Sept. 2018	9	9
Executive Directors	**Chris Daly,** Medical Director and Vice Chair	9	9
	Gill Green, Director of Nursing and Governance	9	9
	Neil Thwaite, Chief Executive	4	9
	Andrew Maloney Director of HR and Deputy Chief Executive	6	9
	Liz Calder, Director of Performance and Strategic Development	0	2

An Associate Director of Operations also attended each meeting of the Quality Improvement Committee on behalf of the Director of Operations. Key areas of focus for the Quality Improvement Committee during 2018/19 are reported on in our Quality Account. A Quality Improvement Committee effectiveness review is planned for early 2019/20.

C. Charitable Funds Committee

Our Charitable Funds Committee aims to ensure that the Trust properly discharges its responsibilities as Corporate Trustee of the Trust's Charitable Funds. During 2018/19, our focus has been on enabling expenditure through, for example, pooling funds and also raising staff awareness of the funds available through a relaunch of the Charitable Fund. Funds designated for research have been transferred to our Research and Innovation budget during the reporting period to support deliver of our Research and Innovation Strategy.

Committee membership during 2018/19 has 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 Charitable Funds Committee met three times in 2018/19 with attendance recorded as follows:

	Name	Number of Charitable Funds Committee Meetings Attended	Number of Meetings the Director could have Attended
Non-Executive Directors	**Anthony Bell,** Committee Chair	2	3
	Julie Jarman, Committee Member	2	3
Executive Directors	**Gill Green,** Director of Nursing and Governance	2	3
	Ismail Hafeji, Director of Finance and IM&T	3	3

All meetings of the Charitable Funds Committee were quorate with at least one Non-Executive Director member and one Executive Director member of the Committee present.

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 remuneration and other conditions of service.

A key focus of the Remuneration and Terms of Service Committee in 2018/19 has been the appointment of the Trust's new Director of Performance and Strategic Development. 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), members of the Committee led a thorough recruitment process with the Chief Executive 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 other Senior Leaders and a formal interview with a selection panel. The selection panel comprised members of the Remuneration and Terms of Service Committee, plus the Chief Executive and an experienced NHS Executive Director operating in the capacity of independent external assessor. At the end of the process, the panel's decision to appoint Liz Calder as the Trust's new Director of Performance and Strategic Development was unanimous.

Further information on the work of the Remuneration and Terms of Service Committee in 2018/19, including Committee membership and attendance at meetings, is provided on page 78 of this report.

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 2019 are shown in the table overleaf:

Register of Interests Declared by the Board of Directors – 31 March 2019

Name	Position /Role	Term of Office	Interests Declared	Type of Interest	Date of Entry onto Register / Amendment
Anthony Bell	Non-Executive Director	31.07.21	Non-Executive Director – Cariocca Enterprises	Non-financial personal	30.10.17
			Non-Executive Director – Inclusion Housing, York	Financial	30.10.17
			Chair – Equity Enterprises Ltd. Subsidiary Board, Equity Housing Group Ltd., Cheadle Hulme, Cheshire	Financial	30.10.17
			Non-Executive Director – Equity Housing Group Ltd., Cheadle Hulme, Cheshire	Financial	11.12.18
Elizabeth Calder	Director of Performance and Strategic Development	N/A	Husband is employed as a Director of Manchester University NHS Foundation Trust	Indirect	11.02.19
Helen Dabbs	Non-Executive Director	09.09.21	Specialist Advisor for the Care Quality Commission (CQC) since 2003	Non-financial professional	24.09.18
			Member of Leeds and York Partnership NHS Foundation Trust since 2015	Non-financial personal	24.09.18
Chris Daly	Medical Director	N/A	Undertakes Category 2 medico-legal work, through time shifting, as agreed in job plan. Assessments are mainly in relation to care proceeding to advise the family courts. Also completes assessments in relation to negligence cases	Financial	23.07.18
Stephen Dalton	Non-Executive Director	31.12.19	NHS England Programme Director, New Care Models Tertiary Mental Health – temporary role (12 months from April 2018)	Financial	26.03.18
			Lead for Chief Executive Development Groups – sponsored by NHS Employers	Financial	26.03.18
			Director – SJ Dalton Ltd.	Financial	26.03.18
Gill Green	Director of Nursing and Governance	N/A	Nominal Director (Council Member) of the Mental Health and Learning Disability Network	Non-financial professional	22.01.19
Ismail Hafeji	Director of Finance and IM&T	N/A	Assessor for the Healthcare Financial Management Association (HFMA) – role involves marking examinations arranged by the HFMA. Work is outside of NHS time.	Financial	25.07.18
			Trustee of Home-Start Blackburn (Charity)	Non-financial personal	30.01.19

Register of Interests Declared by the Board of Directors – 31 March 2019 (continued)

Name	Position /Role	Term of Office	Interests Declared	Type of Interest	Date of Entry onto Register / Amendment
Julie Jarman	Non-Executive Director	31.07.20	Treasurer of MIND in Salford	Non-financial personal	14.02.18
			Trustee – HomeWorkers Worldwide	Non-financial personal	14.02.18
			Company Director of small mineral rights holding company (Blenkie Ltd)	Financial	14.02.18
			Principle Programmes – Equality and Human Rights Commission	Financial	14.02.18
Andrea Harrison née Knott)	Non-Executive Director	31.12.19	Transformation Leader, AstraZeneca PLC	Financial	26.03.18
Pauleen Lane	Non-Executive Director	31.12.19	Group Manager National Infrastructure, The Planning Inspectorate	Financial	30.01.17
			Visiting Lecturer, The University of Manchester	Financial	30.01.17
			Governor, St. Hilda's Primary School, Firswood	Non-financial personal	30.01.17
			Member of Central Manchester University Hospitals NHS Foundation Trust, University Hospital of South Manchester NHS Foundation Trust and Liverpool Women's NHS Foundation Trust	Non-financial personal	30.01.17
			Partner (Martin Rathfelder) is a member of the Manchester Provider Programme Selection Board	Indirect	25.03.19
Andrew Maloney	Deputy CEO/ Director of HR	N/A	Nil	-	26.02.19
Rupert Nichols	Chair	31.06.19	Director - Eddie Stobart Ltd.	Financial	26.03.18
			Director – NeedleSmart Limited	Financial	26.03.18
			Chair – Rainford Academies Trust	Non-financial personal	26.03.18
Deborah Partington	Director of Operations	N/A	Sister (Susan Gambles) is a local Councillor in Wigan – from May 2018	Indirect	24.07.18
			Sister (Susan Gambles) has been a Non-Executive Director on Equity Housing Board since 2016	Indirect	24.07.18
Neil Thwaite	Chief Executive	N/A	Member of Mersey Care NHS Foundation Trust	Non-financial personal	26.02.19

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 removals of Non-Executive Directors during 2018/19.

In July 2018, the Council of Governors approved the re-appointment of Anthony Bell, Non-Executive Director, for a further three-year term (effective from 1 August 2018). This was on the basis of a recommendation received from the Nominations Committee following a review of Anthony Bell's performance.

In September 2018, the Council of Governors approved the appointment of Helen Dabbs as the Trust's new Non-Executive Director. This followed a comprehensive recruitment process led by the Nominations Committee on behalf of the Council of Governors. The role attracted significant interest with 87 applications received by the closing date. The final stage of the selection process required short-listed candidates to meet with key stakeholders (Executive Directors and service users and carers) prior to a formal interview with members of the Nominations Committee.

Our Council of Governors

Our 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 2018/19, key duties exercised by the Council of Governors have included:

- Approving the appointment of the Trust's new Chief Executive and appointing a new Non-Executive Director
- Re-appointing one of the Trust's existing Non-Executive Directors for a second term of office
- Receiving the outcomes of the Chair and Non-Executive Director annual appraisal process and approving an associated pay uplift
- Receiving a report from the Trust's external auditors on their annual audit findings and opinion
- Advising on quality improvement priorities and selecting a local indicator for external assurance
- Giving views on the Trust's forward plans and key strategic developments and challenges

Committees and Working Groups

The Council of Governors has one formal committee (the Nominations Committee) and one Working Group focused on implementation of our Membership Strategy. Both groups operate within clear Terms of Reference and report back on progress to the full Council of Governors.

Elections

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

- **Chris Vogl**, Staff Governor (Nursing) – in April 2018
- **Michael Crouch**, Service User and Carer Governor – in December 2018

Following a by-election, Lesley O'Neill was elected to fill the vacant Staff (Nursing) Governor seat in November 2018 for the unexpired period of the term of office. Jane Lee joined the Council of Governors earlier in the year, in April 2018, as a Staff Governor representing our Allied Health Professionals (AHPs). We also held elections during January to March 2019 to fill a vacant seat in each of our Service User and Carer and Public (City of Manchester) constituencies and seven seats held by Governors coming to the end of their terms of office. The results of these elections were announced on 25 March 2019 with the following candidates elected for three-year terms with effect from 1 April 2019:

Emma Wood, Public Governor – Bolton

Maureen Burke, Public Governor – Salford

Gary Cooke, Public Governor – Trafford

Nayla Cookson, Public Governor – City of Manchester (re-elected for a second term)

Jemaine Chappell, Public Governor – City of Manchester

Angela Beadsworth, Public Governor – Other England and Wales

Margaret Willis, Services User and Carer Governor (re-elected for a third consecutive term)

Diane Hughes, Service User and Carer Governor

Nathan Anthony Prescott, Service User and Carer Governor

We welcomed three new Appointed Governors to the Council of Governors during the reporting period:

Dr Tim Bradshaw, a Reader in Mental Health in the Division of Nursing, Midwifery and Social Work at the University of Manchester

Mat Ainsworth, Assistant Director for Employment (Strategy, Policy and Delivery) at the Greater Manchester Combined Authority (GMCA)

Stewart Lucas, Strategic Lead at Mind in Greater Manchester

Attendance at Meetings

The full Council of Governors met on five occasions in 2018/19. The following table shows governor attendance at meetings during the period.

Constituency	Governor	Term of Office	Number of Meetings Attended	Number of Meetings Governor could have Attended
Elected Governors				
Public: Bolton	Les Allen (Lead Governor)	31.03.2019	5	5
	Albert Phipps	31.03.2020	4	5
Public: Salford	Bryan Blears	31.03.2019	1	5
	David Sutton	31.03.2020	5	5
Public: Trafford	Margaret Kerr	31.03.2019	0	5
	Iris Nickson	31.03.2020	1	5
Public: City of Manchester	Nayla Cookson	31.03.2019	3	5
	Lynn Howe	31.03.2020	4	5
Public: Other England and Wales	Rob Beresford	31.03.2020	5	5
	Phil Saxton	31.03.2019	4	5
Service User and Carer	Michael Crouch	N/a – retired	1	3
	Margaret Riley	31.03.2019	0	5
	Dan Stears	31.03.2020	3	5
Staff: Medical	Margaret Willis	31.03.2019	5	5
	Victoria Sullivan	31.03.2020	2	5
Staff: Nursing	Stuart Edmondson	31.08.2019	5	5
	Chris Vogl	N/a – retired	0	0
	Lesley O'Neill	31.03.2020	1	2
Staff: Psychological Therapies	Nasur Iqbal	31.08.2019	4	5
Staff: Allied Health Professionals	Jane Lee	31.08.2019	4	5
Staff: Non-Clinical Staff	Anita Arrigonie	31.03.2020	3	5
Staff: Social Care	Rick Wright	31.03.2020	2	5
Appointed Governors				
University of Salford	Margaret Rowe, Executive Dean of the School of Health and Society at University of Salford	31.03.2020	5	5
Greater Manchester Police (GMP)	Detective Chief Inspector Sara Wallwork	31.03.2020	3	5
University of Manchester	Dr Tim Bradshaw, Reader in Mental Health, Division of Nursing Midwifery and Social Work	July 2021	3	4
Greater Manchester Combined Authority (GMCA)	Mat Ainsworth, Assistant Director for Employment (Strategy, Policy and Delivery)	September 2021	2	3
Greater Manchester Voluntary Sector	Stewart Lucas, Strategic Lead at Mind in Greater Manchester	October 2021	2	2

The table below shows attendance by Directors at meetings of the Council of Governors in 2018/19. Attendance at Council of Governors meetings by Board members is optional but encouraged, particularly to support discussions on key strategic issues. However, where individual directors are unable to attend Council of Governors meetings the views of the Board are represented by those directors in attendance. Governors are also encouraged to observe Board of Directors meetings to support them in enacting their statutory duties.

	Name	Number of Council of Governor Meetings Attended	Number of Meetings the Director could have Attended
Non-Executive Directors	**Rupert Nichols,** Chair	5	5
	Anthony Bell, Non-Executive Director	2	5
	Helen Dabbs, Non-Executive Director	3	3
	Stephen Dalton, Non-Executive Director	1	5
	Kathy Doran, Non-Executive Director	0	2
	Julie Jarman, Non-Executive Director	3	5
	Andrea Harrison, Non-Executive Director	2	5
	Pauleen Lane, Non-Executive Director	3	5
Executive Directors	**Neil Thwaite,** Chief Executive	5	5
	Liz Calder, Director of Performance and Strategic Development	1	1
	Chris Daly, Medical Director	3	5
	Gill Green, Director of Nursing and Governance	4	5
	Ismail Hafeji, Director of Finance and IM&T	4	5
	Andrew Maloney, Director of HR and Deputy Chief Executive	5	5
	Deborah Partington, Director of Operations	2	5

Council of Governors Effectiveness Review

In October 2018, 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 2018 and agreed areas for improvement to be taken forward by the Membership Strategy Working Group through, for example, upcoming election campaigns and in full Council of Governors meetings.

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 public and service user and carer membership as at the end of March 2019.

Constituency		Members as at Quarter 4 2018/19
Public	Bolton	725
	Salford	604
	Trafford	568
	City of Manchester	2,190
	Other England and Wales	909
Sub-total Public		**4,996**
Service Users and Carers		1,337
Total Public and Service Users and Carers Membership		**6,333**

All members of staff who are eligible to be a member of the Staff Constituency are automatically 'opted in', unless they notify the Trust that they do not wish to be a member.

We routinely monitor and validate the numbers and profile of our membership. Through the work of the Membership Strategy Working Group, we aim to take targeted action to engage a more representative membership community.

Membership Engagement Strategy

The Council of Governors approved a refreshed Membership Strategy in early 2018/19. The Strategy aims to guide governors in their role of engaging with local communities and helping to improve our services through governors' understanding and sharing of the needs of the communities they represent. The strategy is focused on three key priorities - membership community, membership engagement and governor development. Progress made in each area during 2018/19 is as follows:

Membership Community – Work is continuing to review and update the Welcome Pack for new members and also the Governor Toolkit. We have also completed a mapping of governor networks - including with local, regional and national organisations - in order to identify gaps and act on opportunities to strengthen existing links.

Membership Engagement – We have recently started to pilot a new approach to member engagement, which is focused on engaging Public and Service User and Carer Governors in service development and transformation work-streams in their local constituency. This approach is focused on Bolton in the first instance and will then be rolled out more widely. We are also taking forward opportunities to engage more effectively with members through our website. This includes through the introduction of guest bloggers and the publication of a quarterly online newsletter for members.

Governor Development – During 2018/19, we have continued to support governor development as one of three key strands of our Membership Strategy. Governor development activities have included:

- A series of Governor development sessions facilitated by Executive Directors and Associate/Deputy Directors focused on workforce strategy, service user and carer engagement, homelessness and mental health in Greater Manchester, use of social media and the digital agenda;
- A series of Governor development sessions facilitated by Non-Executive Directors focused on the role of the Audit Committee, Quality Governance Committee and Charitable Funds Committee and the role of the designated Non-Executive Director in relation to the Mental Health Act and Mental Capacity Act;
- Regular Chief Executive and Executive Director briefings – for example on performance, the Trust's Care Quality Commission inspection outcomes, progress with the Manchester Transformation programme, the Trust's Operational Plan and the new Long Term Plan for the NHS;
- Briefings from external partners; and
- Continued access to external training and networking opportunities for Governors, including those facilitated by NHS Providers – GovernWell.

Implementation of our Membership Strategy is driven by a dedicated Governor Working Group with updates reported to each Council of Governors meeting.

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 2018/19. 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 are 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 2018/19, the Remuneration and Terms of Service Committee met on four occasions (in July, November and December 2018 and in February 2019). The November meeting was convened as part of the Director of Performance and Strategic Development recruitment process. Attendance at each meeting was as follows:

Name	Number of Meetings Attended	Number of Meetings the Director could have Attended
Rupert Nichols, Chair	4	4
Anthony Bell, Non-Executive Director	4	4
Helen Dabbs, Non-Executive Director	2	3
Stephen Dalton, Non-Executive Director	4	4
Kathy Doran, Non-Executive Director	1	1
Julie Jarman, Non-Executive Director	2	4
Andrea Harrison, Non-Executive Director	3	4
Pauleen Lane, Non-Executive Director	1	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. Neil Thwaite, Chief Executive and Andrew Maloney, Director of HR and Deputy Chief Executive attended all meetings in an advisory capacity. This is with the exception of the December 2018 meeting where the Committee reviewed Executive Director remuneration.

In July 2018, the Committee undertook its annual review of Associate Director pay following publication of the 2018 Agenda for Change pay deal. The Committee approved the movement of the existing Associate Director pay points to the new 2018/19 rates and the associated annual cost of living increase.

In December 2018, the Committee agreed a 1.5% consolidated uplift to Chief Executive and Executive Director remuneration (effective from 1 April 2018) in line with the national pay deal for consultant medical staff and following a review of the outcomes of the annual appraisal process. Decision-making on the Executive Directors' uplift was delayed whilst awaiting publication of guidance from NHS Improvement on Very Senior Managers' pay. The uplift awarded by the Remuneration and Terms of Service Committee was broadly in line with the guidance subsequently published by NHS Improvement.

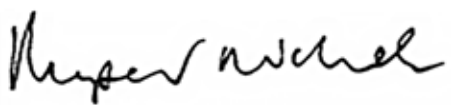
Nominations Committee

The Nominations Committee of the Council of Governors was convened on two occasions during the reporting period in June 2018 and January 2019. The Committee was chaired by the Chair of the Trust and attendance of Committee members at the meeting was as follows:

Name	Number of Nominations Committee Meetings Attended	Number of Meetings could have Attended
Rupert Nichols, Chair	1*	2
Les Allen, Lead Governor	2	2
Stuart Edmondson, Staff Governor (Nursing)	1	2
Lynn Howe, Public Governor (City of Manchester)	1	1
Margaret Riley, Service User and Carer Governor	0	2
Dan Stears, Service User and Carer Governor	2	2
Margaret Willis, Service User and Carer Governor	2	2

** To note, the Chair did not join the January 2019 meeting due to a declared interest in the item under discussion (Chair and Non-Executive Director remuneration). The meeting was chaired by Les Allen, Lead Governor in the Chair's absence.*

In January 2019, the Nominations Committee reviewed Chair and Non-executive director pay rates in the context of the annual appraisal outcomes. The Committee agreed to recommend the award of a 1.5% consolidated uplift for the Chair and all other non-executive directors, in line with the national pay deal for consultant medical staff in 2018/19 and the uplift awarded to the Trust's Executive Directors. This recommendation was approved by the Council of Governors in February 2019 and made effective from 1 April 2018.



Rupert Nichols

Chair

20 May 2019

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.

Only one senior manager (the Chief Executive) received a salary in excess of the £150,000 threshold for disclosure used in the Civil Service for their Board-level role during 2018/19. When originally agreeing this salary, the Remuneration and Terms of Services Committee took into account benchmarking data and advice received from NHS Improvement. Committee members continue to view the agreed baseline salary and subsequent uplifts as appropriate to the role and necessary to attract suitable candidates.

Annual Report on Remuneration

Remuneration of Board Members

The following table details the salary paid to each member of our Board of Directors during 2018/19 in comparison to 2017/18, 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 52 onwards of this report. Details of off-payroll engagements and exit packages in 2018/19 are provided in our staff report ('Our Staff'). As was the case in 2017/18, there were no annual or long-term performance-related bonuses paid to Board members during 2018/19.

Name	Title	2018/19 Salary and Fees (Bands of £5,000) £'000	Taxable Benefits (To nearest £100) £	2018/19 All Pension w Related Benefits* (Bands of £2,500) £'000
R Nichols	Chair	45 - 50		
A Harrison	Non-Executive Director	15 - 20		
P Lane	Non-Executive Director	10 - 15		
S Dalton	Non-Executive Director	10 - 15		
H Dabbs *From Sept. 2018*	Non-Executive Director	5 - 10		
A Bell	Non-Executive Director	10 - 15		
K Doran *To July 2018*	Non-Executive Director	5 - 10		
J Jarman	Non-Executive Director	10 - 15		
B Humphrey	Chief Executive 2017/18	N/a		
N Thwaite	Chief Executive 2018/19 Deputy Chief Executive/ Director of Strategic Development 2017/18	175 - 180	5,900	55 – 57.5
G Green	Director of Nursing and Governance	130 - 135		
I Hafeji	Director of Finance and IM&T	130 - 135	5,500	
A Maloney	Director of HR and Deputy Chief Executive	130 - 135	5,900	
D Partington	Director of Operations	130 – 135	5,000	42.5 - 45
C Daly **	Medical Director	190 - 195		
M Lee *May 2018 to Feb. 2019*	Acting Director of Development and Performance	80 - 85	4,000	145 – 147.5
E Calder *From Feb. 2019*	Director of Performance and Strategic Development	15 - 20		65 – 67.5

2018/19 Total Remuneration (Bands of £5,000) £'000	2017/18 Salary and Fees (Bands of £5,000) £'000	Taxable Benefits (To nearest £100) £	2017/18 All Pension Related Benefits* (Bands of £2,500) £'000	2017/18 Total Remuneration (Bands of £5,000) £'000
45 - 50	45 - 50			45 - 50
15 - 20	15 - 20			15 – 20
10 - 15	10 - 15			10 – 15
10 - 15	10 - 15			10 – 15
5 – 10	N/a			N/a
10 - 15	10 - 15			10 – 15
5 - 10	15 - 20			15 – 20
10 - 15	10 - 15			10 – 15
N/a	185 - 190	4,300	225 – 227.5	415 – 420
235 - 240	130 - 135	5,500	90 – 92.5	230 - 235
130 - 135	130 - 135			130 – 135
140 - 145	130 - 135	5,200	105 – 107.5	245 – 250
140 - 145	130 - 135	5,500	80 – 82.5	220 – 225
180 – 185	130 - 135	7,078	217.5 - 220	355 – 360
190 - 195	190 - 195		85 - 90	275 – 280
230 – 235	N/a			N/a
80 - 85	N/a			N/a

To Note:

** All Pension Related Benefits – 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.*

*** In line with the NHS Foundation Trust Annual Reporting Manual (ARM), the remuneration for the Medical Director includes remuneration for duties that are not part of his management role. The 2017/18 bandings have been restated to reflect this. Chris Daly is 0.6 WTE Medical Director (remuneration band 115 – 120) and 0.4 WTE clinical.*

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	Title	Real Increase in Pension at Pension Age (Bands of £2,500) £'000	Real Increase in Lump Sum at Pension Age (Bands of £2,500) £'000	Total Accrued Pension at Pension Age at 31 March 2019 (Bands of £5,000) £'000
N Thwaite	Chief Executive	2.5 -5	5 – 7.5	45 – 50
I Hafeji	Director of Finance and IM&T			55 – 60
A Maloney	Director of HR and Deputy Chief Executive			40 – 45
D Partington	Director of Operations	0 - 2.5	5 – 7.5	70 – 75
M Lee	Acting Director of Development and Performance	5 – 7.5	20 – 22.5	40 – 45
E Calder	Director of Performance and Strategic Development	2.5 - 5	5 – 7.5	20 - 25

To note:

Gill Green, Director of Nursing and Governance and Chris Daly, Medical Director were not members of the NHS Pension Scheme during 2018/19 and are therefore excluded from the below table.

Total Accrued Lump Sum at Pension Age at 31 March 2019 (Bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2019 £'000	Cash Equivalent Transfer Value at 31 March 2018 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's Contribution to Stakeholder Pension £'000
115 – 120	837	673	138	6
175 – 180	1,411	1,255	98	19
95 – 100	662	562	79	5
210 – 215	1,450	1,215	187	11
125 – 130	1,028	0	220	12
60 - 65	434	329	96	1

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 Medical Director) in 2018/19 was £190,000 - £195,000 (excluding taxable and pension-related benefits). As shown in the following table this was 7.94 times the median remuneration of the entire workforce, calculated on the basis of full-time staff as at 31 March 2019 with amounts annualised according to whole time equivalents and hours paid. The 2018/19 ratio is broadly consistent with the ratio reported for 2017/18.

	2018/19	2017/18
Band of Highest Paid Directors Total	190 – 195 (£000s)	190 - 195 (£000s)
Mid-point of Highest Paid Director	192.5	192.5
Staff Median Total Remuneration	£24,321	£24,547
Ratio	7.94 times	7.86 times

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.

	2018/19		2017/18	
	Governors	Directors	Governors	Directors
Total Number in Office during the year	27	16	24	14
Number Receiving Expenses	4	11	2	12
Aggregate Expenses Sum Paid (to the nearest £'00)	679	9,521	48	9,984

Neil Thwaite

Chief Executive

Date: 20 May 2019

Our Staff

Achievement of our vision through the delivery of high quality services can only be achieved with a highly effective, skilled and motivated workforce.

In early 2018/19 we launched our new three-year 'Workforce and Organisational Development Strategy'. This Strategy sets out the values, leadership behaviours and organisational culture that are essential to providing an outstanding place to work and learn where individuals can reach their full potential. We want our leaders to engage, motivate and inspire others and lead positive performance. We want to provide an inclusive and healthy environment for our employees where everyone is treated with respect and dignity in an organisation that promotes an open and transparent culture.

Staff Costs

Our total staff costs incurred in 2018/19 equated to £223.2million.

	Staff Group		2018/19	2017/18
	Permanent	Other	Total Costs	Total Costs
	(£'000)	(£'000)	(£'000)	(£'000)
Salaries and wages	156,414	12,457	168,871	158,164
Social security costs	14,613	-	14,613	13,757
Apprenticeship levy	804	-	804	732
Employer's contributions to NHS pensions	19,844	-	19,844	18,811
Pension cost - other	190	30	220	412
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	264	-	264	728
Temporary staff	-	19,980	19,980	18,409
Total Gross Staff Costs	**192,129**	**32,467**	**224,596**	**211,013**
Recoveries in respect of seconded staff	(1,427)	-	(1,427)	(1,409)
Total Staff Costs	**190,702**	**32,467**	**223,169**	**209,604**
Of which:				
Costs capitalised as part of assets	797	-	797	217

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 2018/19, we employed 5,460 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 2018/19 (WTE)	Total Number 2017/18 (WTE)
Medical and dental	281	94	375	317
Ambulance staff	-	-	-	-
Administration and estates	584	15	599	551
Healthcare assistants and other support staff	1,521	420	1,941	1,629
Nursing, midwifery and health visiting staff	1,229	155	1,384	1,597
Nursing, midwifery and health visiting learners	30	-	30	-
Scientific, therapeutic and technical staff	821	53	874	732
Healthcare science staff	-	-	-	-
Social care staff	90	-	90	105
Other	130	37	167	163
Total	**4,686**	**774**	**5,460**	**5,094**
Of which:				
Number of employees engaged on capital projects	12	-	12	3

'Other' employment arrangement includes employees that do not have a permanent (UK) employment contract with the Trust. 'Healthcare assistants and other support staff' includes administrative staff employed in clinical areas.

Our number of male and female staff (calculated on a headcount basis and including bank staff) as at the end of March 2019 was:

	Male	Female	Total
Directors	7	7	14
Workforce (excluding Directors)	1,292	3,735	5,027
Total	**1,299**	**3,742**	**5,041**

Gender Pay Gap

Our Workforce and Organisational Development Strategy sets out our ambition to create an inclusive environment which embraces diversity. Our annual Gender Pay Gap Report provides valuable intelligence to enable us to move towards achieving this ambition.

In line with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), we have undertaken gender pay gap reporting on the snapshot date of 31 March 2018.

As at 31 March 2018, our mean average gender pay gap demonstrates that our female staff are paid 11.91% less than our male staff, this is an improvement on the position reported in 2017/18 (12.64%).

Gender	Mean Average Hourly Rate
Male	£17.31
Female	£15.25

The median average gender pay gap shows that our female staff are paid 4.61% less than our male staff compared to 5.04% in 2017/18.

Gender	Median Average Hourly Rate
Male	£14.24
Female	£13.58

With regard to bonus pay, our mean bonus pay gap indicates that female staff are paid more favourably than male staff on the mean average (-1.74%). Our median bonus pay gap shows that female staff are paid 33.33% less bonus than our male staff (a difference of £3,013 per annum). This relates to bonus payments received by medical staff in the form of Clinical Excellence Awards and demonstrates a significant improvement on the previous year's position where the bonus pay gap was 64%.

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)	76.59	23.41
Lower Middle (Mid-Point Band 3 to Mid-Point Band 5)	70.41	29.59
Upper Middle (Mid-Point Band 5 to Mid-Point Band 7)	73.5	26.5
Upper (Mid-Point Band 7 to Doctors/Consultants /Very Senior Managers)	67.27	32.73

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 have made progress with regard to reducing the gender pay gap compared to figures presented in our first Gender Pay Gap Report in 2017/18. 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 11.91%, our mean gender pay gap is below that of the wider public sector. We acknowledge, however, that a pay gap exists and continue to be fully committed to working towards achieving gender pay parity.

Sickness Absence

At 5.88%, our total sickness rate for the 12 months ending March 2019 was a decrease of 0.07% from the previous month. The March in-month total was 5.94%, a decrease of 0.37%. Long term absence continues to make up the greatest proportion of sickness absence.

Our average number of sick days per full time equivalent (FTE) for the period January 2018 to end of December 2018 was 13.0 days, which is equivalent to the previous 12 months.

Staff Sickness Absence	2018	2017
Average FTE	4,513	4,345
Adjusted FTE Days Lost – As Per Cabinet Office Definitions	59,364	56,382
Average Sick Days per FTE	13.0	13.0

Figures provided by the Department of Health and Social Care.

The highest number of days lost due to sickness absence in March 2019 was due to anxiety/stress/depression/other psychiatric illnesses (22%), other musculoskeletal problems/back problems (10%), cough/cold/flu (10%) and gastrointestinal problems (9%). All divisions, with the exception of Manchester Central and City Wide, Salford, Psychological Therapies and Corporate Services reported a sickness rate above the Trust's target of 2.6% at year-end.

The Health and Wellbeing Strategy Group are continuing to focus on developing strategies to support improvements in the mental wellbeing of our workforce. To address the high proportion of staff who are absent from work due to psychological illness, a Task and Finish group has been established to develop a vision for how we can support staff to remain in work, or return to work if unwell. Membership of this group includes staff-side, HR and our Lead Clinical Psychologist.

We have piloted a new course aimed at managers and entitled 'Mental Health and Wellbeing at Work: Toolkit for Managers' during the year, Initial feedback on this course is positive. The course aims to support managers in their managerial role by raising awareness of tools, resources and practical strategies that can be used to support mental health and wellbeing at work. It summarises the Mental Health First Aid Line Managers Resource, raises awareness of key clinical guidance and Trust policies, draws upon the Occupational Therapy view of health and wellbeing and encourages sharing of good practice experience and ideas.

The HR Team support managers with individual cases of sickness absence. Cases are reviewed on a monthly basis to ensure that staff are being supported and that plans to enable staff to return or remain in work are in place, appropriate and maintained.

Policies and Actions

All policies, which affect staff, are developed in partnership with our staff-side representatives. During 2018/19, we have been working jointly to develop our HR policies to support best practice management of staff. Our Trust values are also incorporated in all policies that affect staff to ensure that these are embedded in management practice. 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 use the Equality Delivery System 2 (EDS2) as an assessment tool to measure equality performance with an aim to produce better outcomes for people using, and working in the, NHS. This tool was used to focus on the goal of 'A Representative and Supported Workforce' in a recent grading exercise with a number of actions agreed to address identified areas for improvement.

Our new Trust-wide Equality, Diversity and Inclusion Strategy was launched in February 2019.

Supporting Staff with Disabilities

We have continued to be committed to providing equality of access to jobs, promotions and development during 2018/19 and remain a member of the 'Disability Confident' scheme. Our current status is as a Level 1 employer, however, we are working to achieve a Level 2 status.

Disability Confident Employers commit to:

- Inclusive and accessible recruitment
- Communicating vacancies
- Offering an interview to disabled people
- Providing reasonable adjustments
- Supporting existing employees

During 2018/2019 we have expanded the use of the Disability Passport across the Trust. The document provides a record of the agreements reached to support an individual in work following a discussion between the manger and the member of staff. This also supports staff during times of organisational change as they are able to present this as part of their personal circumstances to inform decisions.

In response to feedback received in our 2018 NHS Staff Survey, a staff listening event focussing on our staff with disabilities and long term conditions took place in April 2019.

Health and Wellbeing

We have continued to progress our commitment to improving staff health and wellbeing during 2018/19 through the implementation of our Trust-wide Health and Wellbeing action plan. Examples of this include:

- Small Bids Fund – this fund continues to support health and wellbeing activities at a local level. These include initiatives focused on physical activities, healthy eating and improving the physical environment (for example, the provision of furniture, plants and lighting to create rest areas and encourage staff to take appropriate breaks)
- Staff listening events focused on staff experience – local action plans are produced to address identified areas for improvement with progress reviewed on a routine basis
- Staff Health Walks are now taking place around the Trust with new walks established in Prestwich and Salford and Fallowfield
- Weekly staff Lifestyle and Smoking Cessation clinics running in Prestwich and Meadowbrook. A new smoking cessation group is also planned to start in Trafford;
- Staff Health and Wellbeing days – taking place across many of our locations. These include a holistic programme of taster sessions and activities
- 'Green Fingers Challenge' focused on growing healthy food

We have also launched our new Staff Health and Wellbeing Intranet page, which includes advice and guidance on Spiritual Wellbeing, Support for Staff Carers, Feeling Safe and Supported at Work, Mental Health and Wellbeing, Physical Health and Wellbeing, Occupational Health, Meaningful Activity, Equality and Diversity, Support for Staff with Disabilities, and Financial Fitness. It also includes:

- Links to information on our Staff Health and Wellbeing Champions Network, small bids fund, newsfeed of Trust health and wellbeing news and calendar of events
- Mindfulness and relaxation links and podcasts
- Health information podcasts
- Links to community resources (Where can we go? Website)
- Links to Green Wellbeing initiatives like Incredible Edible and ways to get involved with connecting with nature

Our staff health and wellbeing Twitter hashtag #GMMHStaff_Health feeds into our staff health and wellbeing intranet page enabling staff to share good practice. Our Staff Health and Wellbeing Champions Network is continuing to grow and a training and networking event is planned for 2019/20.

NHS Staff Survey

Staff Engagement

Our overall theme score for staff engagement in our 2018 NHS Staff Survey was 6.9. This represents an increase on our score of 6.8 in 2017 but remains slightly below the national average of 7.0. We are continuing to work to improve engagement with our workforce and appointed a Staff Engagement and OD Facilitator during 2018/19 to lead on this work.

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 JCNC). 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 74% of respondents said they would recommend the Trust to friends and family as a place to receive care or treatment and 65% said they would recommend the Trust as a place to work.

Summary of Performance

The 2018 NHS Staff Survey was carried out between October 2018 and December 2018. As the second full Staff Survey for GMMH we have been to compare data from the most recent survey to survey conducted in 2017.

We surveyed all employees, rather than a random sample, and achieved a response rate of 47%, which equates to 2,199 members of staff. This is an increase on our previous year's response rate of 34% and may be a result of our decision to undertake an electronic survey for the first time. Our increased response rate also brings us closer to the national average for Mental Health Trusts of 51%.

In the 2018 Survey, a number of changes were made to the way results were collated nationally with key findings replaced by themes. The themes cover the following ten areas of staff experience and whilst there is no ability to compare previous years' key findings with themes, the themes do present results in these areas in a clear and consistent way. Indicator scores for each theme are provided in the following table, alongside a benchmarking score. To note, comparative data is not available for 2016/17 as this pre-dates the Trust's acquisition of Manchester Mental Health and Social Care NHS Trust on 1 January 2017.

	2018/2019		2017/2018	
Theme	**Trust Indicator Score**	**Benchmarking Group**	**Trust Indicator Score**	**Benchmarking Group**
Equality, diversity and inclusion	8.8	8.8	9.0	9.0
Health and wellbeing	5.8	6.1	6.0	6.2
Immediate managers	7.1	7.2	7.1	7.2
Morale	6.0	6.2	-	-
Quality of appraisals	5.4	5.7	5.3	5.5
Quality of care	7.1	7.3	7.0	7.3
Safe environment – bullying and harassment	7.9	7.9	7.9	8.0
Safe environment – violence	9.1	9.3	9.1	9.2
Safety culture	6.7	6.7	6.7	6.7
Staff engagement	6.9	7.0	7.0	7.0

As outlined in our Workforce and Organisational Development Strategy, we will continue to work hard to deliver improvements across all themes. Through triangulation of the Staff Survey data with other key performance indicators, such as reasons for sickness absence, we have identified the following actions as essential as we move forward into the 2019 survey:

Improve employee wellbeing by:

- Reviewing and refreshing our approach to managing employee absence
- Developing a new Employee Wellbeing Policy to replace the current Managing Sickness Policy
- Defining a new Organisational Health & Wellbeing Plan focusing on the positive impact of quality line management supervision; team meetings; visible leadership; increasing opportunities for staff to feedback; increasing ways for recognition of staff.
- Learning from leavers

Reduce violence against staff by:

- Continuing with the Mutual Respect Campaign delivered by the Nursing & Governance Team

Create an environment free from bullying, harassment and discrimination by:

- Reviewing and refreshing our Bullying and Harassment Policy
- Increasing support for staff who experience bullying, harassment or discrimination through the promotion of the role of the Freedom to Speak Up Guardian

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 2018 to 31 march 2019
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	£135,337
Total pay bill	£223,169,000
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%

Expenditure on Consultancy

We have not incurred any expenditure on external consultancy services during 2018/19.

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 2018/19, 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 2019, costing more than £245 per day and lasting longer than six months	2018/19
No. of existing engagements as of 31 March 2019	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 can also confirm that 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 2018/19.

Table 2 – For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2018 and 31 March 2019, costing more than £245 per day and lasting longer than six months	2018/19
No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	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 2018/19.

Table 3 - For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 01 April 2018 and 31 March 2019	2018/19
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 2018/19. The value and type of associated payment is also detailed. The total cost of exit packages in 2018/19 was £264k, compared to £2.913million in 2017/18. We funded 11 exit packages in excess of £100k in 2018/19, of which 2 were in excess of £150k.

Exit Packages Cost Band (incl. any special payment element)	Number of Compulsory Redundancies		Number of Other Departures		Total Number of Exit Packages	
	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18
<£10,000	-	-	2	6	2	6
£10,001 - £25,000	-	-	5	9	5	9
£25,001 - £50,000	-	-	-	12	-	12
£50,001 - £100,000	-	-	-	12	-	12
£100,001 - £150,000	-	-	-	9	-	9
£150,001 - £200,000	-	-	1	2	1	2
>£200,000	-	-	-	-	-	-
Total Number of Exit Packages by Type	**-**	**-**	**8**	**50**	**8**	**50**
Total Resource Cost (£)	£0	£0	£264,000	£2,913,000	£264,000	£2,913,000

As demonstrated in the following table, the non-compulsory departure payments incurred in 2018/19 related to voluntary redundancies. No payments required Treasury approval.

	2018/19		2017/18	
	Payments Agreed (No.)	Total Value of Agreements (£'000)	Payments Agreed (No.)	Total Value of Agreements (£'000)
Voluntary redundancies including early retirement contractual costs	8	264	50	2,913
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	**8**	**264**	**50**	**2,913**
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 Reference	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.	51
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.	52 – 67, 78
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.	70 – 73

Mandatory Disclosures (continued)

Code Reference	Summary of Requirement	Disclosure on Page(s):
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.	51
B.1.4	The board of directors should include in its 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.	51 – 58
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.	79
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.	68 – 69
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.	70 – 71, 75 – 76
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.	60, 61, 65
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.	60
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).	50, 108 – 121
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.	119
C.2.2	A trust should disclose in the annual report: If it has an internal audit function, how the function is structured and what role it performs; or 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	62

Mandatory Disclosures (continued)

Code Reference	Summary of Requirement	Disclosure on Page(s):
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
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.	61 – 64
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.	77
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	70, 74 – 75
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.	76

The 'NHS Foundation Trust Annual Reporting Manual 2018/19' (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.	72 – 74
The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	52 – 55, 70
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.	70, 79
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.	75 – 77
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.	68 – 69, 74

Comply or Explain Disclosures

As at 31 March 2019, the Trust was compliant with all of the Code's provisions with the exception of:

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 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.

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	2018/19 Scores				2017/18 Scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	2	4	1	4	1	1	1	1
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E Margin	1	1	2	2	1	1	1	1
Financial controls	Distance from financial plan	1	1	2	1	1	1	1	2
	Agency spend	4	4	4	4	4	4	4	3
Overall Scoring		3	3	3	3	3	3	3	2

At the end of March 2019, we are reporting a rating of '3' against the Finance and Use of Resources metric against a planned rating of '3'. This rating results from our score against the agency spend metric - a rating of '4' - which is due to an increase in agency costs incurred during 2018/19. Agency expenditure is identified as a key strategic risk on our Board Assurance Framework, with controls in place to mitigate this risk and ongoing actions identified to further strengthen current controls.

Statement of Accounting Officer's Responsibilities

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, total recognised gains and losses and cash flows for the financial year.

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

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- Prepare the financial statements on a going concern basis

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

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

Signed

Neil Thwaite, Chief Executive

Date: 20 May 2019

Annual Governance Statement

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of 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 2019 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 Deputy Chief Executive
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	Director of Performance and Strategic Development
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 Improvement 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 2018/19, with membership including 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 patient safety, governance and 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 the numbers and levels of serious untoward incidents and any emerging trends and action taken. 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), 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 escalation to 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, or de-escalation of risks from the Board Assurance for local management and monitoring. 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
Performance against national and local targets and regulatory standards
Capital investment
Agency expenditure

Information governance and data security risks are also managed through the Risk Management Framework and assessed using the Data Security and Protection Toolkit (formerly 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. 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 Improvement 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:

Internal Controls	External Controls	Quality Assurance Reports
Service User and Carer Feedback	Royal College of Psychiatrists (RCPsych) Service Accreditation	Deep Dive Audit Reports – as commissioned by the Quality Improvement Committee
Mental Health Safety Thermometer	NICE guidance	Intelligent Monitoring
Positive and Safe Forum	NICE Quality Standards	Quality Board Performance Report
Quality Matters	PLACE Activity	Quality Key Performance Indicators
Local & Trust Wide Clinical Audit	National Staff & Patient Surveys	Single Oversight Framework
Clinical Governance Systems	District HealthWatch Feedback	Board Assurance Framework
Complaints & Incidents	CQC Mental Health Act Visits	Board Performance Reporting
CQUIN Programme	CQC regulatory inspections	Quality Matters Walkaround Visits
Council of Governors	Mersey Internal Audit Agency	CareHub Activity Reports
The Dragons' Den – a quality innovation fund used to support quality improvement at a local level	Quality Accounts and Quality Improvement Priorities (QIPs)	Local quality improvement PDSA (Plan, Do, Study, Act) cycles
Non-Executive Director service visits	External Benchmarking	Positive and Safe Dashboards
Task and Finish Groups	POMH (Prescribing Observatory for Mental Health) Improvement Programmes	Safewards reports

In the last quarter of 2018/19, we also established a weekly Executive Director-led Sustainability and Quality Improvement Group to ensure operational and corporate preparedness for any future CQC inspection.

Compliance with NHS Foundation Trust Condition 4 (FT Governance)

I can report no principal 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 2019/20. 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 reviews a Performance Report focused on regulatory and workforce standards at every Board meeting and a separate Performance Report focused on quality on a quarterly basis. We have reviewed our governance structures, including the Terms of Reference for key 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 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.

Workforce Safeguards

NHS Improvement published 'Developing Workforce Safeguards' guidelines in October 2018. The guidelines recommend a 'triangulated approach' to governing and managing safe staffing levels, combining the need to use professional judgements with evidenced-based tools and data. We currently use data extrapolated from Health Roster to assess safe staffing levels on wards. DATIX is used to monitor any concerns about the safety of staffing levels, which are also monitored through our operational Network Hubs. A number of our services have started to run daily 'Safety Huddles', which serve as a real-time, useful sense-check of staffing levels within inpatient services. These Huddles give services the immediate flexibility to ensure each ward meets its required need, not only based on the minimum requirements but also taking into consideration the complexity of the service users at that time, including any increased observation needs. Our Board of Directors maintains oversight of safe staffing levels via a six-monthly Safe Staffing Report, which is also reviewed by our Quality Improvement Committee (QIC) and Operational Leadership Committee. This report highlights presenting trends and hotspots, in addition to any supporting actions that we are taking forward.

Safe staffing and future workforce supply are identified as key strategic risks on our Board Assurance Framework. Controls to mitigate this risk include continued implementation of our Workforce and Organisational Development Strategy 2018 to 2021 (approved in May 2018), which sets out targeted and proactive action to address supply, recruitment and retention challenges.

Nursing and Governance, in partnership with Human Resources and Operations, are reviewing options to increase the sophistication of the use of Health Roster as an e-based safer staffing tool and this is expected to be rolled out during 2019/20.

Conflicts of Interest

The Foundation Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS Guidance'.

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.

Sustainable Development

The Foundation Trust has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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 an over-arching 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, contractual performance targets, workforce and activity measures
- Monthly reporting to the Board of Directors on performance against the NHS Improvement Single Oversight Framework Use of Resources Metric – at the end of March 2019, we are reporting a rating of '3' against this metric. This is due to our expenditure on agency staffing, which is managed as a key strategic risk via our Board Assurance Framework
- Regular reporting to the Board of Directors on progress in the delivery of key strategic priorities/work programmes
- 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 Agency (MIAA)) to provide assurance on our use of resources. Oversight has been provided by our Audit Committee. Our approach to internal audit is risk-based, aligned to our strategic objectives and focused on core systems and other areas that present opportunities for improvement. In 2018/19, keys areas covered by our internal audit plan included:

Governance and Leadership – Risk Management and Assurance Framework Opinion
Financial Performance and Sustainability – Use of Agency Staff and Key Financial Systems
Information and Technology – ICT Asset Management, ICT Infrastructure Sustainability, Critical Applications (Integra) and Data Protection and Security Toolkit
Quality – Safeguarding, Quality Spot Checks, Implementation of the Mental Health Act and Complaints Management
Workforce – Payroll/ESR

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 clearly reflects the risks discussed by the Board.

Information Governance

We aim to deliver a high standard of excellence in Information Governance by ensuring that information is collated, stored, used and disposed of securely, efficiently and effectively and that all of our processes adhere to legal requirements. Following the introduction of the General Data Protection Regulation (GDPR), we have reviewed all of our Information Governance policies and established a full Data Security and Protection Framework to manage all service user, staff and organisational information. Implementing the requirements of GDPR and the Data Security and Protection Toolkit is central to this Framework. The Data Security and Protection Toolkit sets out standards for maintaining high levels of security and confidentiality of information at all times. Our Information Governance Assessment report overall score for 2018/19 was 82% ('Green' grading) and our internal auditors have provided 'Substantial Assurance' as to the adequacy of our Information Governance framework and the validity of our Data Security and Protection Toolkit submission.

Due to a number of legislative changes and the introduction of the GDPR, the Trust has seen an increase in the number of reportable incidents relating to information governance.

We have reported a total of six incidents to the Information Commissioner's Office (ICO) during the reporting period. Five of those incidents have been fully processed with no requirement from the ICO for further action by the Trust. The ICO's review of the remaining incident is ongoing at the time of writing.

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 2018/19, we have identified a number of new priorities for quality improvement in 2019/20 which align with our new Quality Improvement Strategy. The content of our Quality Account 2018/19 presents a balanced view of this organisation over the period, with the views of Governors 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 2018 to March 2019
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'
2018 Community Mental Health Survey
2018 NHS Staff Survey
Friends and Family Test responses
Data Security and Protection 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 2018 to March 2019 (Workforce and Regulatory and Quality)
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 Improvement 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 covering 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 Performance Report (Regulatory and Workforce). 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 Improvement Committee and a 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 care quality by the Quality Improvement Committee and its sub-groups
- Quality Improvement Committee oversight of the clinical audit programme through an annual report from our 'Quality Improvement in Clinical Care Group' (formerly 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 Improvement 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, NHS Resolution 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 or in the wider Annual Report. The Trust has continued to strengthen the system of internal control during the period to ensure that it remains fit for purpose.

Signed

Neil Thwaite
Chief Executive

Date: 20 May 2019

Quality Account

We publish our Quality Account as a separate document. A copy of our 2018/19 Quality Account can be requested from *communications@gmmh.nhs.uk*.

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 2019 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 2019 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 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19.

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	£5.25m (2018: £5m) 1.71% (2018: 1.73%) of operating income	
Risks of material misstatement		**vs 2018**
Recurring risks	Valuation of land and buildings	◄►
	Fraudulent revenue recognition	◄►
	Valuation of LGPS net pension liability	◄►
	New: Fraudulent Expenditure Recognition	▲

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 (£185.9 million; 2018: £183.3) *Refer to page 64 (Audit Committee Report), pages 145-147 (accounting policy) and page 172 (financial disclosures)*	**Subjective valuations:** Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property (MEAV). It is also necessary to consider whether there is any indication of impairment. Impairment could occur as a result of loss of market value due to conditions in the market or due to deterioration in the value in use of the asset, either because of its condition or because of obsolescence Valuation is completed by the District Valuer, an external expert engaged by the Trust, using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, were appropriate and correctly applied. The Trust had a full valuation undertaken in 2016/17, and a desktop valuation performed in February 2019. Calculation of potential movements in values up to 31 March 2019 was carried out using Royal Institution of Chartered Surveyors (RICs) indices data provided by the District Valuer. The Trust complete a formal review of impairment indicators across the Trust's estate covering the period up to year-end. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	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 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. **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.

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

	The risk	Our response
Recognition of NHS Income and deferred income NHS Income (£286.9 million; 2018: £281m) Deferred Income (£12.9 million; 2018: £18.5m) *Refer to page 64 (Audit Committee Report), pages 142-144 (accounting policy) and page 160-161 (financial disclosures)*	**Subjective Estimate** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners. The Trust also receives funding for Education & Training and Research from other bodies in the DH boundary. These activities will frequently span years and as such a significant proportion of the income each year is deferred (£8.9m in 18/19). In addition, the Trust received a significant level of transition and transformation income from commissioners following the absorption of Manchester Mental Health and Social Care NHS Trust (MMHSC) in January 2017. We recognise that incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial covenants, for example pressure on management to deliver the control total each year, rather than broader share based management concerns. We have therefore classified NHS income as a significant risk to respond to this.	Our procedures included: **Test of detail:** We compared the actual income for the Trust's most significant commissioners against the block contracts agreed at the start of the year and checked the validity of any significant variations between the actual income and the contract via agreement to appropriate third party confirmations. **Test of detail:** We compared the income balances reported by the Trust as part of the 2018/19 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. We also tested a sample of income released in year to determine whether income was being recognised appropriately under IFRS 15. **Test of detail:** Cut off procedures were performed in order to gain assurance that income has been correctly recognised in the period.

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

	The risk	Our response
Valuation of LGPS net pension liability LGPS Plan Assets £17.9m (2018: £16.7m) LGPS defined benefit obligation £20.1m (2018: £17.9m) *Refer to page 64 (Audit Committee Report), pages 144 (accounting policy) and page 183-186 (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 is a defined benefit scheme. This follows the Trust's absorption of services as part of the MMHSC transfer in 2017. – 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 the actuary uses an estimated rate of return in the asset roll forward calculations (included in the IAS 19 Actuarial Valuation as at 31 March 2019 for accounting purposes) so there is risk the difference between that and the actual return over the same period, materially impacts the fair value of plan assets during the year. – The gross 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 reviewed the controls in place at Trust that ensures the data provided to 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 2019, to the Trust's financial statements. **Test of detail:** We tested a sample of active members and obtained the number of deferred members and pensioners from the pension fund to there have been no material changes that could impact the actuarial valuation. **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.

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

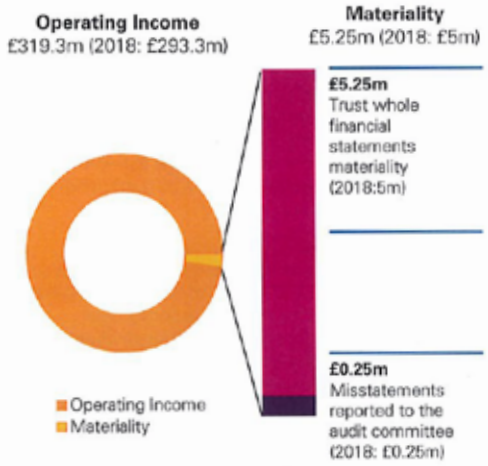
	The risk	Our response
Fraudulent Expenditure Recognition Other Operating Expenditure (excl Staff Costs, impairment and depreciation) (£77 million; 2018: £72 million) Trade and other payables (£30.9 million; 2017/18: £29.7 million) Provisions (£3.7 million; 2017/18: £4.0 million) *Refer to page 64 (Audit Committee Report), page 145 (accounting policy) and pages 163 - 171 (financial disclosures)*	**Subjective Estimate:** – In the public sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. – As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may in some cases be greater than the risk of material misstatements due to fraud related to revenue recognition and so the auditor has regard to this when planning and performing audit procedures – We do not consider this risk to apply to all expenditure in the period. The incentives for fraudulent expenditure recognition lie within accrued expenditure at year-end, as well as completeness of recognition of new provisions or release of existing provisions. Our response to this risk focused on non-pay spend, including agency payments. Salary costs are considered lower risk in terms of the scope for fraudulent recognition and misrepresentation by management.	Our procedures included: – **Test of detail:** We inspected all material items of expenditure in the March and April 2019 cashbooks and to agree these have been accounted for correctly by evaluating when the service had been delivered; – **Test of detail:** We inspected all material items of expenditure in the April 2019 bank statements to identify if there were any unrecorded liabilities that should have been accounted for in the 2018/19 financial statements; – **Test of detail:** We performed a year-on-year comparison of accruals posted in 2018/19 to those posted in 2017/18 to evaluate the completeness of the accruals balance, as well as agreeing a sample to supporting documentation; – **Test of detail:** We considered the completeness of provisions based on our cumulative knowledge of the Trust, inquiries with Directors, and inspection of legal correspondence. We considered whether there were events that would require a contingent liability disclosure in the accounts. We also considered the appropriateness of releases of provisions made in year by critically assessing the justification for the release against the relevant accounting standards; – **Test of detail:** We vouched a sample of journals posted before and after the year end to supporting documentation to confirm inclusion in the correct period and to critically assess whether any manual adjustments to expenditure were appropriate; – **Test of detail:** We inspected confirmations of balances provided by the Department of Health as part of the Agreement of Balances (AoB) exercise and compared the relevant payables recorded in the Trust's financial statements to the receivables balances recorded within the accounts of other providers and other bodies within the AoB boundary. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure to other providers and other bodies within the AoB boundary.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £5.25 million (2017/18: £5 million), determined with reference to a benchmark of forecast operating income (of which it represents approximately 1.71%). We consider operating income to be more stable than either an asset-based or surplus- / deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.25 million (2017/18:(£0.25 million), 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 performed at the Trust's headquarters in Prestwich.



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement on page 90 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's 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, and we did not identify going concern as a key audit matter.

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 2018/19.

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 2018/19 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.

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6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 90 the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are 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; 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. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 90 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

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

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.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial Sustainability	– At month 9, the Trust was forecasting a surplus of £2.27m, which was £2k above the planned control total. This included the planned utilisation of £1,620k of Provider Sustainability Funding. However, the Trust was also £541k behind against its cost improvement (CIP) target of £4.95m. – In addition, the Trust was also experiencing financial pressure in relation to use of agency staff. In 2017/18 agency spend was £18.4m, £6.9m above target. The agency cap set by NHSI for GMMH for 2018/19 was £10.2m. At month 9, agency spend was £15.58m, compared to the agency cap target for month 9 of £7.65m. This was an adverse variance of £7.921m against the target. This reduced the Trust's Finance and Use of Resources metric score for the year to 3 from a planned score of 2. – The Trust also continued to face pressures from Out of Area Placements (OAPs) costs (dealt with under the specific OAP risk within this report).	Our work included: – For the current year, we reviewed the arrangements in place to deliver and report on the forecast outturn, and especially the arrangements in place to deliver the CIP, reduce the agency spend and manage the OAPs position. – Looking ahead to 2019/20, we also considered the extent to which the Trust will be able to deliver its control totals in the future, and maintain a surplus position across the medium term. – This included a review of Operational Plan, including cash flow forecasts, and the arrangements in place to deliver forecast positions. This included delivery of targets required to secure Provider Sustainability Fund (PSF) income. – As part of our work, we also considered other arrangements in place, including financial reporting to the Board to inform decision making and engagement with wider stakeholders to support the delivery of efficiencies, including lead commissioners. **Our findings on this risk area:** *Financial Performance* The financial performance at the end of March 2019 was a surplus of £7.292m, £5.00m above the planned control total. This outturn includes £2,492k of Provider Sustainability Funding for achieving the Trust's control total and an additional incentive and bonus PSF of £3,276K. The Trust have agreed a control total surplus of £1.23m for 2019/20 (after PSF of £2.48m). *Agency Spend* At month 12, agency spend was £19.833m, £9.622m above the 12 months target of £10.211m. Approximately, two thirds of the agency costs were incurred within the Manchester services (formally MMHSC), which had a high level of agency staff use to cover nursing and medical vacancies and for one-to-one observations. The Agency target set by NHSI for 2019/20 is £11.636m, although the Trust plans to deliver a lesser reduction of £3.6m on the 2018/19 outturn. A number of substantive posts have been filled and the Trust is forecasting that the NHS Professionals 'Project' will begin to have an impact on the use of external agencies and associated costs. *Cost Improvement Plan (CIP)* The Trust delivered £4,214m of CIP in 18/19, with a shortfall of £736k being reported in the overall financial position at month 12. For 2019/20, the Trust is required to deliver 1.1% of savings in line with the planning guidance and a further 0.5% as per the financial Control Total issued to GMMH for 2019/20. Detailed CIP plans for 2019/20 are still being finalised, with £3m of savings having been identified to date. Despite the ongoing challenges to financial sustainability we consider there to be appropriate arrangements in place to effectively identify and manage the risk, including identification of mitigating actions where there are gaps in control. We have concluded that the risk will not result in a modified value for money opinion

Significant Risk	Description	Work carried out and judgements
Management of Out of Area Placements (OAPs)	– Following the acquisition of MMHSC in 2017, GMMH NHS FT remains in a period of transition as processes and systems are integrated. With demand rising nationally and the issues inherited from the transfer of the Manchester services, the Trust continues to experience significant financial pressure in this area. A key pressure is around OAPs, where the Trust was aiming for a 33% reduction in bed nights during 2018/19. – A long-term funding solution to remove this pressure has not yet been identified. However, the Trust continued to receive transitional support from Commissioners (£1.8m received in year) with negotiations continuing for more funding. – Despite funding and demand challenges, the quality of data on OAPs has however improved in terms of the number of placements and where these are. – The CQC Core Service with Well-led Inspection (Sept. 2017 to Dec. 2017) concluded the Trust had effective systems in place to monitor OAPs and plans to address performance.	Our work included: – Procedures focused on confirming the scale of financial pressure presented by OAPs and arrangements in place to mitigate the financial sustainability risks, including obtaining evidence of the Trust working with Commissioners to secure additional support to fund current levels and invest in alternative models of care to reduce demand for beds. – We reviewed the work of the dedicated transformation work streams put in place and management oversight and reporting of these. – Our Quality Accounts work also looked at the data quality of indicator reporting linked to OAPs. **Our findings on this risk area:** – Actual spend on OAPs for the financial year 2018/19 was £9.684m. The Trust achieved a reduction of 63% on the 2017/18 position exceeding the 33% target required. This equated to a reduction reportable OAP bed nights from 1646 in April 2018 to 5 in March 2019. – Commissioners have supported GMMH with non-recurrent support for OAPS to fund the over performance in year. In addition a number of schemes such as Maryfield Court, Beech House, MacColl and Griffin Wards have been supported by commissioners. – There will be a continued focus on the sustained reduction of all OAPs including those locally monitored. The total costs for OAPs included in the 2019/20 financial plan is £7.1m. The target for 2019/20 is a 66% reduction in bed days from the 17/18 position and £2.6m of additional non-recurrent funding from Commissioners has already been agreed to support this. – As a result of there being arrangements in place to identify and manage the risk, including identification of mitigating actions where there are gaps in control, we have concluded that the risk will not result in a modified value for money opinion.

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.

Robert Jones
for and on behalf of KPMG LLP (Statutory Auditor)

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

28 May 2019

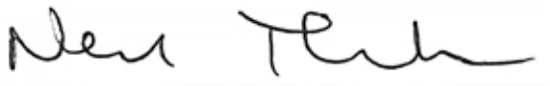
KPMG

Financial Review

Foreword to the Accounts

These accounts for the year ended 31 March 2019 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.

Signed



Name: Neil Thwaite
Job Title: Chief Executive
Date: 20 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	280,211	258,000
Other operating income	4	39,075	35,292
Operating expenses	5	(308,340)	(280,086)
Operating surplus/(deficit) from continuing operations		**10,946**	**13,206**
Finance income	10	163	149
Finance expenses	11	(109)	(195)
PDC dividends payable		(5,886)	(4,981)
Net finance costs		**(5,832)**	**(5,027)**
Other gains / (losses)	12	(12)	3
Surplus / (deficit) for the year from continuing operations		**5,102**	**8,182**
Surplus / (deficit) for the year		**5,102**	**8,182**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(3,723)	952
Revaluations		4,378	13,494
Other recognised gains and losses:		-	-
Remeasurements of the net defined benefit pension scheme liability / asset	29	(906)	457
Other reserve movements		(15)	(15)
Total comprehensive income / (expense) for the period		**4,836**	**23,070**

Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	5,102	8,182
Remove net impairments not scoring to the Departmental expenditure limit	2,190	(4,387)
Remove non-cash element of on-SoFP pension costs	136	214
Adjusted financial performance surplus / (deficit)	**7,428**	**4,009**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	13	2,344	1,691
Property, plant and equipment	14	191,512	191,304
Receivables	16	10,393	9,968
Total non-current assets		**204,249**	**202,963**
Current assets			
Inventories		-	-
Receivables	16	23,233	16,265
Cash and cash equivalents	19	29,578	38,748
Total current assets		**52,811**	**55,013**
Current liabilities			
Trade and other payables	20	(30,955)	(29,744)
Borrowings	23	(326)	(5,762)
Other financial liabilities	21	-	-
Provisions	25	(563)	(717)
Other liabilities	22	(12,902)	(14,947)
Liabilities in disposal groups	18	-	-
Total current liabilities		**(44,746)**	**(51,170)**
Total assets less current liabilities		**212,314**	**206,806**
Non-current liabilities			
Trade and other payables	20	-	-
Borrowings	23	(2,125)	(2,449)
Other financial liabilities	21	-	-
Provisions	25	(3,160)	(3,262)
Other liabilities	22	(2,174)	(4,662)
Total non-current liabilities		**(7,459)**	**(10,373)**
Total assets employed		**204,855**	**196,433**
Financed by			
Public dividend capital		108,991	105,406
Revaluation reserve		30,659	30,552
Pension reserve		18	924
Other reserves		410	425
Income and expenditure reserve		64,777	59,126
Total taxpayers' equity		**204,855**	**196,433**

The notes on pages 142 to 191 form part of these accounts.

The financial statements were approved by the Trust Board on 20 May 2019 and signed on its behalf by:

Name: **Neil Thwaite**
Job Title: Chief Executive
Date: **20 May 2019**

Statement of Changes in Taxpayers' Equity

Statement of Changes in Equity for the year ended 31 March 2019

	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 2018 - brought forward	**105,406**	**30,552**	**924**	**425**	**59,126**	**196,433**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-	**-**
Surplus/(deficit) for the year	-	-	-	-	5,102	**5,102**
Transfers by absorption: transfers between reserves	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(548)	-	-	548	**-**
Other transfers between reserves	-	-	-	-	-	**-**
Impairments	-	(3,723)	-	-	-	**(3,723)**
Revaluations	-	4,378	-	-	-	**4,378**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	**-**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	-	-	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	-	-	-	**-**
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	-	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	(906)	-	-	**(906)**
Public dividend capital received	3,585	-	-	-	-	**3,585**
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 2019	**108,991**	**30,659**	**18**	**410**	**64,777**	**204,855**

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**
Prior period adjustment	-	-	-	-	-	**-**
Taxpayers' equity at 1 April 2017 - restated	**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**

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 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	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		10,946	13,206
Non-cash income and expense:			
Depreciation and amortisation	5.2	7,558	6,789
Net impairments	6	2,190	(4,387)
Non-cash movements in on-SoFP pension liability		136	214
(Increase) / decrease in receivables and other assets		(7,393)	(5,335)
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilties		(3,547)	9,853
Increase / (decrease) in provisions		(260)	(2,811)
Other movements in operating cash flows		(15)	(15)
Net cash generated from / (used in) operating activities		**9,615**	**17,514**
Cash flows from investing activities			
Interest received		163	149
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(1,399)	(1,664)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(9,411)	(6,354)
Sales of property, plant, equipment and investment property		10	3
Receipt of cash donations to purchase capital assets		-	-
Net cash generated from / (used in) investing activities		**(10,637)**	**(7,866)**
Cash flows from financing activities			
Public dividend capital received		3,585	3,357
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		(5,762)	(324)
Interest on loans		(73)	(138)
Other interest		-	-
PDC dividend (paid) / refunded		(5,858)	(5,268)
Cash flows from (used in) other financing activities		(40)	-
Net cash generated from / (used in) financing activities		**(8,148)**	**(2,373)**
Increase / (decrease) in cash and cash equivalents		**(9,170)**	**7,275**
Cash and cash equivalents at 1 April - brought forward		**38,748**	**31,473**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**38,748**	**31,473**
Cash and cash equivalents transferred under absorption accounting		-	-
Cash and cash equivalents at 31 March	19.1	**29,578**	**38,748**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention

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

Note 1.2 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 25 March 2019, the Trust Board considered the IAS 1 requirement and confirmed that a going concern basis for accounts preparation was appropriate.

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 Revenue

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme

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 29.

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 1st 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 pensions 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement

Valuation

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

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

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

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

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

Note 1.7.3 De-recognition

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

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

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

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

Note 1.7.4 Donated and grant funded assets

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

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

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

The Trust does not have any PFI or LIFT assets.

Note 1.7.6 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	1	72
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	7
Furniture & fittings	3	3

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

Note 1.8 Intangible assets

Note 1.8.1 Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development

Software

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

Note 1.8.2 Measurement

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

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

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

Amortisation

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

Note 1.8.3 Useful economic life of intangible assets

	Min life Years	Max life Years
Development expenditure	3	7
Software licences	3	7
Other (purchased)	3	7

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 Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO_2 emissions. The Trust is not registered with the CRC scheme.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 De-recognition

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

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

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.

Note 1.14 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 1.14.1 The trust as lessee

Finance leases

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

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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 1.14.2 The trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's 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 1.15 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 25 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 1.16 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 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, 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 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 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 1.19 Corporation tax

The Trust does not pay any corporation tax.

Note 1.20 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 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 1.22 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 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 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 1.24.1 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 2018/19 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 2018/19 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 decrease in carrying values of £309k.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset recorded in note 14.

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 2019 and 31 March 2018 in measuring the present value of the defined benefit scheme liabilities are:

Financial Assumptions	**31 March 2019**	31 March 2018
	% pa	% pa
Pension Increase Rate (CPI)	**2.5%**	2.4%
Salary Increase Rate	**3.3%**	3.2%
Discount Rate	**2.4%**	2.7%

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

	31 March 2019	31 March 2018
Demographic Assumptions (life expectancies)	**Years**	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 2019
	%	**£000**
0.5% decrease in real discount rate	**12%**	**2,354**
0.5% increase in salary increase rate	**1%**	**300**
0.5% increase in pension increase rate	**10%**	**2,015**

		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

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 is applicable from 1 April 2020. There will be a requirement for the Trust to recognise the underlying assets (represented by the present value of the lease payments) and corresponding liabilities inherent in all of its lease agreements (and contracts containing leases), in addition, the income statement will be charged with depreciation and interest instead of the lease payments, which is expected to 'front load' the expense to the earlier part of the agreement, but at this stage it is not expected that this will represent a material adjustment.

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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Mental health services		
Cost and volume contract income	5,892	4,557
Block contract income	208,136	187,805
Clinical partnerships providing mandatory services (including S75 agreements)	29,008	29,829
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	34,561	35,393
All services		
Agenda for Change pay award central funding	2,614	-
Other clinical income***	-	416
Total income from activities	**280,211**	**258,000**

*** *Other clinical income in 2017/18 relates to funding from Strategic Partnerships for clinical services. These services ceased during 2017/18.*

Note 3.2 Income from patient care activities (by source)	2018/19 £000	2017/18 £000
Income from patient care activities received from:		
NHS England	63,309	63,833
Clinical commissioning groups	154,911	135,161
Department of Health and Social Care *	2,614	-
Other NHS providers	32,297	31,992
NHS other	-	37
Local authorities	24,790	25,211
Non NHS: other	2,290	1,766
Total income from activities	**280,211**	**258,000**
Of which:		
Related to continuing operations	280,211	258,000
Related to discontinued operations	-	-

**Department of Health and Social Care income relates to the Agenda for Change pay award central funding.*

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

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	4,906	4,591
Education and training (excluding notional apprenticeship levy income)	15,814	13,627
Non-patient care services to other bodies	-	-
Provider sustainability / sustainability and transformation fund income (PSF / STF)	6,698	3,426
Other contract income ***	11,283	13,271
Other non-contract operating income		
Charitable and other contributions to expenditure	15	15
Rental revenue from operating leases	359	362
Total other operating income	**39,075**	**35,292**
Of which:		
Related to continuing operations	39,075	35,292
Related to discontinued operations	-	-

*** Other Income comprises:

	2018/19	2017/18
	£000	£000
Car parking	254	247
Clinical excellence awards	191	323
Catering	205	193
Property Rentals	675	552
Apprentice levy reclaim	363	334
VAT reclaims	1,455	331
Transition and transformation income**	3,587	5,888
Release of deferred income **	3,246	3,818
Other	1,307	1,585
	11,283	**13,271**

** 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 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	6,263
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 4.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019
	£000
within one year	-
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	**-**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 Income from activities arising from commissioner requested services

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

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	280,211	258,000
Income from services not designated as commissioner requested services	39,075	35,292
Total	**319,286**	**293,292**

Note 5.0 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	9,396	10,864
Purchase of healthcare from non-NHS and non-DHSC bodies	17,571	15,122
Purchase of social care	586	589
Staff and executive directors costs	218,554	205,647
Remuneration of non-executive directors	140	142
Supplies and services - clinical (excluding drugs costs)	5,112	3,378
Supplies and services - general	5,757	4,688
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	5,002	4,668
Consultancy costs	-	-
Establishment	3,300	3,270
Premises	9,144	8,519
Transport (including patient travel)	2,854	2,948
Depreciation on property, plant and equipment	6,812	6,269
Amortisation on intangible assets	746	520
Net impairments	2,190	(4,387)
Movement in credit loss allowance: contract receivables / contract assets	15	
Movement in credit loss allowance: all other receivables and investments	-	160
Increase/(decrease) in other provisions	253	-
Change in provisions discount rate(s)	(148)	114
Audit fees payable to the external auditor		
audit services- statutory audit	65	63
other auditor remuneration (external auditor only)	14	22
Internal audit costs	152	156
Clinical negligence	1,051	851
Legal fees	750	22
Insurance	42	49
Research and development	4,902	4,384
Education and training	4,980	3,312
Rentals under operating leases	6,017	5,765
Early retirements	-	-
Redundancy	264	728
Car parking & security	345	297
Hospitality	52	8
Losses, ex gratia & special payments	132	9
Other services, eg external payroll	287	229
Other	2,003	1,680
Total	**308,340**	**280,086**
Of which:		
Related to continuing operations	308,340	280,086
Related to discontinued operations	-	-

The main movements on expenditure in 2018/19 when compared to 2017/18 are as a result of the increase in pay due to the national Agenda for Change pay award. In addition there was an impairment in 2018/19 following a desk top revaluation by the District Valuer (reversal of previous impairment in 2017/18).

Note 5.1 Other auditor remuneration	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	14	15
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	7
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**14**	**22**

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 6 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	2,190	(4,387)
Other	-	-
Total net impairments charged to operating surplus / deficit	**2,190**	(4,387)
Impairments charged to the revaluation reserve	3,723	(952)
Total net impairments	**5,913**	**(5,339)**

A desktop revaluation of land and buildings was undertaken as at 31 March 2019 by the District Valuer and resulted in a net impairment of £5,913,000.

Note 7 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	168,871	158,164
Social security costs	14,613	13,757
Apprenticeship levy	804	732
Employer's contributions to NHS pensions	19,844	18,811
Pension cost - other	220	412
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	264	728
Temporary staff (including agency)	19,980	18,409
Total gross staff costs	**224,596**	**211,013**
Recoveries in respect of seconded staff	**(1,427)**	(1,409)
Total staff costs	**223,169**	**209,604**
Of which		
Costs capitalised as part of assets	797	217

Note 7.1 Retirements due to ill-health

During 2018/19 there were no early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £0k (£83k in 2017/18).

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

Note 7.2 Directors Remuneration	2018/19 £	2017/18 £
Salary	1,232,908	1,183,427
Taxable benefits	26,370	28,939
Pensions - final pay controls charge ***	0	90,660
Employer's pension contributions	55,249	112,123
Total	**1,314,527**	**1,415,149**

**** Additional charge made by NHS Pensions in relation to the retirement of the former 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 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 1st 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.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	274	274
Contingent rent	-	-
Other	85	88
Total	**359**	**362**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	213	216
- later than one year and not later than five years;	851	863
- later than five years.	1,950	2,410
Total	**3,014**	**3,489**

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:

i) ownership of the asset does not transfer to the lessee at the end of the lease

ii) the Trust as lessee does not have the option to buy the asset at a price below the fair value of the asset

iii) the lease is not for the major part of the economic life of the asset

iv) at inception, the present value of the minimum lease payments is not at least substantially all of the fair value of the asset

v) 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.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	6,017	5,765
Total	**6,017**	**5,765**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	5,665	5,550
- later than one year and not later than five years;	15,937	16,036
- later than five years.	39,634	43,587
Total	**61,236**	**65,173**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	163	149
Total finance income	**163**	**149**

Note 11.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	73	149
Total interest expense	**73**	**149**
Unwinding of discount on provisions	4	8
Other finance costs	32	38
Total finance costs	**109**	**195**

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 debt interest.

Note 12 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	-	4
Losses on disposal of assets	(12)	(1)
Total gains / (losses) on disposal of assets	**(12)**	**3**
Total other gains / (losses)	**(12)**	**3**

Note 12 Discontinued Operations

The Trust has no discontinued operations.

Note 13 Intangible assets - 2018/19

	Software licences	Internally generated information technology	Development expenditure	Other (purchased)	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**2,912**	**-**	**-**	**96**	**3,008**
Transfers by absorption	-	-	-	-	**-**
Additions	416	-	983	-	**1,399**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Valuation / gross cost at 31 March 2019	**3,328**	**-**	**983**	**96**	**4,407**
Amortisation at 1 April 2018 - brought forward	**1,243**	**-**	**-**	**74**	**1,317**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	739	-	-	7	**746**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Amortisation at 31 March 2019	**1,982**	**-**	**-**	**81**	**2,063**
Net book value at 31 March 2019	**1,346**	**-**	**983**	**15**	**2,344**
Net book value at 1 April 2018	**1,669**	**-**	**-**	**22**	**1,691**

Note 13.1 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Development expenditure	Other (purchased)	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**1,258**	**-**	**-**	**76**	**1,344**
Prior period adjustments	-	-	-	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**1,258**	**-**	**-**	**76**	**1,344**
Transfers by absorption	-	-	-	-	**-**
Additions	1,654	-	-	10	**1,664**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	10	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Valuation / gross cost at 31 March 2018	**2,912**	**-**	**-**	**96**	**3,008**
Amortisation at 1 April 2017 - as previously stated	**750**	**-**	**-**	**47**	**797**
Prior period adjustments	-	-	-	-	**-**
Amortisation at 1 April 2017 - restated	**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**	**-**	**-**	**74**	**1,317**
Net book value at 31 March 2018	**1,669**	**-**	**-**	**22**	**1,691**
Net book value at 1 April 2017	**508**	**-**	**-**	**29**	**547**

Note 14.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**19,053**	**186,237**	**4,289**	**1,006**	**696**	**7,046**	**2,403**	**220,730**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	-	7,161	46	67	963	340	**8,577**
Impairments	-	(4,669)	-	-	-	-	-	**(4,669)**
Reversals of impairments	890	-	-	-	-	-	-	**890**
Revaluations	1,895	-	-	-	-	-	-	**1,895**
Reclassifications	-	9,266	(9,266)	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(25)	-	(1)	(62)	(41)	-	**(129)**
Valuation/gross cost at 31 March 2019	**21,838**	**190,809**	**2,184**	**1,051**	**701**	**7,968**	**2,743**	**227,294**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**21,908**	**-**	**710**	**460**	**4,303**	**2,045**	**29,426**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,183	-	57	67	1,219	286	**6,812**
Impairments	-	3,126	-	-	-	-	-	**3,126**
Reversals of impairments	-	(992)	-	-	-	-	-	**(992)**
Revaluations	-	(2,483)	-	-	-	-	-	**(2,483)**
Reclassifications	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(21)	-	(1)	(62)	(23)	-	**(107)**
Accumulated depreciation at 31 March 2019	**-**	**26,721**	**-**	**766**	**465**	**5,499**	**2,331**	**35,782**
Net book value at 31 March 2019	**21,838**	**164,088**	**2,184**	**285**	**236**	**2,469**	**412**	**191,512**
Net book value at 1 April 2018	**19,053**	**164,329**	**4,289**	**296**	**236**	**2,743**	**358**	**191,304**

Note 14.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**18,928**	**176,637**	**671**	**940**	**728**	**5,982**	**2,306**	**206,192**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**18,928**	**176,637**	**671**	**940**	**728**	**5,982**	**2,306**	**206,192**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	-	5,938	75	24	1,099	97	**7,233**
Impairments	-	(323)	-	-	-	-	-	**(323)**
Reversals of impairments	25	1,326	-	-	-	-	-	**1,351**
Revaluations	100	6,569	-	-	-	-	-	**6,669**
Reclassifications	-	2,320	(2,320)	-	1	(1)	-	**-**
Transfers to / from assets held for sale	-	-	-	-	38	-	-	**38**
Disposals / derecognition	-	(292)	-	(9)	(95)	(34)	-	**(430)**
Valuation/gross cost at 31 March 2018	**19,053**	**186,237**	**4,289**	**1,006**	**696**	**7,046**	**2,403**	**220,730**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**28,697**	**-**	**632**	**439**	**3,162**	**1,754**	**34,684**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2017 - restated	**-**	**28,697**	**-**	**632**	**439**	**3,162**	**1,754**	**34,684**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	4,639	-	87	77	1,175	291	**6,269**
Impairments	-	12	-	-	-	-	-	**12**
Reversals of impairments	-	(4,323)	-	-	-	-	-	**(4,323)**
Revaluations	-	(6,825)	-	-	-	-	-	**(6,825)**
Reclassifications	-	-	-	(1)	1	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	38	-	-	**38**
Disposals / derecognition	-	(292)	-	(8)	(95)	(34)	-	**(429)**
Accumulated depreciation at 31 March 2018	**-**	**21,908**	**-**	**710**	**460**	**4,303**	**2,045**	**29,426**
Net book value at 31 March 2018	**19,053**	**164,329**	**4,289**	**296**	**236**	**2,743**	**358**	**191,304**
Net book value at 1 April 2017	**18,928**	**147,940**	**671**	**308**	**289**	**2,820**	**552**	**171,508**

Note 14.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	21,838	164,088	2,184	285	236	2,469	412	**191,512**
NBV total at 31 March 2019	**21,838**	**164,088**	**2,184**	**285**	**236**	**2,469**	**412**	**191,512**

Note 14.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	19,053	164,329	4,289	296	236	2,743	358	**191,304**
NBV total at 31 March 2018	**19,053**	**164,329**	**4,289**	**296**	**236**	**2,743**	**358**	**191,304**

Note 14.5 Gross carrying amount of any fully depreciated assets still in use

There are 345 (2017/18 257) equipment assets which are fully depreciated. The gross carrying cost of these totals £5,921,382 (2017/18 £3,899,918).

Note 15 Investment Property

The Trust does not hold any Investment Property.

Note 16 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	21,194	
Contract assets*	-	
Trade receivables*		10,809
Accrued income*		3,704
Allowance for impaired contract receivables / assets*	(458)	
Allowance for other impaired receivables	-	(515)
Prepayments (non-PFI)	2,091	1,516
VAT receivable	396	735
Other receivables	10	16
Total current trade and other receivables	**23,233**	**16,265**
Non-current		
Prepayments (non-PFI)**	10,393	9,968
Total non-current trade and other receivables	**10,393**	**9,968**
Of which receivables from NHS and DHSC group bodies:		
Current	17,925	11,159
Non-current	10,393	9,968

**Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.*

***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 16.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**515**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	515	(515)
New allowances arising	258	-
Changes in existing allowances	-	-
Reversals of allowances	(243)	-
Utilisation of allowances (write offs)	(72)	-
Allowances as at 31 Mar 2019	**458**	**-**

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 16.2 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	
Prior period adjustments	370
Allowances as at 1 Apr 2017 - restated	**370**
Transfers by absorption	
Increase in provision	325
Amounts utilised	(15)
Unused amounts reversed	(165)
Allowances as at 31 Mar 2018	**515**

Note 17 Other assets

The Trust does not hold any other assets in 2018/19 (2017/18 Nil).

Note 18 Liabilities in disposal groups

The Trust has no liabilities in disposal groups in 2018/19 (2017/18 Nil).

Note 19.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**38,748**	**31,473**
Prior period adjustments	-	-
At 1 April (restated)	**38,748**	**31,473**
Transfers by absorption	-	-
Net change in year	(9,170)	7,275
At 31 March	**29,578**	**38,748**
Broken down into:		
Cash at commercial banks and in hand	592	595
Cash with the Government Banking Service	28,986	38,153
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**29,578**	**38,748**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**29,578**	**38,748**

Note 19.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019	31 March 2018
	£000	£000
Bank balances	306	309
Monies on deposit	470	560
Total third party assets	**776**	**869**

Note 20 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	10,684	7,720
Capital payables	1,798	2,632
Accruals	11,345	12,589
Receipts in advance (including payments on account)	-	-
Social security costs	4,056	3,865
VAT payables	195	-
Other taxes payable	-	-
PDC dividend payable	173	145
Accrued interest on loans*	-	11
Other payables**	2,704	2,782
Total current trade and other payables	**30,955**	**29,744**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	6,355	3,092
Non-current	-	-

** Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.*

*** Other payables includes outstanding NHS Pensions contributions of £2,704k (2017/18 £2,574k).*

Note 20.1 Early retirements in NHS payables opposite

The payables note opposite includes amounts in relation to early retirements as set out below:

	31 March 2019 £000	31 March 2019 Number	31 March 2018 £000	31 March 2018 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 21 Other financial liabilities

The Trust has no other financial liabilities.

Note 22 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	12,902	14,947
Total other current liabilities	**12,902**	**14,947**
Non-current		
Deferred income: contract liabilities	-	3,530
Net pension scheme liability	2,174	1,132
Total other non-current liabilities	**2,174**	**4,662**

Note 23 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	326	5,762
Total current borrowings	**326**	**5,762**
Non-current		
Loans from the Department of Health and Social Care	2,125	2,449
Total non-current borrowings	**2,125**	**2,449**

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. The Revenue support loan was repaid in May 2018.

Note 23.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Total £000
Carrying value at 1 April 2018	**8,211**	**8,211**
At start of period for new FTs	**-**	**-**
Cash movements:		**-**
Financing cash flows - payments and receipts of principal	(5,762)	**(5,762)**
Financing cash flows - payments of interest	(73)	(73)
Non-cash movements:		**-**
Impact of implementing IFRS 9 on 1 April 2018	11	11
Transfers by absorption	-	**-**
Additions	-	**-**
Application of effective interest rate	64	**64**
Change in effective interest rate	-	**-**
Changes in fair value	-	**-**
Other changes	-	**-**
Transfer to FT upon authorisation	-	**-**
Carrying value at 31 March 2019	**2,451**	**2,451**

Note 24 Finance leases

The Trust has no finance leases.

Note 25 Provisions for liabilities and charges analysis

	Pensions: injury benefits*	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**3,429**	**225**	**213**	**112**	**3,979**
Change in the discount rate	(148)	-	-	-	**(148)**
Arising during the year	301	71	108	-	**480**
Utilised during the year	(168)	-	(197)	-	**(365)**
Reversed unused	(99)	-	(16)	(112)	**(227)**
Unwinding of discount	4	-	-	-	**4**
At 31 March 2019	**3,319**	**296**	**108**	**-**	**3,723**
Expected timing of cash flows:					
- not later than one year;	159	296	108	-	**563**
- later than one year and not later than five years;	636	-	-	-	**636**
- later than five years.	2,524	-	-	-	**2,524**
Total	**3,319**	**296**	**108**	**-**	**3,723**

** In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.*

Provisions relate to:

Pensions - Injury Benefit	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-structurings	The amount associated with planned organisational restructures.
Other	Includes amounts in respect of estates costs. No individual provision is greater than £1m.

Note 25.1 Clinical negligence liabilities

At 31 March 2019, £2,214k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Greater Manchester Mental Health NHS Foundation Trust (31 March 2018: £1,788k).

Note 26 Contingent assets and liabilities

	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(223)	(222)
Gross value of contingent liabilities	**(223)**	**(222)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(223)**	**(222)**
Net value of contingent assets	**-**	**-**

Note 27 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	2,832	2,116
Intangible assets	-	-
Total	**2,832**	**2,116**

Note 28 Other financial commitments

The Trust does not have any other financial commitments.

Note 29 Defined benefit pension schemes

Note 29.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2018/19	2017/18
	£000	£000
Present value of the defined benefit obligation at 1 April	**(17,860)**	**(17,608)**
Prior period adjustment		-
Present value of the defined benefit obligation at 1 April - restated	**(17,860)**	**(17,608)**
Transfers by absorption	-	-
Current service cost	(241)	(374)
Interest cost	(482)	(460)
Contribution by plan participants	(50)	(73)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	(1,696)	386
Benefits paid	263	269
Present value of the defined benefit obligation at 31 March	**(20,066)**	**(17,860)**
Plan assets at fair value at 1 April	**16,728**	**16,233**
Prior period adjustment		-
Plan assets at fair value at 1 April -restated	**16,728**	**16,233**
Transfers by normal absorption	-	-
Interest income	450	422
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets	-	71
- Actuarial gain / (losses)	790	-
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	-	-
Contributions by the employer	137	198
Contributions by the plan participants	50	73
Benefits paid	(263)	(269)
Plan assets at fair value at 31 March	**17,892**	**16,728**
Plan surplus/(deficit) at 31 March	**(2,174)**	**(1,132)**

Note 29.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2019	31 March 2018
	£000	£000
Present value of the defined benefit obligation	(20,066)	(17,860)
Plan assets at fair value	17,892	16,728
Net defined benefit (obligation) / asset recognised in the SoFP	**(2,174)**	**(1,132)**
Fair value of any reimbursement right	-	-
Net (liability) / asset recognised in the SoFP	**(2,174)**	**(1,132)**

Note 29.3 Amounts recognised in the SoCI

	2018/19	2017/18
	£000	£000
Current service cost	(241)	(374)
Interest expense / income	(32)	(38)
Total net (charge) / gain recognised in SOCI	**(273)**	**(412)**

Note 29.4 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 2019				Period ended 31 March 2018			
	Quoted prices in active markets	Quoted prices not in active markets	Total	Percentage of total assets	Quoted prices in active markets	Quoted prices not in active markets	Total	Percentage of total assets
	£000s	£000s	£000s		£000s	£000s	£000s	
Equity Securities:								
Consumer	988		988	6%	954		954	6%
Manufacturing	1,034		1,034	6%	1,145		1,145	7%
Energy and Utilities	1,005		1,005	6%	907		907	5%
Financial Institutions	1,416		1,416	8%	1,378		1,378	8%
Health and Care	528		528	3%	427		427	3%
Information Technology	319		319	2%	268		268	2%
Other	196		196	1%	164		164	1%
Debt Securities:								
Corporate Bonds (investment grade)	669		669	4%	620		620	4%
Corporate Bonds (non-investment grade)								
UK Government	118		118	1%	145		145	1%
Other	454		454	3%	465		465	3%
Private Equity:								
All		838	838	5%		560	560	3%
Real Estate:								
UK Property		850	850	5%		573	573	3%
Overseas Property								
Investment Funds and Unit Trusts:								
Equities	4,045		4,045	23%	4,527		4,527	27%
Bonds	2,226		2,226	12%	2,169		2,169	13%
Hedge Funds								
Commodities								
Infrastructure		858	858	5%		433	433	3%
Other	349	1,543	1,892	11%	440	941	1,381	8%
Derivatives:								
Inflation								
Interest Rate								
Foreign Exchange								
Other	9		9	0%				
Cash and Cash Equivalents:								
All	447		447	2%	612		612	4%
Totals			17,892	100%			16,728	100%
Present value of defined benefit obligation			**(20,066)**				**(17,860)**	
Net benefit deficit			**(2,174)**				**(1,132)**	

Note 30 Financial instruments

Note 30.1 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 Receiveables 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 30.2 Carrying values of financial assets

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	20,746	-	-	**20,746**
Cash and cash equivalents at bank and in hand	29,578	-	-	**29,578**
Total at 31 March 2019	**50,324**	**-**	**-**	**50,324**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	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**

Note 30.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	2,451	-	**2,451**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	26,531	-	**26,531**
Other financial liabilities	-	-	**-**
Provisions under contract	3,319	-	**3,319**
Total at 31 March 2019	**32,301**	**-**	**32,301**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	8,211	-	**8,211**
Other borrowings	-	-	**-**
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**

Note 30.4 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 30.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	27,016	26,214
In more than one year but not more than two years	966	491
In more than two years but not more than five years	1,926	1,473
In more than five years	2,393	9,133
Total	**32,301**	**37,311**

Note 31 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	7	-	12	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	45	96	182	15
Stores losses and damage to property	1,452	83	2,029	101
Total losses	**1,504**	**179**	**2,223**	**116**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	48	17	41	8
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**48**	**17**	**41**	**8**
Total losses and special payments	**1,552**	**196**	**2,264**	**124**
Compensation payments received		-		-

Note 32 Gifts

There were no gifts.

Note 33.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £11k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 33.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 34 Related parties

In 2018/19 one member of the Trust Board had a relationship with an organisation with which the Trust had transactions occuring in the normal course of business as detailed below:

Elizabeth Calder, Director of Performance and Strategic Development is married to a director at Manchester University NHS Foundation Trust. The Trust had the following transactions with this organisation during 2018/19:

	£000
Income	1,710
Expenditure	7,635
Receivables at 31 March 2019	11,083
Payables at 31 March 2019	1,155

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 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Value of balances with Related parties at 31 March 2019				
Department of Health and Social Care	325	223	-	47
Other NHS Bodies (DH Group)	27,993	20,904	6,182	2,889
Other (WGA + LA's)	1,785	2,599	10,802	7,624
Total	**30,103**	**23,726**	**16,984**	**10,560**

	Income		Expenditure	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Value of balances with Related parties at 31 March 2019				
Department of Health and Social Care	5,977	2,673	0	3
Other NHS Bodies (DH Group)	278,049	257,409	21,000	19,888
Other (WGA + LA's)	26,033	27,003	36,765	35,020
Total	**310,059**	**287,085**	**57,765**	**54,911**

Note 35 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 or 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 Accounts 2018/19

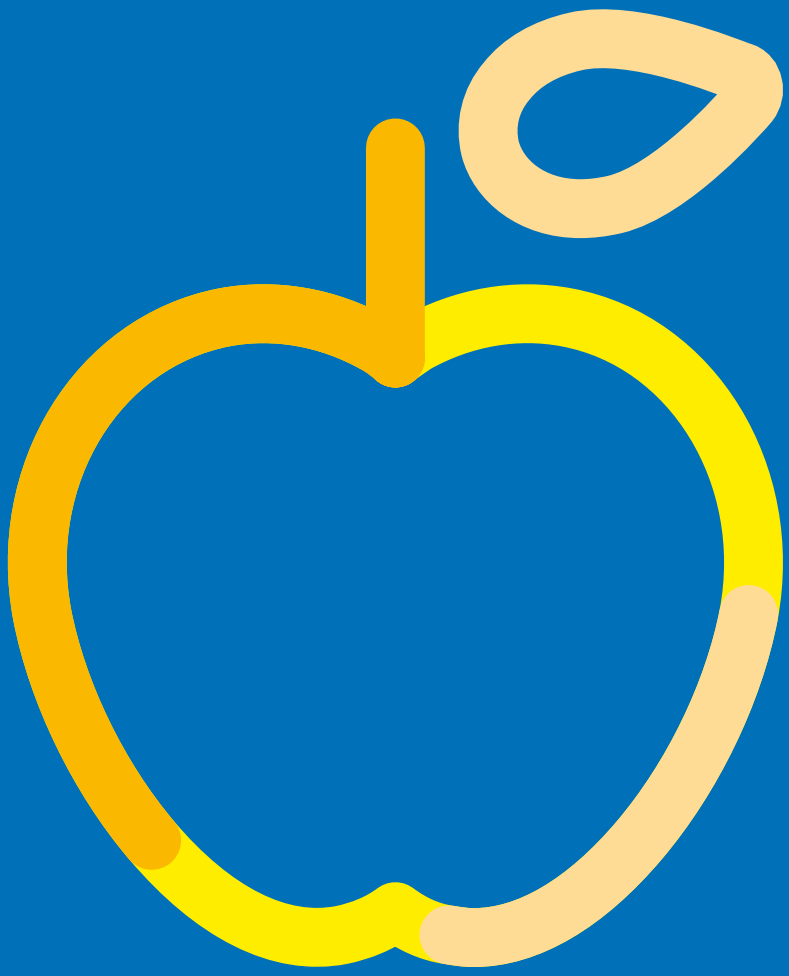
Improving Lives

Greater Manchester Mental Health NHS Foundation Trust

Quality Account 2018/19

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

PART 1 – Our Commitment to Quality



1.1 Chief Executive's Welcome

On behalf of the Trust Board, I am proud to present our Quality Account for 2018/19. This report sets out the steps taken during the period to improve the quality of care we provide. It demonstrates our commitment to further quality improvement in the year ahead, including some notable achievements and accolades, and the publication of our first GMMH Quality Improvement strategy.

Through engagement with our key stakeholders, we have identified three key quality priorities for 2019/20. We have aligned these priorities to our Quality Improvement strategy, which is currently in development. Further detail on these priorities, including how they were identified and developed in partnership with a wide range of stakeholders is set out in part four of this Quality Account.

Throughout 2018/19, we have continued to work hard to enable the meaningful involvement of our service users and their carers in service development activities. The Carers, Family and Friends Strategy sets out how the Trust is working with partners in health, social care and the voluntary sector to support the thousands of Greater Manchester carers who look after people with mental health problems. The strategy recognises the important work of family and friends, young and old, caring for people who need help due to a mental illness, addiction or dementia. It sets out how GMMH will involve and support carers across Bolton, Salford, Trafford, Prestwich, Manchester, and Cumbria as well as how they will work with local organisations to make life better for carers.

We also strengthened our commitment to the patient voice by updating our service user engagement strategy. Our success as a high-performing mental health NHS Foundation Trust not only depends on what services we provide, but on how we provide them, and our service users have a wealth of experience of using mental health services. Here at GMMH, we recognise that service user involvement is hugely important in ensuring that our services are relevant and recovery focussed.

2018/19 also saw the launch of our Equality, Diversity and Inclusion Strategy. This is built around the four goals stipulated by the Equality Delivery System for the NHS, which focus on service user health outcomes, experience and access to services, workforce and inclusive leadership. The priorities set out the approach to ensuring that services are accessible to all, that the workforce is reflective of the diverse communities we serve and that equality is central to everything we do. The principles of equality, diversity and inclusion are critical to delivering high-quality services and employment for all.

Throughout the year, we have continued to work hard to both improve the quality of our existing services, and develop new services that meet the needs of our communities, our service users and their families. We were delighted to open a new mental health inpatient ward for women funded by Bolton Clinical Commissioning Group (CCG) and GMMH. Honeysuckle Lodge, based on the Royal Bolton Hospital site, provides rehabilitation and recovery services for women with mental health issues, who may otherwise receive care out of the local area.

GMMH also hosted a launch event for the first cluster-commissioned tender in the North West to provide alcohol and drug community recovery services across Bolton, Salford and Trafford. The contract runs over the next five years, covers a population of 760,000 people, and will be delivered by GMMH and a range of subcontractors including The Big Life Group, Great Places, THOMAS (Those on the margins of society), Salford Royal NHS Foundation Trust, Early Break and Intuitive Thinking Skills. GMMH already delivers the Achieve service in Salford and some services in Trafford. The new Achieve contract retains Salford services, and extends services in Trafford and across Bolton.

70 YEARS OF THE NHS 1948 - 2018

Thursday 5 July 2018 marked the 70th birthday of the National Health Service and was a time of reflection for everyone who works in the NHS. Staff represented GMMH at the celebration events held in Westminster Cathedral and York Minster. The anniversary was an opportunity to reflect on the fact that we are part of something bigger than our own role and our own organisation. We are part of the NHS, the nations' most loved, treasured institution. We can all be proud to say that we have played some part in making the NHS what it is today, one of the most effective universal healthcare systems in the world.

We are always proud to be recognised for the quality of our services and were honoured to receive delegates from China's Government, from the province of Zhejiang, who visited the Chapman Barker Unit. The delegates were from the Drug Rehabilitation Association of Zhejiang Province which is home to 54 million people, the tenth largest division in China. They came to learn, and share best practice on detoxing from cannabis and cocaine withdrawal.

Our Research and Innovation (R&I) service has continued to go from strength to strength, and throughout the year, we have worked hard to increase access to research for our service users to deliver high quality care across the Trust. Our R&I service has continued to seek out and maximise opportunities for the community served by GMMH to participate in research and to benefit from developments in both research and innovation. They have also ensured that our clinical services are informed and improved by research involvement, and that this is translated into service delivery. Our R&I team also continue in their efforts to ensure that the Trust becomes a world-leading organisation for mental health research and innovation.

We were pleased to launch a number of key professional strategies throughout 2018/19, which will strengthen our efforts to improve lives, and deliver high quality and clinically effective services to our service users and their families.

Through the implementation of our social work strategy we will ensure that social work as a profession is recognised and that the contribution of social workers to providing high quality care is acknowledged. I believe that the social work strategy will empower and support our social workers to deliver the best possible care and promote the journey of recovery for our service users.

Our Autism Strategy aims to deliver high quality care to individuals with autism across GMMH. It provides the framework for how we intend to learn from best practice, and implement autism statutory guidance. This will ensure that our care for individuals with autism is in line with expectations outlined in the Autism Act (2009) and results in high quality care for individuals with autism across all GMMH services.

Our recently approved Spiritual Care Strategy is a collaboration with chaplains, service users, staff and carers, developed over a twelve-month period. It aims to promote the Trust vision on spirituality for all our service users, staff and carers. GMMH has made a commitment to increasing the diversity of faiths and non-faiths in the Chaplaincy and Spiritual Care Team and in establishing a Spiritual Care hub. We will also continue to build good relations across Greater Manchester with all faith and non-faith communities. The identity of Spiritual Care is an integral component in helping us to understand, treat and promote recovery from mental illness. The provision of skilled, effective and evidenced based spiritual care impacts positively both upon the services we provide and the people within our services.

Finally, in June 2019 GMMH produced its first Quality Improvement (QI) Strategy. This strategy articulates our commitment to improving the quality of care for our service users and outlines how we will make this a reality by equipping our staff with the skills and tools to deliver high quality, safe and clinically effective services at all times.

Our QI strategy will ultimately drive the organisation to deliver quality care through a journey of continual improvement and learning. We recognise that in order to accomplish our quality goals, that leadership is central to both establishing our vision, and defining our QI ambitions. As Chief Executive, I have a vital role to play in building an improvement culture that is both innovative and inclusive.

Looking ahead, 2019/20 promises to be just as challenging from a financial perspective, in terms of increasing demand for our services and in 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.

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

20 May 2019

1.2 Quality Assurance

As an organisation that seeks to continually improve, we take steps to quality check 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 robust quality assurance and a culture of continuous improvement, the Board has established a subcommittee with delegated authority to set the strategy for quality and to ensure delivery against it.

The Quality Improvement Committee (QIC) is chaired by a non-executive director and has representation from the Trust Board, lead clinicians from all clinical services and from corporate leads with responsibility for quality improvement. The structure and business of the QIC has been informed by an assessment against the national Quality Governance Framework.

QIC 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. QIC develops the Trust's quality strategy on behalf of the Board and identifies key quality priorities, goals and standards for GMMH. This is set out both in our Quality Governance Framework and in our Quality Improvement Strategy.

Trust Board and QIC 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 across GMMH. Throughout the year, we have continued to embed 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 Key Performance Indicators
- Care Quality Commission insight reports
- Intelligent monitoring reports
- 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
- Quality Board performance reports
- NHS Benchmarking Network reports
- Additional activities including deep dives and external reviews, as commissioned by the QIC

1.3 A Year of Accolades

The last 12 months has been challenging and uncertain, nevertheless, teams and individuals have continued to exceed expectation and continued to make remarkable achievements during 2018/19.

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:

Stacey Staton, a Level 3 Pharmacy Technician won 'Science Apprentice of the Year' at Trafford College's Apprentice of the Year awards. After seeing the success of previous apprentices, she chose to pursue an apprenticeship with GMMH and Trafford College, and learnt more about medicines and pharmacy.

Tara McGinley, Mental Health Nurse, was appointed the title of Queen's Nurse. Tara has been a mental health nurse since her training at Prestwich hospital in 1985. For the last 25 years, her main role has been working in the Salford community. Within the last 10 years, Tara's role has developed into an Advanced Nurse Practitioner within the Community Mental Health Team. Alongside this, Tara is also the Professional Lead for Nursing in the Salford division. Tara applied to the Queen's Nurse Institute at the start of the year, drawn in by their commitment to the advancement of community nursing care, through leadership programmes and support of innovative projects working to improve care and outcomes for service users.

Psychiatrist, Dr J S Bamrah was honoured for services to mental health, the NHS and Diversity. He was awarded a CBE as part of Her Majesty Queen Elizabeth II's Birthday Honours. Dr Bamrah is a senior consultant psychiatrist at Greater Manchester Mental Health NHS Foundation Trust (GMMH) and an Honorary Reader at the University of Manchester. He received his honour for services to mental health, the NHS and diversity after a career, which has seen him serve on the Royal College of Psychiatrists Council and as a director and council member for the British Medical Association. Throughout his career Dr Bamrah has worked to tackle the inequalities faced by BME communities seeking mental health treatment.

GMMH Community Mental Health Team Leader, Simone Litvaitis, won Greater Manchester Health and Social Care Partnership's People's Champion Award. She was nominated by a service user who said her actions had saved her life as Simone broke down barriers to secure treatment for the service user. After picking up her award at a ceremony in Manchester, attended by Mayor Andy Burnham, Simone said: "It was a fantastic evening and it really makes everything we do feel worth it. It means so much to me to be nominated by a service user and that someone took the time to nominate me for my work." The Greater Manchester Health and Care Champion Awards are the first in the city-region to recognise members of our paid and unpaid health and care workforce who regularly go above and beyond to improve the health and wellbeing of the people of Greater Manchester.

Imam Fahmid Syed won a Community Cohesion Award at the Fusion Awards 2018. Senior Imam, Fahmid oversees the Mosque within the Wirral Deen Centre, and occasionally leads prayers as well as being an active and commendable member of the chaplaincy team at GMMH and a highly valued employee. Imam Fahmid promotes a message of 'cohesion' and building faith, both in the Edenfield unit and the adolescent services on the Prestwich site.

Mark Dawson, Research Initiation and Delivery Manager, and Senior Clinical Studies Officer, won a Greater Manchester research award. He won Best Debut at the 2018 Greater Manchester Clinical Research Awards, which recognised his work to help embed a culture of research and innovation within the Trust. The whole team is working extremely hard to improve standards, raise the profile of research and ensure that all service users have access to participate in research. Having recognition of GMMH within the wider research community is a great achievement.

GMMH's Annual Staff Awards took place during 2018. The winners and highly commended nominees are as follows:

The 'We are Caring and Compassionate' Patient Experience Award

Winner: Katie Horton, Cromwell House CMHT

Highly Commended: Natalie MacFarlane, North Trafford CMHT

The 'Open and Honest' Award

Winner: Bethan Rowe, North Trafford CMHT

Highly Commended: Alison Walmsley, Park House

The 'We Work Together' Team Award

Winner: Chapman Barker Unit, Prestwich

Highly Commended: Honeysuckle Lodge, Bolton

The 'We Inspire Hope' Award

Winner: Kay Darlington, Mulberry Ward, Park House

Highly Commended: Su Martland, Bolton Early Intervention Team

The 'We Value and Respect' Service User Award

Winner: Thomas Cashin, Manchester Central West CMHT

Highly Commended: Kath Eccleston, Bolton Primary Care Psychological Therapy Service

Our teams have also won many accolades over the last 12 months. These include:

Prescott House and Cromwell House have achieved the prestigious national accreditation from the Royal College of Psychiatrists, becoming the first Community Mental Health Teams in the Trust to do so. Beginning the process in August 2016, Greater Manchester Mental Health Community Mental Health Teams based in Prescott and Cromwell House have undergone a year and a half of collecting service user and carer evidence, assessments and peer reviews. The process gave staff a chance for reflection, an opportunity to regroup and a morale boost, providing a vision for the coming year.

A report from the CQC in 2018 has highlighted GMMH and Bolton Approved Mental Health Professionals (AMHPs) as an example of good practice. The report described a review of how Approved Mental Health Professional (AMHP) services are being delivered across the country. The review was conducted through site visits that took place throughout 2017. The report highlighted GMMH, and particularly Bolton AMHPs, as a good example of the new models of AMHP service delivery. The services were praised for the system which has helped to manage workload and work more effectively. AMHPs carry out a series of functions within the Mental Health Act 1983, with one key responsibility being co-ordinating statutory assessments which ensures appropriate legislation and Code of Practice are being maintained. It is therefore a huge achievement that Bolton AMHPs and GMMH have been recognised for their good practice.

GMMH won the 'We Take Care of Talent' Award for the work done with apprenticeships at the HPMA North West Excellence Award 2018. GMMH's submission, titled Putting Apprenticeships at the Heart of a Talent Management Strategy, highlights the work of the Apprenticeship Team and Workforce Development in facilitating apprenticeships across the Trust, for new staff and existing staff who would like to progress or take a new direction in their career. As the climate for recruiting in the NHS is increasingly unsteady, apprenticeships are a way to invest in new and existing staff, and show the commitment to supporting our workforce to progress and achieve.

Apprenticeship Team Training

PART 2 – Statements of Assurance from the Board for 2018/19

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 2018/2019 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
- Community Child and Adolescent Mental Health Services
- Public Health Improvement 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 2018/2019 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 include our current integrated clinical information system (PARIS), 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 included the implementation of PARIS as the clinical information system across the Trust. This is already leading to a range of benefits including 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 2018/19 represents 100% of the total income generated from the provision of relevant health services by GMMH for 2018/19.

2.2 Participation in Clinical Audits and National Confidential Enquiries

During 2018/19, There were 7 national clinical audits and 1 national confidential enquiry 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 2018/19 are as follows:

Prescribing Observatory for Mental Health: Rapid Tranquillisation in the Context of Pharmacological Management of Acutely Disturbed Behaviour.
Prescribing Observatory for Mental Health: Prescribing Clozapine
Prescribing Observatory for Mental Health: Assessment of the side effects of depot antipsychotics
National Clinical Audit of Psychosis (Spotlight Audit)
National Audit of Early Intervention in Psychosis (Spotlight Audit)
National Audit of Anxiety and Depression
National Audit of End of Life Care
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

The national clinical audits and national confidential enquiries that GMMH participated in during 2018/19 are all included in the above list.

The national clinical audits and national confidential enquiries that GMMH participated in and for which data collection was completed during 2018/19, are listed on the next pages alongside the number of cases submitted to each audit or inquiry as a percentage of registered cases required by the terms of that audit or enquiry are listed in the table over the next pages.

National Clinical Audits:

Audit Title	Participation	% of cases Submitted
Prescribing Observatory for Mental Health: Rapid Tranquillisation in the Context of Pharmacological Management of Acutely Disturbed Behaviour.	Yes	100%
Prescribing Observatory for Mental Health: Prescribing Clozapine	Yes	100%
Prescribing Observatory for Mental Health: Assessment of the side effects of depot antipsychotics	Yes	100%
National Clinical Audit of Psychosis (Spotlight audit)	Yes	100%
National Audit of Early Intervention in Psychosis, (Spotlight audit)	Yes	100%
National Audit of Anxiety and Depression	Yes	100%
National Audit of End of Life Care, Organisation Level Audit	Yes	100%

Information about the Audits

Prescribing Observatory for Mental Health (POMH)
Rapid Tranquillisation in the Context of Pharmacological Management of Acutely Disturbed Behaviour. Report dated October 2018.

The audit standards are based on NICE Clinical Guideline, NG10 Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings. The audit data provides evidence of compliance with these practice standards for clinical services in each Trust and in the national sample.

It focused on the physical health monitoring following an episode of rapid tranquillisation. Data collection took place during April and May 2018. In total, 83 patients met the criteria for inclusion in the audit. Data collected included:

- Details of the episode (including behaviours displayed)
- Non-pharmacological interventions attempted
- Medications prescribed (dose and route)
- Physical health monitoring after rapid tranquillisation
- Post rapid tranquillisation clinical team debrief and care planning

Prescribing Observatory for Mental Health: Prescribing Clozapine.
Report dated February 2019

The audit standards were extrapolated from relevant recommendations in the NICE Clinical Guideline 178, Psychosis and Schizophrenia in Adults: Prevention and Management and from the Royal College of Psychiatrists Use of Licensed Medicines for Unlicensed Applications in Psychiatric Practice College Report CR142. Data was collected from the clinical records of 186 patients who met the inclusion criteria during June and July 2018 and submitted online onto the POMH database. Some of the practice standards are listed below and include whether:

1. Pre-treatment screening included physical examination with assessment of the cardiovascular system.
2. Monitoring took place in the first two week of treatment included at least daily assessment of temperature, blood pressure and pulse.
3. For patient's started on clozapine as inpatients, there was consideration of the implications for dosage of any change in smoking status on discharge.
4. Patients established on clozapine treatment for more than a year were reviewed at least annually.

Prescribing Observatory for Mental Health: Assessment of the Side Effects of Depot Antipsychotics, Report due April 2019.

The standards are derived from NICE guideline 178, Psychosis and Schizophrenia in Adults: Prevention and Management and examined whether patients prescribed depot/long acting injectable antipsychotic medication have had a formal or informal clinical assessment of side effects in the last year. Where side effects were identified, there was also consideration as to whether or not an appropriate clinical management plan was documented.
Data collection took place in October and November 2018 and included 212 patients.

National Audit of Psychosis, Spotlight audit.
Report due: June 2019

This re-audit aims to demonstrate that full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors took place in patients with schizophrenia in inpatient and community settings. 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

Data was collected from the clinical records of 150 patients, 100 from Community Mental Health Teams and 50 from Inpatient services.

National Audit of Early Intervention in Psychosis. (Spotlight Audit)
Report due: April to May 2019

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 spotlight audit will provide further evidence that service users are offered physical health interventions, including advice and/or signposting to health eating, physical activity and smoking cessation services and will also seek to establish that the following outcomes have been achieved:

Smoking That a random sample of service users (included in the core audit in 2017/18) have stopped smoking following an intervention.

Body Mass Index (BMI) That a random sample of service users (included in the core audit in 2017/18) have not gained more than 7% of body weight in the first year of taking antipsychotic medication.

For this audit, 670 data entries were submitted in November 2018. This included 400 services users for the re-audit plus 105 service users for the smoking cessation outcome and another 165 service users for the BMI indicator.

National Audit of End of Life Care, Organisation Level Audit.
Reported dated: February 2019.

This audit was commissioned in October 2017 by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. The overarching aim is to improve the quality of care of people at the end of life in acute, mental health and community hospitals.

The audit monitors progress against the five priorities for care set out in the 'One change to get it right' report and NICE Quality Standard 144, which addresses last days of life with the context of NICE Quality Standard 13, which addresses last years of life.

At this stage, GMMH were only required to take part in the organisational level audit which focused on service models, specialist palliative care workforce, support processes for friends/family, staff and volunteers. The audit also considered access to bereavement services and counselling services. Data was submitted October 2018.

National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

National confidential inquiry	Questionnaires received from NCI 2018/2019	Questionnaires completed and returned back to NCI	%
Suicide	48	47	98%

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 Health and Care 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.

The reports of 4 national clinical audits were reviewed by the provider in 2018/19 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: Rapid Tranquillisation in the Context of Pharmacological Management of Acutely-Disturbed. Report issued October 2018.	GMMH will establish a clinically led task and finish group to develop a Rapid Tranquillisation (RT) Care Bundle, including the introduction of quality improvement multidisciplinary work around RT.
National Clinical Audit of Psychosis, Core Audit 2017/18. Report issued June 2018	GMMH will continue to ensure that regular monitoring is in place to ensure that all patients have a completed and documented assessment for each of the cardio metabolic parameters and that a record of interventions is offered where indicated, for patients who are identified as at risk. GMMH will also ensure the implementation of the patient clinical record (PARIS) has been rolled out across the organisation which will make the recording and monitoring of physical health assessments more robust.
National Audit of Early Intervention in Psychosis, Core Audit 2017/18. Report issued April 2018	GMMH will continue to ensure and monitor that service users are offered physical health interventions, including advice and/or signposting to health eating, physical activity and smoking cessation services. GMMH will also continue to ensure that carers are referred to and/or take up a carer-focussed education and support programme.
National Audit of End of Life Care Report issued February 2019	Whilst GMMH does not have a specialist palliative care service. Specialist palliative care is accessed externally, GMMH will ensure that this is appropriate across the localities covered by the organisation and is based on support from a range of palliative care services who offer a varied level of support. In addition, GMMH has now recruited a bereavement nurse.

The reports of 114 local clinical audits were reviewed by the provider in 2018/19. A full list of these local audits is included in Annex 5 of this Quality report. Recommendations and action plans for each local audit have been agreed and shared with relevant services in line with our Clinical Audit Policy. If you are interested in learning more about the actions GMMH intends to take 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 Quality Improvement in Clinical Care Group (QICC), which meets on a bi-monthly basis and is chaired by the Trust's Medical Director. QICC aims to ensure that actions agreed following audit reports are supported and completed. The outcomes of discussion at QICC are reported up to, and considered at, the Trust's Quality Improvement Committee.

2.3 Participation in Clinical Research

The Research & Innovation Service has continued to establish itself over the last 12 months with further posts being filled to strengthen infrastructure within the R&I Office, the Research Delivery Team and the Research Units. The service has been fully funded by external research income including National Institute for Health Research (NIHR) grant successes leading to Research Capability Funding, a growing commercial research portfolio and income from the NIHR Greater Manchester Clinical Research Network (GM:CRN) and Health Innovation Manchester (HinM).

The R&I Strategy was finalised in December 2017 and progress has been made throughout 18/19 against all 6 key aims particularly in relation to our Research Units. The strategic 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 2018/19 for all active grants awarded to GMMH is £3,397,447, which is higher than last year. There have also been a number of new NIHR grant successes within the last 12 months, which will run over the next 3-5 years including:

Navigating access to effective services for children and young people with common mental health problems, Steven Prymachuk, (£838,099, NIHR Health Services & Delivery Research)

The effect on relapse of Culturally-adapted Family Intervention (CaFI) compared to usual care among African & Caribbean people diagnosed with psychosis in the UK: a Randomised Controlled Trial, Dawn Edge (NIHR Health Technology Assessment, £2,343,567)

Improving prediction of psychosis in ARMS using a clinically useful prognostic tool: IPPACT, Alison Yung and Filippo Varese (NIHR Health Technology Assessment, £997,661)

The Prevention Of Suicide in Prison: Enhancing Access to Therapy (PROSPECT) Programme, Dan Pratt (NIHR Programme Grant, £1,576,929)

Avoidable harm in Prisons, Jenny Shaw (NIHR Policy Research Programme, £1,090,434)

In addition to the above grant income we also support 3 NIHR Senior Investigators (Prof Karina Lovell and Prof Kathryn Abel and a new award for 18/19 to Prof Alison Yung).

NIHR grant income generates additional Research Capability Funding (RCF) from the NIHR, which enables us to support research growth. As a result of grant successes in the previous year, in 2018/19 the Trust received £767,608 in Research Capability Funding. In line with our strategy, this funding has supported a number of internal research initiatives including the continuation of six Research Units. In order to access this funding stream, the Units are required to demonstrate clear service user involvement, alignment with clinical services and applications for NIHR or commercial funding.

Research Unit	Lead	18/19 successes
Psychosis Research Unit	Tony Morrison	New service user researchers Continued grant and project success Continued academic and clinical collaborations Sharing of best practice service user involvement with other Units
CAMHS Digital	Kathryn Abel/ Pauline Whelan	Grant successes Joint working with industry partners New Children and Young People's group developed
Trauma & Resilience	Filippo Varese	Experts by experience group established Grant successes Close working with psychological forum Active journal club
Dementia and Healthy Brains	Ross Dunne (previously Iracema Leroi)	New leadership established Commercial clinical trial growth Links with primary care Patient and Public Involvement programme developed
Patient Safety	Dan Pratt/ Gillian Haddock	Grant successes Collaboration with substance misuse services Established Patient and Public Involvement group
Youth Mental Health	Sophie Parker (previously Alison Yung)	New leadership established Grant successes Links with clinical services and joint working with third sector Patient and Public Involvement group established

Further smaller RCF awards have also been made in 2018/19 to support research activity in substance misuse, forensic services, metacognitive therapy and nursing.

Research Delivery

During 2018/19, over 1800 patients, staff, relatives and carers participated in research projects approved by the Health Research Authority in GMMH. Around 600 of these participants were patients receiving relevant health services provided or sub-contracted by GMMH. GMMH was involved in 118 clinical research studies throughout the year ending 31 March 2019, 73 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 2018/19 annual project audit showed that **72%** of Principal Investigators of studies declared some level of service user involvement in the research process itself.

The Research Initiation and Delivery team has been strengthened in 18/19 with the appointment of Mark Dawson who joined us from Oxford University Foundation Trust. The hard work Mark has put in during his first year in post was rewarded with the 'best debut' award at the Greater Manchester Clinical Research Annual Awards. Carmel Thomas, Senior Clinical Studies Officer, was also runner up in the 'research practitioner of the year' category.

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.

We continue to work closely with the NIHR GM:CRN to bring more research opportunities to GMMH service users and carers. Research office staff, research nurses and clinical studies officers set up, publicise and recruit participants for a wide range of mental health and dementia 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 4 service user researchers currently employed and a very well-established Service User Reference Group (ten people with experience of psychosis), led by Dr Eleanor Longden (Service User Researcher and Chief Investigator for the Talking with Voices trial), which contributes to the development of research questions and the design, conduct and dissemination of all research studies including clinical trials.

GMMH continues to support Join Dementia Research (a national service for people across the UK to register their interest in participating in dementia research). We have recruited a new Patient and Public Involvement Coordinator to support this area of work and the GM team were rewarded for their efforts with a public engagement award at the Greater Manchester Clinical Research Annual Awards.

Impact of research

This year has seen an announcement from the Care Quality Commission (CQC) that it will include key research related questions in its inspection framework for the Trust-wide well-led key question recognising the role research plays in delivering high quality patient care. The additional research questions aim to determine how well an NHS trust integrates research into its corporate strategy, planning and how well research opportunities are communicated to patients.

This major step forward in the updated framework delivered by CQC signifies the value for NHS trusts to embed research in its ethos. This development is welcomed by GMMH as we are confident that continuing to increase access to research for our service users will drive high quality care across the Trust.

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 2018/19 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 2018/19 the value of the CQUIN payment £5,345,520

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 2018/19, 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 2018/19 – national, local CCG and NHS England. For 2017/18, there was a two-year agreement for national CQUINs which covers until March 2019. In 2018/19 these focused 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 are being delivered with a comprehensive Health and Wellbeing action plan in place. There are staff champions in local services and a Trust wide health and wellbeing day was held in December. GMMH also took part in Britain's Healthiest Workplace in 2018 and the results of this will inform the priorities for 2019.

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. The Trust meets all the national targets. A vegan choice of food is being offered from January 19 in the Trust Waterdale restaurant. The Trust has also recently been awarded a 'Healthier Catering Award' by Bury Council.

Indicator N1c – Improving the Uptake of Flu Vaccinations for Frontline Clinical Staff

This is aimed at achieving an uptake of flu vaccinations of 75% by February 2019. GMMH has successfully achieved this target for 2018/19.

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. For 18/19 this includes new targets about implementing training, monitoring of weight gain and smoking for those in Early Intervention services. Achievement is evidenced via the results of national audits which will not be available until later in the year. The 2017/18 outcome was received in May. GMMH did not achieve the national targets however did achieve higher results than national averages for other Trusts. Action plans have been in place during 2018/19.

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 an 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. Joint work with our commissioners is ongoing.

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. This was achieved for the first cohort of patients in 2017/18.

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 including training staff to deliver interventions and identifying local champions to maximise opportunities for screening and intervention as appropriate. This has been supported by the establishment of a dedicated Health Improvement Team to maximise smoking cessation support for inpatients. GMMH became Smoke Free in Quarter 3 of 2018/19.

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 2017/18 for Manchester services, which will run until March 2019. This was based on a similar two-year CQUIN in Bolton, Salford and Trafford that ended in 2017/18. Representation at the GM Executive Suicide Prevention Strategy Group and Multi agency Suicide Prevention Strategy groups have ensured a collaborative approach and comprehensive action plans are in place. Training has been a key part of this CQUIN in order to increase the competencies of staff in embedding best practice approaches into clinical practice relating to the suicide prevention agenda.

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). All schemes will run until 31 March 2019. Three new indicators are being consulted upon for 19/20. The current 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 3 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 outcome measures has been ongoing this year. For 2018/19, 90% of the target patient group should participate in courses, 80% report positive outcomes and a second edition of the prospectus has been published.

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 3 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 focused on extending this to all wards in medium and low secure services. Year 3 has seen continued improvement to nursing care plans to embed collaborative working between service users and staff, consultation on the Positive and Safe Framework and the relaunch of Safewards and training for staff for example.

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 was new in 2017/18. It required 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 with the focus on successful discharges. Monitoring of estimated date of discharge is now embedded and work to enhance discharge processes in meaningful and sustainable ways continues.

CAMHS Inpatient Transitions

This CQUIN is in its second year of delivery and is aimed at improving 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. Good progress is being made and efforts continue to improve response rates for service user and carer surveys.

Further details of the agreed CQUIN goals and achievements for 2018/2019 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

Tel: 0161 358 1366
E-mail: Miranda.washington@gmmh.nhs.uk

2.5 Registration with the Care Quality Commission (CQC)

GMMH is required to register with the CQC. The CQC has not taken any enforcement action against GMMH during 2018/19, and GMMH has not participated in any special reviews or investigations by the CQC. The table below provides a summary of the ratings received from the CQC within their inspection report, which was received in February 2018.

Domain	Rating
CQC Domain	GMMH rating
Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well Led	Outstanding
Overall rating for GMMH	**Good**

A comprehensive inspection plan for GMMH is in place covering all actions identified by the CQC, of which many have already been addressed. These are subject to ongoing monitoring at the GMMH Sustainability and Quality Improvement Group.

The Sustainability and Quality Improvement (SQI) Group was established to co-ordinate Trust activity in preparation for future CQC Well Led with Core Service inspections. The main focus is on ensuring an accurate state of readiness and assurance and identifying specific areas that require sustainable action and improvement. The initial focus is to identify key current risks and issues, whilst ensuring sufficient oversight is given to all of the Domain areas within the CQC inspection guide.

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, following our last inspection.

The CQC has subsequently notified the Trust on 27th February 2019 that it will undertake its next well-led inspection within 6 months. A meeting was held with the CQC on 5th March to ensure that the Trust has robust plans in place, and to discuss the Provider Information Request, prior to the inspection.

Our SQI group will hold a key role in preparing GMMH for this next well-led CQC inspection. This will include holding weekly meetings with Executive Directors and Associate Directors, as well as being responsible for assessing current issues. The SQI group will also provide monthly reports to both the Quality Improvement Committee and the Board of Directors.

2.6 CQC Mental Health Act Monitoring

Between 1 April 2018 and 31 March 2019, CQC undertook Mental Health Act monitoring visits to the following GMMH wards:

Bolton – Honeysuckle Lodge and Oak

Manchester – Bronte, Anderson, Cavendish and Acacia

Salford - Bramley Street, Copeland, Chaucer, Eagleton and MacColl

Trafford – Irwell, Medlock, Brook, Bollin and Greenway

Specialist Services Network – Silverdale, Pegasus, Buttermere, Loweswater, Coniston, Newland, Dovedale, Rockley House, Delaney, Hayeswater and Isherwood

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 2018/2019 to the Secondary Uses Service (SUS) via the MHSDS for inclusion in the Hospital Episodes Statistics, which are included in the latest published data (September 2018). 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%**

GMMH has made a concerted effort during 2018/2019 to ensure that the importance of accurate quality data and ensuring effective collection processes are embedded across the organisation, this is achieved by:

Using appropriate policies and procedures, which have all been subject to a comprehensive review in line with GDPR.
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.
The appointment of a SAR (Subject Access Request) Co-ordinator to assist in the delivery of requested materials in line with nationally mandated requirements and legislation

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. With the introduction of GDPR our polices have been reviewed and a full Data Security and Protection framework has been established which provides a framework for the management of all service user, staff and organisational information. Implementing the requirements of GDPR and the Data Security and Protection Toolkit is part of this framework. The Data Security and Protection 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 Assessment report overall score for 2018/19 was 82% and was graded green.

2.9 Clinical Coding

GMMH outsources its clinical coding processes. During 2018/2019, this arrangement and the accuracy of the results received by GMMH were subject to the Payment by Results clinical coding audit as part of the Data Security and Protection Toolkit. The audit confirmed an accuracy level of 98.04% for primary diagnosis and 96.04% for secondary diagnosis against a sample of 50 records. This has reaffirmed confidence in the existing system for the Trust. GMMH will continue to participate in this audit to improve data quality.

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 YTD Q3 2018/19.

Performance	CPA 7 Day Follow-Up	
	YTD Q3 2017/2018 (%)*	Q3 2018/2019 (%)
GMMH	96.9	95.3**
National Average	96.3	95.7*
Lowest Trust	84.6	79.1*
Highest Trust	99.7	100.0*

**Source: https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/*

2017/18 figures are YTD Q1-Q3.
2018/19 figures are YTD Q1-Q3.

***Source: Board Performance Report YTD March 2019, page 102.10.1.*

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 with ongoing work to embed processes to record accurately in our Paris clinical information system now that it has been rolled out to all areas.

A task and finish group has been set up in Bolton to look at how to improve seven day follow up for those with no fixed abode

We will continue our work to harmonise our policies 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.

Performance	Gatekeeping	
	Q3* 2017/2018 (%)	Q3 2018/2019 (%)
GMMH	97.5	99.35**
National Average	98.6	98.1*
Lowest Trust	91.5	87.0*
Highest Trust	100.0	100.0*

**Source: https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/*

2017/18 figures are YTD Q1-Q3
2018/19 figures are YTD Q1-Q2 (latest published figures as at 12/02/2019 pertain to Q2).

***Source: PARIS. YTD as at end of March 2019*

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

The Trust response rates for the 2018 staff survey rose to 46.8%, compared to a 33.8% response rate in 2017.

Reporting has changed in 2018 meaning that answers are sorted into 10 key themes (previously known as key findings). Below is a summary of the findings within 2018 survey compared to that of the 2017 survey and the national average when compared with other Mental Health and Learning Disability Trusts.

Theme	2017	2018	National Avg.
Equality, Diversity & Inclusion	9.0	8.8	8.8
Health & Wellbeing	6.0	5.8	6.1
Immediate Managers	7.1	7.1	7.2
Morale	N/A	6.0	6.2
Quality of Appraisals	5.3	5.4	5.7
Quality of Care	7.2	7.1	7.3
Safe Environment (Bullying & Harassment)	7.9	7.9	7.9
Safe Environment (Violence)	9.1	9.1	9.3
Safety Culture	6.7	6.7	6.7
Staff Engagement	7.0	6.9	7.0

GMMH considers that this data is as described for the following reasons. Through reviewing individual questions, the Trust has scored more favourably compared to the national average for Mental Health and Learning Disability Trusts in the following questions: -

- Last experience of harassment/bullying/abuse reported
- Don't work any additional unpaid hours per week over and above contracted hours
- Satisfied with level of pay
- Organisation acts fairly in relation to career progression
- Not experienced harassment, bullying or abuse from other colleagues

The areas where we scored least favourably compared to the national average for Mental Health and Learning Disabilities were: -

Receive regular updates on patient/service user feedback in my directorate
Feedback from patients/service users is used to make informed decisions within directorate
Team members often meet to discuss team's effectiveness
Often/always look forward to going to work
Had training, learning or development in the last 12 months

GMMH intends to take the following actions to improve these scores, and so the quality of our services: -

Undertaking thorough analysis of the data to identify cross cutting themes arising from all the Divisional information to corporately drive a programme of work to support improvements that will impact across the whole Trust. Upon identifying those cross-cutting themes, Listening Events will be held to understand the story behind the data and thus make improvement actions more meaningful. This will be led through the Workforce Strategy Programme Board.
Delivery of the "Workforce and Organisational Development Strategy - 2018 to 2021" will support work in improvements overall. The Strategy (approved in late 2018) outlines four workforce priority high impact areas: — Supply, recruitment and retention — Creating an Outstanding place to work — Outstanding leadership and management development — Transforming our workforce

Within each of these areas are a number of commitments that upon delivery will make improvements to the working lives of staff. Previously a stand-alone strategy, Health & Wellbeing now runs through the heart of each of the areas ensuring that staff are supported through positive leadership and management.

Locally results will be shared with Divisions and individual improvements will be driven through the Network Hub Meetings and Senior Leadership Team Meetings.

All work will be carried out in partnership with Trade Union Colleagues.

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 colleagues was 15.2% (national average 17%)

Indicator KF21 - % of staff believing that the Trust provides equal opportunities for career progression or promotion was 83.5% (national average 82.3%)

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 2018. As in previous years, we used an independent approved contractor (Quality Health) to run the survey on our behalf in 2018.

People aged 18 and over were eligible for the survey if they were not currently an inpatient, were receiving specialist care or treatment for a mental health condition and had been seen by the trust between 1 September 2017 and 30 November 2017. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between February and June 2018.

GMMH considers that this data is as described for the following reasons. For 2018, results were better than most other mental health trusts for the question 'how well does this person (the Health and Social Care worker) organise the care and services you need. Results were more or less the same as other mental health trusts in all other areas.

Section	Thematic score 2018	Lowest score nationally	Highest score nationally
Health and Social Care Workers	7.3	5.9	7.7

The Trust's highest thematic scoring category for 2017 was for organising care for our service users. GMMH did not receive any results in the worst scoring 20% of all mental health trusts.

For 2018, there are a number of areas where service users continue to feedback a positive experience of the Trust's community mental health services. Areas include:

- Service users reporting that they have been given enough time to discuss needs and treatment
- Service users knowing who to contact if there is a concern about care
- How well NHS mental health services organise care and services
- Service users reporting that changes to their care have not adversely affected their care and treatment
- Carer and family member involvement
- Service users reporting being treated with respect and dignity by NHS mental health services

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:

- Developing wallet sized information cards to provide to service users with information about care planning, useful numbers and who to contact during a crisis
- Ensuring that crisis helpline information is available and easy to navigate on the GMMH website
- Ensuring that service users and their carers are able to access information in plain English about their medications, via the Choice and Medications website
- Maintaining an ongoing focus on care planning as part of our Quality Matters programme
- Incorporating care planning training into clinicians essential to job role matrix

GMMH has taken the following actions to improve these scores, and so the quality of our services. The results from the survey were discussed at a joint meeting of the CareHub and GMMH Service User and Carer Engagement Leads meeting held on 14th November 2018. This was followed by further discussions to identify a series of rapid improvement actions. The actions were agreed by a team comprised of corporate, clinical and management representatives, and will be monitored at 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 service user FFT, as a consistent way to measure the service user and carer experience across the breadth of our services. At the end of Quarter 3 2018/19, 2162 service users had answered the FFT question. This is a decrease from the 3755 service users from the same reporting period of the previous year. The organisation has had some technical issues with the electronic feedback devices, however these issues will be resolved moving forward. During this period, 78% of service users would recommend GMMH 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, support and help.**

Included below are some typical comments from the service users and carers who completed the FFT in 2018/2019:

'*Staff are amazing and try their hardest to accommodate all our needs, from taking us on leave to sitting up with us at night listening to all our fears'*
Keats, Salford

'Staff have been caring, understanding and very helpful'
Poplar, Park House

'Staff are welcoming and friendly and work very hard and go above and beyond to help you'
Oak Ward, Bolton.

'Helped me to recover and get my son home. Lovely staff'
Whitehaven Substance Misuse Team

'*Wentworth House can give you a safe place to stay when you feel scared or paranoid'*
Wentworth House, Adult Forensic Service

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 a Quality Matters programme to provide internal assurances surrounding care delivery, if service user feedback highlights any local issues the organisation can mobilise this programme to provide local support. GMMH continues to implement a 'You said - We did' campaign which is communicated locally and trust wide. Below are some examples of where we have used feedback to improve our services:

'You are left on your own and there is not much communication with your named nurse'

The Quality walk around team visited this Bolton ward and explored the named nurse model of care and expectations of the staff and service users regarding quality and frequency. The Ward Manager raised this feedback with the service users in a community meeting and collaboratively developed a set of mutual expectations moving forward.

'Lunch times are really boring'

The forensic ward has co-produced a new programme called Fit2be. This initiative has included revising the lunchtime menu, starting exercise classes and also looking at good lifestyle choices.

'Staff were not aware of our loved one's cultural needs'

This was in relation to a Jewish service user's needs at mealtimes. The service highlighted these issues to the catering department and a system was implemented to support staff and service users. Enhancing cultural competencies for staff has been added as a priority for the organisations Equality, Diversity and Inclusion Strategy.

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 overleaf 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 incidents occur during the care of a service user it is vital that this is reported as soon as possible so we can review what happened and take effective and sustainable actions to reduce the likelihood of similar incidents occurring again. We maintain consistent incident management and review processes which demonstrate a positive reporting culture and ongoing commitment by 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 implementation of the Greater Manchester suicide prevention strategy and development of the GMMH suicide prevention website has continued and further work has progressed in the training of staff in specific suicide prevention interventions, in routinely providing safety plans for those accessing emergency departments and in undertaking thematic reviews to further develop awareness. Following attendance at emergency departments service users who are deemed appropriate for discharge back to the care of their GP are offered a supportive call from the Samaritans within 48 hours of their attendance.

In addition, we have recruited to a 12-month Bereavement Liaison post to support those families, carers and staff bereaved by suicide of a service user through the Suicide Prevention CQUIN work.

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.

The data in the table overleaf 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, an example of this is the development of a self-harm toolkit to aid practitioners to safely and effectively manage such incidents.

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 that during April 2017 to September 2017, the incident team encountered delays in reporting to NRLS. This was due to a number of factors including demand caused by internal pressures, an increase in service provision with the development of the new organisation and significant increase in numbers of incidents being reported. Figures for October 2017 to March 2018 will reflect some of those delayed from the previous time period and increased staffing compliment in the incidents team.

	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	Apr 18 – Sep 18	4999	Data not available	10	0.2	18	0.4
	Oct 17 – Mar 2018	5827	Data not available	7	0.1	23	0.4
	Apr 17 – Sep 17	3055	21.51	4	0.1	20	0.7
	Oct 16 – Mar 17	5117	36.03	7	0.1	14	0.3
Total number of incidents for mental health organisations	Apr 18 – Sep 18	169041	Data no available	548	0.3	65	0.7
	Oct 17 – Mar 2018	166787	Data not available	569	0.3	1331	0.8
	Apr 17 – Sep 17	167477	Data not available	532	0.3	1212	0.7
	Oct 16 – Mar 17	157154	Data not available	538	0.3	1233	0.8
Highest value reported from any mental health organisation	Apr 18 – Sep 18	9204	65.8	128	2.1	110	2.3
	Oct 17 – Mar 2018	8134	96.72	121	2.1	138	3.9
	Apr 17 – Sep 17	7384	126.47	89	2	83	3.4
	Oct 16 – Mar 17	6447	88.21	72	1.8	100	3.8
Lowest value reported from any mental health organisation	Apr 18 – Sep 18	16	Data not available	0	0	0	0
	Oct 17 – Mar 2018	1	14.88	0	0	0	0
	Apr 17 – Sep 17	12	16	0	0	0	0
	Oct 16 – Mar 17	68	Data not available	0	0	0	0

NRLS incident benchmarking data is discussed at the GMMH Quality Improvement Committee, shared at Senior Leadership meetings and discussed at Quality and Performance meetings with commissioners. Benchmarking data reports from the NRLS demonstrates that there is a positive and consistent incident reporting culture within the organisation. 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 Improvement 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 and more recently from the governance risk, safeguarding and patient safety leads. At the conclusion of the Walkaround, the team provide 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 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 Improvement 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 Improvement 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 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. Last year, 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 1st April 2018 to 31st March 2019 815 of GMMH patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

228 deaths in the first quarter
204 deaths in the second quarter
212 deaths in the third quarter
171 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 overleaf highlights, out of the 815 deaths, 304 were expected deaths.

**Inpatient deaths refer to those service users who are inpatient on a mental health ward.*

Quarter	Unexpected Outpatient	Unexpected Inpatient	Expected Outpatient	Expected Inpatient	Total
1	127	5	92	4	**228**
2	130	2	70	2	**204**
3	132	1	74	5	**212**
4	112	2	54	3	**171**
Total	***501***	***10***	***290***	***14***	***815***

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 (236) 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 511 deaths were unexpected. The majority of our service users are cared for in the community and the figure of 501 relates to those service users 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.

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.

Learning from deaths is an essential part of quality improvement work for organisations. Since September 2017, all Trusts in England have been required to have a process in place for mortality reviews, following the publication of the CQC review in December 2016 'Learning, candour and accountability: a review of the way Trusts review and investigate deaths of patients in England' and the National Guidance on learning from deaths published by the National Quality Board in March 2017.

By 31st March 2019, 158 investigations and 4 case record reviews* have been carried out in relation to the deaths included above. In zero 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:

43 serious incident root cause analysis investigations, 1 case record reviews* in the first quarter
42 serious incident root cause analysis investigations, 2 case record reviews* in the second quarter
57 serious incident root cause analysis Investigations, 1 case record reviews* in the third quarter
16 serious incident root cause analysis Investigations, 0 case note reviews* in the fourth quarter

**Structured Judgement Reviews are referred to as 'case record reviews'.*

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. As mandated, this is this broken down by quarter as follows:

Zero representing 0% in the first quarter
Zero representing 0% in the second quarter
Zero representing 0% in the third quarter
Zero representing 0% in the fourth quarter

It should be noted that 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.

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 Post 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 2018 GMMH participated in a pilot study to trial the use of the Royal College of Psychiatrists Care Review Tool. It is based on the Structured Judgement Review methodology, originally developed by the Royal College of Physicians. The aim of the tool is to determine areas of good care that can be recognised and further developed and where areas can be improved. The work of SJR's is still in the early stages of being rolled out across MH Trusts, GMMH will continue to work alongside neighbouring Trusts to review how this is implemented and learn lessons. A launch event held in November 2018 was attended by representatives from GMMH. This piece of work will be undertaken as part of the GM Mortality Group.

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.

GMMH continue to hold a regular Mortality Review Group meeting with support and attendance from Professor Nav Kapur. The group supports and enables frequent overview and review of deaths occurring within the Trust and captures themes and trends. This remains an integral part of the Trusts Governance and Quality Improvement approach to learning from deaths. 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. As part of the Trust's annual audit programme, a thematic analysis of themes from RCA investigations into deaths between 1st April 2017 and 31st August 2018 has been completed and is due to be presented at the Trusts Mortality Review Group with recommendations from this to be taken forward by the group.

Learning from incidents is re-enforced 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 specifically focused on deaths are commissioned by our Mortality Review Group and our Executive Post Incident Review Panel to understand any changes in incident reporting and explore emerging patterns and peaks in around incident themes in any of our clinical areas.

There is a requirement for all NHS Providers to report quarterly mortality figures to its Board and to provide a narrative around this data. The Mortality data includes those inpatient and community deaths and those that have led to a Trust investigation. It also captures deaths of service users with a Learning Disability that are subject to review via the LeDeR programme.

As a result of learning from investigations conducted in relation to patient deaths at GMMH, the following actions have been taken:

STORM 'Train the Trainer' has been completed, with eight staff being trained to deliver the training within GMMH to frontline staff who work directly with service users at risk of self-harm or suicide
Clinical Risk Management Training is delivered by a core group of staff, with a separate specialist risk management programme developed for new preceptorship staff. It is a requirement that all clinical staff attend training every 3 years
Record keeping and Datix training is delivered on a regular basis to staff groups to support documentation standards required by GMMH
An audit into the quality of risk formulation within risk assessments is planned for audit year 2019/2020
A specialist Bereavement Liaison post has been appointed to for a 12-month period to support carers and staff bereaved by suicide and other traumatic deaths within GMMH

It is intended that delivery of these actions will have a positive impact on the service user experience of care and treatment at GMMH.

2.11 Locally Selected Quality Indicator

For the 2018/19 local data indicator, GMMH has selected care-planning information. Our Council of Governors chose this during their February 2019 meeting. The data has been gathered from our programme of audits into care planning quality standards for inpatients, undertaken throughout 2018/19. This also includes data recorded on Paris for CPA Care plan assessments.

The audit programme commenced in October 2017, and was repeated during April and October of 2018. In total, 2336 individual service user care plans were audited over this period.

Within the previous CQC inspection report, produced in February 2017, GMMH was rated as 'good' in the caring domain. One of the many reasons for this rating was because the CQC felt that patients, carers and staff were involved in developing care plans and that people who use our services feel listened to.

The CQC also felt that our services took account of patients' individual needs. Care plans are used at GMMH to support service users with a mental illness who have several healthcare professionals working with them. A care plan explains the support provided by each of those professionals and when treatment should be provided. A care plan might also include what to do in a crisis or to prevent relapse.

Care plans are used to help work out what services may be needed for individual service users. They set goals and decide treatment options. Care plans should always be individual, and personal for each service user, taking into account their mental health but also other important aspects of their lives. Providing ongoing care and support for someone who is living with a mental illness can involve many different support organisations.

These may include psychologists, GPs, psychiatrists, psychiatric nurses, social workers or other health professional from across multi-disciplinary teams. They are all part of the healthcare team, which work together to provide safe, high quality and clinically effective care at all times for our service users.

Everyone's treatment needs are different. A care plan puts down in writing the support that individual service users can expect from each of the people in their care team. This is important as it ensures that everyone knows who is responsible for what and when. Service users themselves, along with their carers, where this is agreed, are an important part of this team and should be fully involved in preparing and agreeing mental health care plans on a regular basis.

In addition to the information held on our Paris clinical information system, GMMH uses a variety of different approaches that help to measure the quality of our care planning processes. This includes our Quality Matters Inpatient Patient Safety and Quality Metrics (IPSQ) tool, and our clinical audit activity aimed at improving the quality of care plans.

For our programme of audits into care plan quality for GMMH inpatients, we identified and incorporated a range of quality standards into our audit tool, including the following:

Does the Care Plan reflect a recovery and outcome based pathway approach, identifying and reviewing any potential barriers to discharge?
Within the Care plan, is there evidence that planning for discharge/transition has started on admission?
Is there evidence that the service user has been involved in developing their Care Plan?
If the service user has carer involvement, Is there evidence that the carers have been appropriately involved in developing the Care Plan?
Are the aims and objective for admission clearly stated in the Care Plan?
Are the risks and safety associated with the person's holistic needs and the interventions to address these clearly stated in the Care Plan?
Is there evidence in the Care Plan of regular reviews between the service users and, If appropriate, their carers and the MDT?
Is the legal basis for admission and treatment clearly stated in the Care Plan?
Are the Care Plans clearly written in language that is meaningful and jargon free and reflect principles of positive support?
Does the service user have a copy of the Care Plan?
If applicable, does the carer have a copy of the Care Plan?
Does the Care plan contain evidence that least restrictive principles, practice and language is being used?

Overall, based on the care plan audits undertaken throughout the reporting period, there is robust evidence of good practice in a number of key areas. This includes:

- Care plans reflecting a recovery and outcome based whole care pathway approach, identifying and reviewing any potential barriers to discharge
- Evidence of service user involvement in developing the care plan
- The risks associated with the service user's holistic needs and the interventions to address these are clearly stated
- Aims and objective for admission clearly stated
- The legal basis for admission and treatment is clearly stated
- Language is meaningful, jargon free and reflective of least restrictive practice
- Care plans containing evidence of least restrictive principles, practice and language

There are a small number of areas where further improvements are required. This relates mainly to carer involvement in care planning, which will be addressed via our Carers, Family and Friends strategy 'involving carers in care' priority. Through the GMMH Care Programme Approach group, we will also continue to deliver on our quality improvement activities which are reported within part three of this Quality Account. This included a broad range of improvement activity comprising:

- Ensuring that our steering group, with involvement from service users, carers and professionals continues to drive quality improvements around our care planning approaches
- Reviewing our CPA policy and procedures to ensure that there is effective engagement and collaboration with service users and carers producing personalised care plans
- Identifying the training needs of our staff and co-designing (with service users and carers) a care-planning training programme for delivery to staff with care planning responsibilities
- Continuing to deliver care planning training to all new preceptorship nurses, and ensure that effective monitoring is in place
- Continuing with our bi-annual trustwide audit around care planning to share good practice and local innovation, identifying ward or service areas where quality improvement may be required
- Continuing to 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
- Reviewing our CPA documentation and ensure that our GMMH care planning information is service user and carer friendly
- Through application of NHS Improvement guidance, continue to work towards developing a culture where service user and carer involvement with care-plans is considered an 'always event'

In addition, plans are also in place to commence a programme of audit and quality improvement into care plans for our community based service users. Our plans are still in development but are likely to include a deep dive to explore recovery treatment outcomes, service user and carer involvement and risk management planning.

2.12 **Freedom to Speak up**

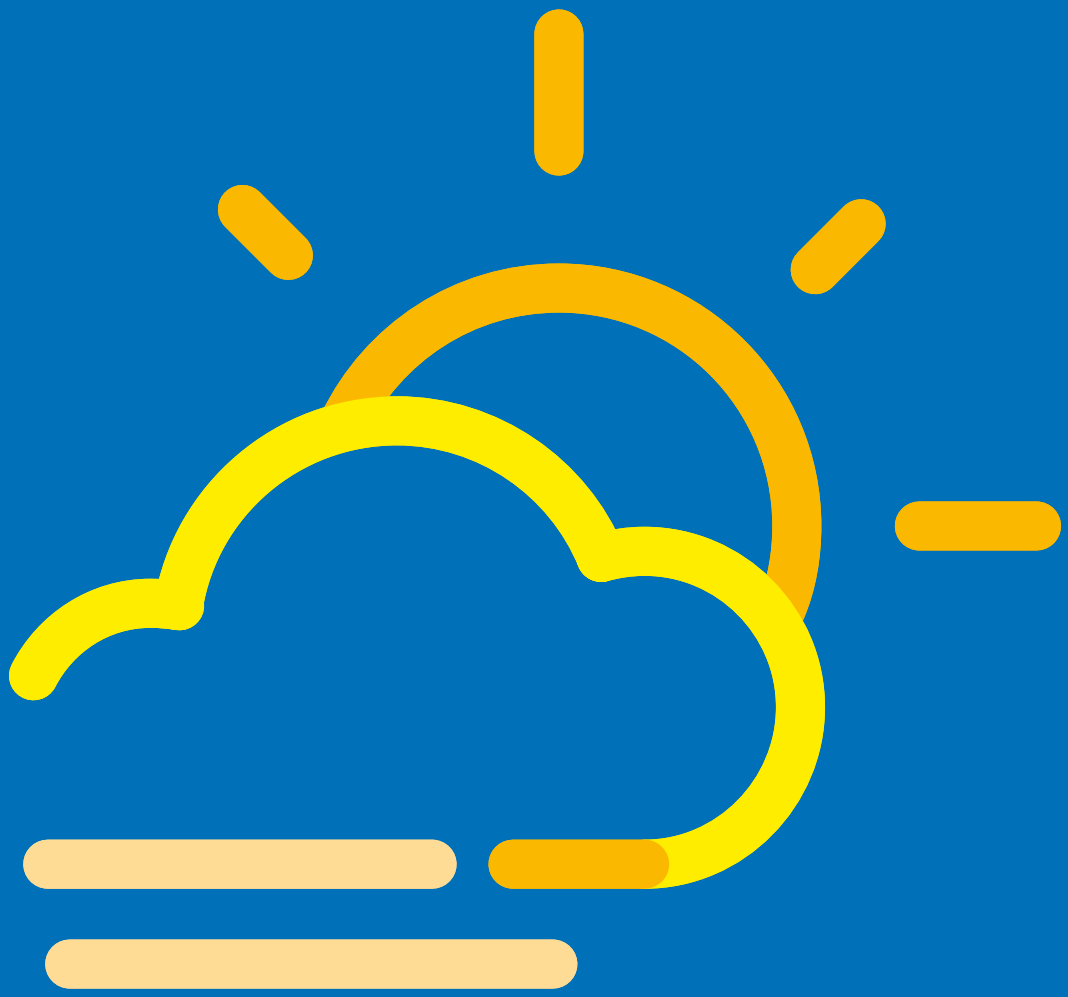
The Trust has adopted the national 'Freedom to Speak Up' Policy to promote an open culture across the Trust and to ensure staff feel safe to report incidents and raise concerns.

The Trust has a nationally registered Freedom to Speak up Guardian whose role is to support and enable staff to raise concerns, in addition to both an Executive Lead and a Non-Executive Lead for Freedom to Speak Up. In line with the national policy, staff are encouraged to raise concerns with line managers and line managers are encouraged to listen and act on staff's concerns. It is appreciated that, at times, staff may not feel able to do this and the role of the Freedom to Speak Up Guardian is widely promoted through a variety of methods including through the Corporate Welcome Day, as a continual feature on the Intranet Site and wide coverage within operational meetings held throughout the organisation.

The Freedom to Speak Up Guardian works closely with Trade Union Representatives and they act as advocates for the Freedom to Speak Up route and guide staff accordingly when concerns may arise. The Trust is committed to ensuring that staff do not suffer any detriment as a result of speaking up. Trust wide this is achieved through ensuring that all messages relating to speaking up are delivered by a member of the Executive Team to outline the highest level of support for wanting staff to feel able to speak up. More locally the Freedom to Speak Up Guardian keeps in close regular contact with those who raise concerns through the speaking up route, any such indicator that identifies that a staff member feels they are suffering a detriment will be dealt with immediately. The Freedom to Speak Up Guardian also regularly promotes the role through visits to Wards and other areas within the organisation to ensure that staff know that if they are raising concerns locally and these concerns are being dealt with and managed effectively, there is still a route for them to take should anything change within that process.

Freedom to Speak up

PART 3 – Review of Quality Performance in 2018/19



3.1 Delivery of Quality Improvement Priorities in 2018/2019

As highlighted in last year's Quality Account, we continue to deliver our annual Dragon's Den quality innovation programme, which helps to support the delivery of our quality improvement priorities, and to make them meaningful and relevant for our local services.

The Dragon's Den is a Quality Innovation fund that was established to encourage quality improvement at local service level, and to support the delivery of the GMMH Quality Improvement Priorities (QIPs). The improvement priorities are developed and published within the GMMH annual Quality Account. This year, the QI strategy has aligned itself to support the development of the improvement priorities, and the themes identified throughout our 'Quality Conversations' will form the basis of the QIPs for 2019/20.

Each year, £250k of non-recurrent funding is made available. The fund is promoted annually during April/May, which is when the improvement priorities for the forthcoming year are drafted. 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 operational services may be engaged with. There is no lower limit but funding bids are usually capped at £10k.

For 2018/19, there were approximately 162 bids for funds, with 64 of these being successful. Successfully funded projects ranged from animal assisted therapy, community radio and accessible gardening, through to music therapy, outdoor sports activities and dementia friendly external spaces. Financial support for the projects ranges from £189, up to £10,000. Plans are now in development to initiate the programme for this year's round of QIPs. The Dragon's Den is an effective way of promoting ownership and accountability of our organisational strategic priorities, in a way that is relevant and relatable to our local services.

We have made significant progress against all of our 2018/19 priorities for improvement. Summaries of our key achievements are detailed in this section. Each achievement reflects the immense commitment of our staff, services users and carers to continually improving quality. We have provided evidence of our key achievements, with case studies from Dragon's Den funded projects. These are set out 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 from the use of the 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 2018/2019 the CARE Hub has launched two of its key strategies – Service User Engagement (2018-21) in July 2018 and Carer, Friends and Family (2018-2021) in December 2018. Both strategies prioritise listening to service users and carers and using their feedback to improve our services.

The CARE Hub and local divisions have developed action plans to address these priorities moving forward. Progress is formally monitored via the CARE hub with reports to the Quality Improvement Committee and Operational Leadership Committee on a quarterly basis.

National guidance highlighting different levels of service user participation has been incorporated into the Service User Engagement Strategy and various marketing materials have been developed for service users, carers and staff.

Both strategies have key aims on improving the recording of our service user and carer protected characteristics and ensuring our engagement schemes span across all of the diverse communities that we serve. We continue to adapt our feedback methodologies and have developed a bespoke British Sign Language option for our deaf service users and more visual options on our kiosks.

There continues to be a variety of methods to encourage feedback across GMMH. During 2018, the DEPEND study (National Institute Health Research) concluded its findings into the effectiveness of different methodologies of service user feedback and supported the use of electronic systems. The study worked with GMMH services and highlighted the effectiveness of having volunteers with lived experience to gather feedback.

During 2018, we launched the online survey and developed business cards with an URL address for community service users and carers to leave their feedback. Service user and carer stories continue to be used to support staff morale, share learning and evaluate service improvement programmes. These stories are shared at Trust Induction, learning from complaints and many staff training programmes (Recovery Academy etc). Learning conversations and seven-minute briefings continue to develop and during this year, these have been shared at Ward Manager network, Consultants meetings and via splash screens.

Utilising Dragons Den funds, the CARE Hub has successfully recruited into a Service User Coordinator post. This post has specified lived experience as a fundamental requirement and its role is to engage with service user and carer groups and ensure any communication barriers are identified and addressed. Part of their role will be to co-deliver care-planning training to GMMH clinicians. The new service user engagement coordinator role will also have responsibility in coordinating service user and carer stories moving forward in 2019.

The Dragon's Den was also able to fund a wide range of projects that aimed to Improve the way we receive feedback from service users and carers using different methods and technologies. This included our Young Voices Talking Out project, which was delivered in partnership with Bolton FM. This project helped to raise awareness of young carers with parental mental health difficulties, and enabled young carers to talk about their experiences to others in similar situations. It also helped to open up the conversation and engage other young carers in schools to increase emotional wellbeing, confidence and self-esteem for young carers in Bolton.

Our Volunteering and peer mentorship programme continues to go from strength to strength. There are approximately 144 volunteers and approximately 36 peer mentors in the Trust. Additionally, approximately 16 people have applied to future peer mentor posts. A range of services now utilise peer mentors as part of their workforce, some examples are acute admission wards, child and adolescent mental health services, early Intervention teams, rehabilitation services, substance misuse teams and excitingly, we have seen the first peer mentor in one of our community mental health teams.

Case Study Priority 1: Service User and Carer Experience – Listening to, Learning from and Acting on Service User and Carer Feedback

The den is always keen to hear bids which do not just meet the quality improvement priority, but also involve other organisations which can bring another element of expertise and knowledge to a project.

One such example is an art project - the Start Art group which will be run by Start in Salford over the course of 12 months. The overall purpose of the group is to create a large piece of artwork that can be displayed on the main corridor of the Meadowbrook Unit to make it a more welcoming space. At the end of the project there would be an exhibition to showcase all of the service users' artwork.

This project is in direct response to the Friends and Family test and the inpatient survey which reflect the views expressed by service users in community meetings that they would like to see an increase in activities available on the ward. Service users from all four wards at Meadowbrook will be able to attend these sessions. The benefits they will enjoy are vast – it helps boost motivation, it is validating to have one's artwork displayed and is inspiring for other service users. Group work such as this can help to increase social skills and relationships with others in a setting which feels safe. It provides a sense of achievement and brightens up the environment.

Getting involved in an art project can be absorbing and a welcome distraction from a service user's thoughts, symptoms and feelings. These can be channelled into something rewarding and meaningful. This has been backed up by research. The British Medical Association published a paper on '*The Psychological and Social Needs of Patients'* (2011) which found that creating a therapeutic environment extends beyond the elimination of boredom. Arts and humanities programmes have been shown to have a positive effect on inpatients. The measured improvements include:

Inducing positive physiological and psychological changes in clinical outcomes
Reducing illicit substance consumption
Shortening hospital length-of-stay
Promoting better staff-patient relationships
Improving mental health care

Working with Start in Salford brings extra benefits as they already provide activities in the community. By linking in with Meadowbrook, they can build up strong therapeutic relationships with service users which will increase the chance of them continuing to engage after discharge.

Priority 2 Recovery: Promoting Recovery – Improving Outcomes through the Delivery of Recovery Focused, 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 2018/19, we continued with our efforts to reduce restrictive practice including levels of restraint, seclusion and rapid tranquilisation use across the organisation. We have been looking at the data as progress over time and regularly feed this back through the Positive and Safe forum to highlight trends and peaks in the use of restrictive practices. This has also been compared with the data on the use of Safewards interventions and early indications show that an increase in the use of Safewards is having an effect on reducing restrictive practice.

The Positive and Safe group commissions assurance reports from ward managers where monthly use of restraint, seclusion and rapid tranquilisation 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 Positive and Safe lead has continued to monitor implementation of the 10 Safewards modules across all inpatient settings. Additional training has been provided to the Positive and Safe team who are now providing additional ward-based training in addition to the Positive and Safe lead when required. The Positive and Safe team have developed guidelines and continue to be responsive to particular needs or challenges in inpatient areas.

The secondment of a ward-based nurse has increased opportunity for the team to understand current challenges in inpatient areas and has provided more resource for training and promoting good practice across the trust. The work of the Positive and Safe team has been recognised by the national Safewards team which has led to the Positive and Safe team being asked to host a mental health team from Indonesia to demonstrate the implementation and maintenance of Safewards.

Unit-based Positive and Safe meetings have been set up in most areas of the trust. These are chaired by local Safewards leads and are supported by the trustwide Positive and Safe team. Individual wards feedback progress and share challenges, enabling peer support and sharing of innovation and good practice on a local level. This has also been utilised as a forum for communication with the Positive and Safe team in order to keep units up to date with latest developments and guidelines and to provide access to additional support with issues as they arise.

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, additional information was requested from the wards which have reported green scores. This will be collated into a Big Book of Good Practice and newsletter which will be made available as a resource for wards to provide ideas for developing implementation.

Safewards training is now fully embedded throughout Prevention and Management of Violence and Aggression (PMVA) training which is also used as a forum for sharing good practice and innovation across the trust. Training in post-incident debriefs has also been included and a template for debriefs has been created and is currently being implemented in some areas as part of a PDSA cycle.

A task and finish group has been set up with front-line staff and the Positive and Safe team to review current PMVA training to ensure compliance with new Restraint Reduction Network (RRN) training standards and future accreditation which is due to become mandatory in April 2020 in line with the Mental Health Units (Use of Force) Act 2017. A key aim is to ensure training is trauma-informed. The Positive and Safe team have received some training on trauma and the relationship with restrictive practice. This is due to continue during 2019/20 with the involvement of psychologists, nursing/AHP staff and service user representatives. This will include representatives from the Complex Trauma Research Unit.

The Positive and Safe team continue to support the preceptorship training programme to deliver training on Safewards, Positive Behavioural Support plans, formulation and post-incident debriefs. The team are also involved in CAMHS induction training and have supported a local lead to deliver training on Safewards. PMVA training includes awareness of the specific requirements of staff working with pregnant and deaf people. A member of the Positive and Safe team will be completing BSL stage 1 training in 2019/20 to improve communication and understanding with deaf patients and staff.

Specific PMVA training for older adults continues to be delivered to staff working on these wards.

GMMH hosted the first Northern Reducing Restrictive Interventions conference. This provided an opportunity for sharing good practice between trusts. A thematic review of feedback has been shared with co-organisers and local leads. Plans are in place to follow up with a future conference.

Case Study Priority 2: Promoting Recovery – Improving Outcomes through the Delivery of Recovery Focused, Positive and Safe Services

Loneliness has a huge impact on mental health and wellbeing and the Dragons were very keen to fund a project which directly tackled this issue.

The 'You're Not Alone' project seeks to reduce the sense of loneliness felt by older people with a mental health diagnosis in the community. Over 12 months, a new music theatre piece will be created by groups of older people and used as a basis for an anti-loneliness campaign across Manchester. Manchester Camerata musicians and theatre makers will work with four groups of older people to create a new piece which will be toured across 20 community care settings.

Each group will work with a composer, musician and theatre makers via workshops to explore the theme of anti-loneliness and create the narrative, script and musical accompaniment of a new piece. Participants will work together in a relaxed environment to contribute to the creative process in a way which feels comfortable for them.

Participants will also have the opportunity to work with a film maker to produce their own documentary about the project, process and outcomes. The film will not only raise aware awareness of the anti-loneliness campaign, but it will also be used as a training tool for care staff to help them under personal experiences of living in isolation and how best to help someone living with loneliness.

Manchester Camerata will also signpost anyone who participates in the project, or attends performances to other arts projects taking place in Manchester, in order to encourage engagement in group activities which will support their positive mental wellbeing in the long term.

In summary, this ground-breaking project will:

Provide a platform for older people to express and share their views about loneliness and isolation
Provide an opportunity for older people who are lonely or isolated to join a social activity
Provide an opportunity for older people to work together as a group to create a new, high quality artistic piece
Improve participant's quality of life and wellbeing
Provide an opportunity to change expectations of older people with mental health issues, positioning participants as artists in their own right
Raise awareness of loneliness and isolation and how to combat it, to hundreds of people in a range of community settings across Manchester

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 2018/2019 Woodlands Hospital in Salford has devised Education sessions that have been delivered monthly and are offered to all Older Adult services in GMMH. These have been well attended over the last year from all services and they have been found to improve clinical knowledge. There has been two psychology Continuing Professional Development (CPD) events; one of them focussed on how services can support older adults with personality difficulties. This allowed for debate around prevalence and presentation of working age adults and older adults.

There has been an audit of ACE III assessments in older adult services; the audits were completed in four teams in the organisation and this showed that some improvement in its use was required. As a result, a group of psychologists devised trust standards for older adult services to use going forward. This will influence future training and competencies that practitioners will achieve in our older adult services. The training is in the process of being finalised.

In relation to ACE II Cognitive screening measure, the standards in the use of this are currently being finalised. A scoping exercise is required as to where these assessments are being used. In relation to the Positive and Safe agenda, a member of the PMVA team has been aligned to the older adult services in GMMH to look at risk and restrictive practice to bring in line with working age services.

NICE has released revised guidelines around capacity assessments; and as a result, older adult services have reviewed the current GMMH policy. Audits have also been carried out on compliance with T2/T3 forms in Manchester and Woodlands. Results from these audits are currently being shared and disseminated across divisional older adult services.

Within Bolton MATS, work is continued to ensure effective in-reach into our Asian, Polish, LGBT and Black communities. We have continued to produce translated service flyers for these groups and have maintained our engagement over the year with the created BME network of community services to promote access. Developments are continuing to be shared via the Older Adult Steering group.

Psychology professionals working in Older adult services have developed a procedure as to how to transfer cases between inpatient and community services. The GMMH Policy for the Transfer of Service Users to Acute Care has been completed and ratified during 2018/19. This policy will assist with patient care when there are transfers to acute services and back from acute services. A roll out of the check list included within the policy will be disseminated to older adult wards for staff to use as guidance.

The inpatient Flow Lead for GMMH is looking at how we are managing Delayed Transfer of Care (DTOC) in our local areas and what escalation is required when someone is identified, along with recording and any required actions. There is a plan to have a Delayed Transfer Of Care (DTOC) team with an initial focus on our Manchester services.

Arrangements and plans are being put in place for Maple Ward at Manchester to be the pilot for IV fluids within the Trust. A draft protocol has been written and this is being reviewed by senior nurses across GMMH. This will be fed back to the older adult steering group and the GMMH Physical health care committee. There has been Three task and finish

groups established to explore the emerging themes from the reviewed NICE guidance. The three groups include: Changes to medications, Psychological and Carers support. The older adult steering group monitors progress and provides oversight on developments.

Greenway and Bollin Wards from Trafford services and Hazelwood Ward from Woodlands have received accreditation from the RCPsych. The older adults CMHT is currently going through the accreditation process. GMMH have also hosted training for staff to become Peer reviewers for Older Adult services across the country.

Dementia United has now established a number of priority areas that will form the basis for their work plan over the next three years. There is representation from GMMH for all the priority areas identified.

Case Study Priority 3: Enhancing Quality of Life of People with Dementia and Older People with Functional Illness

The Dragons are always amazed at how staff develop ways in which they can support people living with conditions such as dementia. There is a lot of research which illustrates how things like horticulture can improve quality of life, which is why staff from our Memory Assessment and Treatment service requested funds to develop some dementia-friendly gardens at Woodlands Hospital.

Ward gardens should be an important therapy space for service users to use. The project aims to re-design the existing gardens into a safe, stimulating, dementia-friendly environment. Outside space is as important as inside space for service users, as wards can be their home for long periods of time. A welcoming garden will encourage service users and their visitors to maintain the upkeep of them, which in turn provides cognitive stimulation.

Being outside also provides Vitamin D which is so important for good health. Well-designed dementia-friendly gardens will provide use for familiar activities such as planting, watering, hanging out washing and exercise. They also stimulate the senses as fragrant and vibrantly-coloured plants and ornamental shrubs provide extra-sensory stimulation.

Time spent in the gardens will also help service users to relax and feel calm, relieving stress and agitations. There are also plans to include extra features such as:

- Secure water features
- Outside speakers for gentle music or nature sounds
- Suitable paths
- A secure pet area

In summary, these dementia-friendly gardens will:

- Provide cognitive stimulation therapy
- Improve physical health
- Provide familiar activities
- Be used for exercise
- Provide relaxation and lessen agitation and distress
- Provide sensory stimulation
- Be a lovely, safe, caring environment for both service users and their visitors

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:

During 2018/2019, we have continued with a significant amount of work across GMMH to provide a range of physical healthcare interventions that support the need to reduce health inequality and to improve the long-term health outcomes of our service user population. Delivering high quality physical healthcare assessment in our services remains a focus of commitment that will be supported by the development of a physical health and wellbeing strategy that we will ensure is progressed via the GMMH Physical Healthcare Committee.

Our work to improve the care provided to Diabetic patients through the delivery of care bundles, is ongoing and we have continued to build on progress that has already been made. As part of this, we delivered a planned 'Deep Dive' into Diabetes care across our services and reported the key findings to the Quality Improvement Committee. An action plan has been developed and was implemented during Quarter 4 of 2018/19. In addition to this the trust has engaged with Diabetes specialists across Greater Manchester as part of the strategic clinical network and is working collaboratively address areas of inequality.

Throughout the year we reviewed the service level agreement for Podiatry services to ensure that it is appropriate for our service user population. We now have a single provider contract agreed and this is scheduled to be implemented by the end of this year. This will ensure the consistent provision of high quality foot care which will assist with the prevention of diabetic foot complications

We have completed a review of end of life care provision across GMMH services. As part of this, a task and finish group has been meeting for several months and has now moved to the older adults steering group to progress standards for end of life care across GMMH. Recruitment has now been completed for a Bereavement Nurse who commenced in post earlier this year.

We have also continued our work to enhance the skills of the nursing workforce in order to reduce the need for transfers of care in our older adult services. We are starting to train our older adult nurses around the use of IV fluid for rehydration. A plan to introduce the ability to administer intravenous fluids for rehydration by nursing staff has been presented at the Physical Healthcare Committee. A draft protocol has been produced which will be consulted on during March 2019.

We have been working hard to implement a consistent approach to Early Warning Score monitoring which is in line with National Guidelines. To support this, an implementation plan has been developed to support the introduction of NEWS 2. GMMH is currently engaging with Health Innovation Manchester to look at a GM wide action plan to support implementation in mental health. During January 2019 the trust hosted a process mapping event with regional trusts to support the development of an action protocol for specific use in mental health services. This positive work is being continued during March 2019 with a further event hosted by GMMH.

In addition, we have continued our ongoing work to develop a standardised approach to the delivery of cardio metabolic risk training across the organisation. Funding (£15K) was approved to implement an e-learning package earlier this year by Trust Board. This has progressed over quarters 1 and 2 and was completed during Quarter 3. It will be rolled out to key staff over the remainder of this year and will form part of ongoing role specific training trust wide.

Over the year, we have taken significant steps to implement a smoking cessation service to support our service users and staff to reduce the harms associated with smoking behaviour. A GMMH smoking cessation service is now available and fully established with staff in post providing smoking cessation support as well as overseeing the GMMH smoke free implementation. Our Health Improvement Coaches run weekly clinics in all districts. Going forward, Health Improvement Coaches will increase their presence in Salford and Manchester, taking into account the higher volume of admissions and the quick turnaround of patients in some of the wards.

Brief Advice training through NCSCT continues to be promoted by ward managers to all frontline staff. Following the launch of Smoking Cessation Level 2 Training earlier in the year, around 150 staff have successfully completed the Open Award registered course. The Health Improvement Coaches have been supporting the inpatient units throughout the year, with some success. Interventions are delivered in one to one or group basis, and they range from information given on electronic cigarettes and Nicotine replacement therapy, to more structured behavioural support interventions.

Our work to develop, deliver and evaluate a weight management intervention to support our service users in early intervention teams has also progressed over the year. GMMH has engaged with NHS Improvement and has implemented an eight-week programme designed to improve physical fitness and wellbeing. The 'motiv8' programme was piloted in the Edenfield Centre and the first service users have been recruited to participate in the project. The programme is specifically targeting those service users with a BMI > 35 and provides a range of assessments and interventions designed to improve motivation and cardiovascular fitness through access to a range of health professionals and peer mentors. The programme was the winner of the "Closing the Gap, Experts by Experience Award" for the most coproduced improvement project delivered by a team. The award was granted by the service user representatives supporting the collaborative. A second cohort has commenced during quarter 4.

Finally, we have progressed our work to develop a mobile application which supports our service users to manage their own physical healthcare. A mobile app "Health Matters" has now been developed and is available to download in the App store.

Case Study Priority 4: Physical Health – Improve Assessment and Treatment and Promote Health Improvement

The Dragons recognise that physical health can be as important as mental health, when supporting service users to recovery and greater wellbeing. This is especially true in the Trust's Mental Health and Deafness service, where communication is key and why the Dragons were happy to support the Communication Sunburst project.

Communication Sunburst is an observation-based assessment tool, which generates a visual summary of an individual's language and communication strengths and needs. It allows for comparison to be made between how the person functions at different points in their recovery pathway and/or across other parameters such as between BSL and English. Clinicians can then adapt their own communication accordingly and deliver more effective therapeutic interventions, which in turn increases service user engagement and advances towards recovery.

The assessment pack comprises a manual and score sheets, a DVD with British Sign Language explanation and software for an electronic version. It is quick and easy to use and does not create any extra assessment processes. It captures information which can be observed within every day routines. Identified needs signpost the individual and team to consider strategies that will support in those areas.

The Communication Sunburst was developed by Kim Williams and Lindsey Gagan, Speech and Language Therapists at the John-Denmark Unit (the Trust's Centre for Mental Health and Deafness).

They developed it in response to an NHS England initiative for a universal approach to the assessment of language fluency. There is no other similar tool in use and the Deafness, Cognition and Language Research Centre at University College London felt that Sunburst may have international relevance as the scale is not limited to any particular language – signed or spoken. The Dragons fully supported this bid to help give the team the resources to develop this fantastic initiative.

Priority 5: The Development of a Framework for Working with People with Personality Disorder in GMMH

Aim: Improving the clinical effectiveness of all Trust services and practitioners working with service users of all ages with personality problems.

Progress, Achievements and review against specified improvement measures:

During 2017/2018, a draft Framework was prepared. This document, prepared in consultation with service users and carers and practitioners from all over the Trust, set down a number of principles for working with people with personality problems and aspirations for the Trust in terms of improving practice in the area. During 2018/2019, we set the following objectives for the process of implementing the Framework:

- Work with the relevant department to undertake a survey using the Personality Disorder Institute's *Knowledge, Attitudes 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 team 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;
- 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 GMMH 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;

Liaise with the Trust's Suicide Prevention Group in order to ensure that the GMMH personality disorder framework is aligned with the GM Suicide Prevention strategy;

Work with Health and Justice service managers to identify the barriers to access to mental health services for men and women leaving HM Prison and Probation Services and who are in need of follow up mental health care due to personality difficulties; and

Establish a peer support/supervision network of practitioners who can assist clinical teams across the Trust to develop ideas for working well with clients with personality disorder in their care and to support pathway development and planning.

All of the improvement measures listed above have been or are in the course of being addressed. The survey has been completed – but it will be repeated again in the coming months. The Recovery Academy has launched a personality disorder learning stream in its spring 2019 prospectus. Work is being supported with the Organisational Development team to both encourage more Knowledge and Understanding Framework training across the Trust – and to look at training alternatives that may be more accessible to more staff and service users, as well as sustainable.

The Framework website has been established as part of the Trust intranet, and is in the process of being populated and maintained. A survey of clinical supervision has been undertaken through the relevant Trust department, but work remains to be done to interrogate these data for an indication of the availability of clinical supervision for practitioners working with service users with personality problems. A considerable amount of work has been undertaken to support service user network development and training and support. The formulation tile has been established and launched on Paris and various events are taking place to publicise this and instruct colleagues on its optimal use.

Work is ongoing mapping barriers to access to mental health services for service users with personality problems. This remains a significant piece of outstanding work, as does the desire to have service users in a position to choose from the support and therapeutic options available to them for the treatment and management of their personality problems.

However, the Trust has been awarded £300k to develop an intensive intervention and risk management service in partnership with the National Probation Service to assist high risk personality disordered offenders leaving prison and trying to stay safely in the community and, where applicable, involved with local mental health services. In Q4, a review was undertaken of all the serious incidents in the Trust during 2017/2018 (including suicides and attempted suicides) in order to determine the influence of personality problems in the genesis of the incidents under investigation. A peer support/supervision network has yet to be established.

Case Study Priority 5:

As part of the process of preparing this Framework, over 20 service users were consulted in several different ways – in one-to-one meetings, in service user consultation events, and in mixed practitioner and service user consultations. Together, they highlighted five important points about services for people with the range of needs that they have:

Service users with personality problems are deserving of respect
Their experiences invariably arise from early experiences of trauma, abuse and neglect, which have in turn shaped their expectations about themselves and the world
An approach that tries to understand why they are as they are and do the things they do is most likely to be productive in terms of building an effective therapeutic relationship
But they can struggle to access services, especially if their problems are complex, if they are seen as scary as well as distressed, and if their desire for treatment wavers
People with personality problems can struggle to 'get better' in the traditional way – to recover – which can make it hard for services to manage the care needs of these clients

The service users and carers consulted agreed on the following essential requirements for services that could claim to be responsive and truly caring:

1. They want to feel a sense of trust in the practitioner and in the team that practitioner represents;
2. They need consistency in care provision, between practitioners and over time, which means not being asked the same questions every visit and not having to repeat one's story – and pain – every time a new person takes over;
3. They would really like practitioners who act towards them in a way that suggests they are empathic, supportive and able to validate or authenticate their feelings;
4. Practitioners who listen, quietly, and do not talk over them or tell them what they are thinking or feeling, are a godsend!
5. As are practitioners who are knowledgeable about both the service user, about the problems they have and what to do about them, as opposed to practitioners who are uninformed and unskilled and who seem more anxious in response to the service user's problems than capable of responding proactively to them;
6. Service users appreciate practitioners who communicate compassion – a willingness to try to understand and to do their best;
7. And they regard services that are organised, with clearly articulated entry and exit criteria, which make it clear where people with personality disorders can receive what treatment, from whom and with what kind of potential outcomes, as the best possible care.

Priority 6: 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.

Progress, Achievements and review against specified improvement measures:

During 2018/19 GMMH has harmonised the Care Programme Approach policy and is currently delivering a series of workshops to harmonise care planning documentation. The trust has also developed a care planning steering group to address the personalisation and collaboration of care planning process in inpatient services. This has led to a suite of interventions to support the care planning process and ensure documentation is service user friendly.

GMMH has worked in partnership with the EQUIP study (University of Manchester) to develop and deliver care planning training to clinicians. All newly registered preceptees can access the care planning training and plans are underway for all clinicians to access this co-produced programme.

Internal processes are in place to audit collaborative care planning and service users and carers receiving a copy. During Q3, 88% of service users care plans evidenced service user involvement, this had improved from Q1 (85%). However, carer involvement remains an issue; in Q3, 44% of care plans evidenced carer involvement (67% Q1). Work is being carried out to further evidence carer involvement in the audit tool, as carer engagement can often happen at ward reviews and individual sessions. Yet, service users and carers consistently report that they 'felt' involved in their care (Q3 97% reported this in their feedback questionnaires) and in Q3 64% of carers said they were involved in care planning.

A collaborative set of expectations for care planning have been developed with service users, staff and via the EQUIP study. Marketing materials are being developed for inpatients and community service users to explain what a care plan is and what they should expect. Key areas from the National Community Survey have also been added to the materials to empower service users with the knowledge of who to contact in a crisis.

The organisation continues to train and support services to utilise the Recovery Star, Node Link Mapping, Motivational Interviewing and Advanced Decisions.

GMMH has attended an NHS England Always Event (NHS Improvement initiative) and is working towards developing a culture whereby service user and carer involvement in care-planning is considered an 'always event.' Irwell, Trafford is the planned pilot site and considerable work has been undertaken to involve service users in ward reviews and setting some minimum standards for care plan reviews. Plans are in place to share this practice across the organisation.

Case Studies Priority 6: Improving the Quality and Effectiveness of Service User Care Plans

Irwell ward, Psychiatric Intensive Care Unit (PICU) at Moorside, Trafford has been a pilot site for NHS England 'Always Events' Always Events is a co-production driven quality improvement methodology which seeks to understand what really matters to service users and their families, incorporating co-designed changes to improve the experience of care.

Service users and carers in Trafford have provided feedback to suggest that they don't always feel involved in their care and treatment. Irwell PICU staff have delivered engagement events with service users and peer mentors to explore what involvement should look like, and to capture suggestions for improvement measures. Service users have highlighted the importance of establishing trusting relationships with staff so they can open up about any current issues or problems. Service users also expressed their frustrations when they saw different clinicians and were unable to develop important, therapeutic relationships. Additionally, service users suggested they did not understand what a ward round was for and did not feel empowered to get involved. Overall, service users wanted to feel valued, respected and listened to in order for them to feel involved in their care.

To make the quality improvements in care planning, Irwell PICU staff have reviewed the roles and responsibilities for the named nurse model, and have provided extra guidance around expectations. There is now an expectation that all service users have at least one hour of protected time to review their care plan with their name nurse. The ward staff have also co-developed with service users, care planning packs, which have a suite of materials that will help to empower service users to plan and be actively involved in their care plan. There is also a carer map, which encourages service users to reflect on their supportive networks and explore how they would like their family/friends involved in their care. All of this quality improvement work was delivered in conjunction with safe ward interventions. PICU staff have also developed a ward round form that provides information about what a ward round should involve, and what information service users would like to include.

These quality improvement measures have already seen service user and carer feedback improve significantly, and overall those receiving care and treatment have felt more involved and empowered. Irwell ward has enthusiastic peer mentors who have driven some of these improvements and are instrumental in reviewing progress and seeking service user views. This quality improvement methodology will be shared with other GMMH wards to increase service user and carer involvement in care planning across the board.

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).

Patient Experience	2017/18	2018/19	Comments
PLACE inspections. The assessment evaluates cleanliness, condition/appearance, privacy and dignity and food.	**93.10%**	**See comment**	2017/18 figure taken from PLACE formal assessment inspection results published by NHS Digital. Due to the review of PLACE being undertaken by NHS digital and the changes to documentation following the review, the scheduling of the PLACE programme 2018/19 for all Trusts has been rescheduled so that inspections will now take place between September and November 2019.
Complaints – total number of complaints received per 10,000 recorded service user contacts	**8.8**	**8.7**	***Source:*** *PARIS and Datix (As at Mar 2019)*
Compliments – total number of compliments received per 10,000 recorded service user contacts	**13.4**	**11.3**	***Source:*** *PARIS and Datix* (As at Mar 2019)

Clinical Effectiveness	2017/18	2018/19	
Community Mental Health Survey - % of responses that rated the services received from our Trust as good, very good or excellent	**Score - 69.3%**	**Score - 67.7%**	***Source:*** *CQC (Community Survey 2018 Results, Q37, Rank 7-10 as % of Ranks 0-10)*
Friends and Family Test – Service Users – % of Service Users who responded as "Extremely Likely" or "Likely".	**75.8%**	**77.9%**	***Source****: Friends and Family Service Users Submission to Unify. (YTD As at Mar 2019)*
Total staff sickness absence (%) – rolling 12-month position	**5.9%**	**5.9%**	Average sickness rate for Mental Health / Learning Disability Trusts in the North West is 6.1%* **Source**: Board Performance Report (Mar 2019) via Electronic Staff Record (ESR) *Source: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/november-2018-provisional-statistics
Safety	**2017/18**	**2018/19**	
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	**68.9%**	**73.0%**	***Source:*** *Datix* *(As at Mar 2019)*
% of all patient safety incidents that resulted in severe harm or death	**1.5%**	**1.7%**	Further information on this indicator can be found in Section 2.10.7 of this Quality Account ***Source:*** *Datix* *(As at Mar 2019)*
Number of under 18s admitted to our adult mental health inpatient wards	**10**	**14**	***Source:*** *PARIS (Apr 18 – Mar 19)*

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 NHS England in the 'Five Year Forward View for Mental Health' published in February 2016 and by NHS Improvement (NHSI) in the Single Oversight Framework updated in November 2017 are summarised here (operational SOF requirements only).

We are registered with Monitor, the regulatory body for Foundation Trusts and have consistently achieved all required targets and standards for continued registration.
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.

Indicator	Target	2017/18	2018/19	Comments
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)	53.0%	85.1%	72.2%	As at March 2019. ***Source:*** *Board Performance Report (Mar 2019)*
2. Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:				
a) Inpatient wards	90.0%	71.6%	**See comments*	The 2018/19 data is not available at the time of writing this report. Please see the note below.
b) Early Intervention in Psychosis services	53.0%	51.3%	**See comments*	The 2018/19 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)	75.0%	64.2%	**See comments*	The 2018/19 data is not available at the time of writing this report. Please see the note below.
3. Data Quality Maturity Index (DQMI) - MHSDS Dataset Score. Completion in MHSDS of:- • Ethnic Category • Registered GP Practice Code • NHS Number • Commissioner Org Code • Current Gender • Postcode of Usual Address	95.0%	N/A	92.6%	As at March 2019. The reportable measurement changed during 2017/18 and is now taken from the DQMI however the local calculation method was not changed until April 2018. There is therefore no 2017/18 outturn. ***Source:*** *Board Performance Report (Mar 2019)* Instead of our local estimated figure can we include the latest national published figure which is Q1 17/18? We report this in addition to our local figure in the Board report and due to the changes in the DQMI its becoming increasingly difficult to use our local figs to determine our national published figures? I know this would be different to that used previously. I have suggested this to Kin in addition for the annual report.
4. Improving Access to Psychological Therapies (IAPT)/talking therapies (from IAPT minimum dataset):-				
a) Proportion of people completing treatment who move to recovery	50%	41.2%	43.7%	As at March 2019. ***Source:*** *Board Performance Report (Mar 2019)*
b) Waiting time to begin treatment within 6 weeks of referral	75%	61.8%	62.4%	As at March 2019. ***Source:*** *Board Performance Report (Mar 2019)*
c) Waiting time to begin treatment within 18 weeks of referral	95%	94.8%	91.0%	As at March 2019. ***Source:*** *Board Performance Report (Mar 2019)*
5. Inappropriate out-of-area placements for adult mental health services (Total number of bed days)	In line with agreed trajectory for eliminating OAPs by 2021	15211	5731	As at March 2019. ***Source:*** *Board Performance Report (Mar 2019)*
6. Care Programme Approach (CPA) follow up: proportion of discharges from hospital followed up within 7 days	95%	97.2%	95.3%	As at March 2019. ***Source:*** *Board Performance Report (Mar 2019)*
Admissions to adult facilities of patients under 16 years old	Target Unknown	0	0	As at March 2019 ***Source:*** PARIS

** Please note that GMMH scores for 2018/19 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 30th June 2019.*


We inspire hope

PART 4 – Priorities for Quality Improvement in 2019/2020

This section of the Quality Account sets out our priorities for improvement that we intend to deliver during 2019/2020. These priorities were identified as part of our 'Quality Conversations' programme, 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 Improvement Committee, and from a range of corporate quality initiatives undertaken throughout the reporting period. For 2019/20, our improvement priorities will be aligned with our Quality Improvement (QI) strategy. The three emerging areas of focus on the next page will be developed as overarching priorities, involving a range of different projects with different leads. These will be delivered across our services throughout 2019/20.

4.1 Consultation feedback

Our discussions around potential Quality Improvement Priorities were delivered via our 'Quality Conversations' programme.

This commenced in December 2018, and concluded in March 2019. In addition to hosting open meetings, discussions also took place at key existing meetings, including our district senior leadership teams, ward manager, medical and psychology professional networks. A range of potential themes were identified as a result of this process, and these were subsequently explored further during discussions with our stakeholders throughout the engagement period.

Throughout this process, we have taken on board a wide range of views, from a breadth of different stakeholders including over 400 members of staff, service users and carers across GMMH. We have also received feedback from our external stakeholders including from our HealthWatch colleagues across Bolton, Manchester, Salford and Trafford, from our local commissioning organisations and from the Health Scrutiny Committees at the local authorities, which operate across the GMMH footprint.

This has led to the agreement of three high level Quality Improvement Priorities for delivery during 2019/20. These are set out in section 4.2 of this Quality Account, and include the following areas:

1. To improve outcomes
2. To deliver the safest care
3. To integrate care around the person

Our Quality Improvement Priorities will be subject to robust, ongoing monitoring, which will take place at the GMMH Quality Improvement Committee. Our monitoring arrangements are set out in Section 4.3 of this Quality Account.

4.2 Improvement Priorities for 2019/20

The Quality Improvement Priorities for Greater Manchester Mental Health NHS Foundation Trust during 2019/20 include the following:

PRIORITY 1 – To Improve Outcomes	
Quality domain	Effectiveness and Service User Experience
Themes to be incorporated by the Quality Improvement Priority:	— Deliver outstanding care and experience every day, with quality at the heart of everything we do — Work with our service users and carers in developing and delivering our services — Increase our focus on staff wellbeing, so that staff can provide the best possible care — Act with compassion and kindness at all times — Improve our care planning processes and outcomes through making smart improvements to both engagement and recording — Use of quality improvement programmes to improve outcomes, and share good practice to support learning — Improving the lives of our service users by continuing to reduce poor physical health outcomes across all services — Increasing our focus on trauma informed care as a care philosophy

PRIORITY 2 – To Deliver the Safest Care	
Quality domain	Safety and Service User Experience
Themes to be incorporated by the Quality Improvement Priority:	— Ensure that our service users are cared for in safe environments — Scale up our work around Positive and Safe, working toward a phased reduction in restrictive practices across our wards — Continued monitoring of Datix and additional support offered to areas where uses of restrictive interventions are more frequent — Further embedding of the Positive and Safe and Safewards approaches across services and continued sharing of good practice — Increased focus on the impact of trauma on staff and patients involved in the use of restrictive interventions and strategies to reduce the impact — Development of a policy for the Use of Force with an emphasis on strategies to reduce the use of restrictive interventions and involve patients in decisions around their care and management of aggression — Achieve accreditation for PMVA training in line with Restraint Reduction Network training standards — Increase focus on debrief following incidents involving the use of restrictive interventions in order to explore alternative options and reduce the risk of future incidents

PRIORITY 3 – To integrate our care around the person	
Quality domain	Effectiveness and Service User Experience
Themes to be incorporated by the Quality Improvement Priority:	— Improve access to care, specifically around crisis support for our service users with a clear focus on equity of access — Address health inequalities, specifically for smoking cessation across community mental health services — Making use of opportunities within Digital Strategy to support frontline clinical interventions — Continued elimination of out of area placements across GMMH — Focus on our internal transitions across care pathways — Improved integration and development of effective links between community services to ensure easier access to support — Ensure that 'navigating' mental health provision is easier, that there is flow and correct processes in place in regards to urgent care, inpatients and community services — Improve communication, dissemination of information and invest in improving quality in relationships with partner agents and staff

4.3 Monitoring our Quality Improvement Priorities

These Quality Improvement Priorities will be subject to robust monitoring during 2019/20. 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 Improvement 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 aim to 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 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 19/20 or any other quality improvement activity at the Trust.

ANNEXES

ANNEX 1 – **Feedback from Key Stakeholders**

Feedback from NHS Bolton CCG on behalf of Bolton, Salford and Trafford Clinical Commissioning Groups

Greater Manchester Mental Health NHS Foundation Trust
Quality Account 2018/19 - Feedback from Bolton, Salford and Trafford CCG's

Bolton CCG has coordinated this response on behalf of the CCGs involved in the multilateral contract.

The CCG's have once again work ed closely with GMMHFT in 2018/19 to gain assurance that the Trust has provided safe, effective and patient focused services. Performance and quality continues to be monitored via a collaborative and clinically led process and the content of this account is consistent with the information presented in year.

The CCG's continue to believe that the Account's scale and format is not ideal for a public facing document. It is again also difficult, due to a lack of clear measures, to determine whether the 18/19 priorities have been fully met and whether the actions undertaken have led to the desired outcomes.

The CCG's are pleased with service developments that have taken place such as Achieve, the continued attainment of CQUINs, the development of the estate such as Honeysuckle Lodge, the CQC's overall 'Good' rating, and we are assured areas that require improvement, specifically around safety, continue to be addressed.

The overall Account is positive and reflects numerous accolades for both individuals and teams and shows high levels of staff and user involvement. It is also encouraging to see the high levels of audit compliance, research and innovation that have taken place in the last year. There continues to be an absence of integrated care reflected in the account and we would like to see this featured next year as we continue to develop neighbourhood networks.

The CCG's also recognise that a number of key professional strategies have been launched in the last year and it will be good to see progress against these strategies detailed in next year's account. In particular the CCG's note that the key priorities for the coming year align to the priorities in the Trust's Quality Improvement Strategy.

As stated earlier, reviewing performance against last year's priorities isn't easy and there are no clear measures for the three 19/20 priorities either and although the CCG's are supportive of the areas of focus, achievement again will be difficult to determine.

The Account describes an organisation that is able to deliver services to a high standard, is innovative and patient focused. We look forward to working with the Trust in 19/20 to not only support implementation of the Quality Improvement and other strategies, but to further develop the delivery of mental health services in line with Bolton, Salford and Trafford's transformation plans whilst ensuring service users continue to receive safe, effective and patient focused 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

MHCC response to Greater Manchester Mental Health Trust (GMMH) Quality Account 2018-19

Manchester Health and Care Commissioning (MHCC) is a partnership between Manchester City Council and NHS Manchester Clinical Commissioning Group and is responsible for the commissioning of health, public health and adult social care services in the city of Manchester.

MHCC would like to thank GMMH for their detailed and comprehensive account of their hard work to improve the quality and safety of services for the patients and communities they serve. We have been grateful to the way the Trust has worked openly and professionally with MHCC staff, taking our concerns seriously and responding to questions helpfully and in a timely way.

Since the acquisition of Manchester mental health services in January 2017, an ambitious two year programme of clinical transformation took place to improve the way mental health service are delivered. MHCC is pleased with the progress made and will work closely with the Trust to ensure the changes continue to have a positive impact on improving access and outcomes for the people of Manchester.

Over the last two years, the Trust has been working hard to deliver the quality improvements set out in the national Commissioning for Quality and Innovation (CQUIN) scheme. This two year scheme came to an end in March 2019, and we would like to thank staff across the Trust for their hard work in the delivery of the CQUINs. We look forward to working with the Trust in the delivery of the new CQUINs for 2019-20.

Patient safety is of paramount importance to MHCC and continues to remain an ongoing commitment of the Trust. GMMH has developed greater rigor in its approach to serious incident management and MHCC will continue to work with the Trust to ensure learning from serious incidents are truly embedded within the organisation. There is a good culture within the Trust of reporting patient safety incidents, and the Trust holds learning events to share good practice with staff. MHCC is working with the Trust to encourage more of this work.

During 2018/19, MHCC undertook a quality walk round of the Redwood Ward at the trust's Park House Unit, based at North Manchester General Hospital. The overall feedback from the walk around was positive. Patients were happy with the quality of care provided. The ward was managing safety incidents well and there was regular monitoring of patients physical health. Looking forward into 2019-20, MHCC plans to undertake a walk around of the Trust's Community Mental Health Team.

MHCC recognises the importance of the Trust's CARE Hub which proactively seeks feedback from servicer users, carers, staff, and volunteers to improve the quality of care. We note the launch of the Service User Engagement Strategy and the Carers, Friends and Family Strategy, both designed to improve engagement and use feedback to improve services. There has been service user engagement with the use of the Friends and Family Test (FFT), and we recognise that further work is needed to increase the number of people completing the test.

The implementation of the 'safe-ward' model within the inpatient units is welcomed. The model is designed to reduce conflict (aggression, rule breaking) and containment (coerced medications, restraint and seclusion). MHCC is also pleased with the progress to improve the physical health care of service users across both inpatient and community services and the ongoing work to implement the National Early Warning Toolkit designed to improve the detection and response to clinical deterioration in adult patients in hospital.

The opening of the section 136 suite in July has been a notable milestone. Manchester now has a place of safety for those in a mental health crisis. GMMH has also been leading on a programme of work to reduce the number of people placed outside of Greater Manchester (GM) for acute inpatient care. This work has resulted in fewer people being sent outside of GM. It is also worth highlighting the increases the number of people with mental health conditions accessing psychological therapy.

MHCC is pleased to see GMMH set ambitious objectives for improving quality. These ambitious objectives align closely with themes from serious incidents, complaints and national and MHCC priorities. We support the Trust's three quality priorities for 2019/20 of:

- Improving patient outcomes
- Delivering the safest care
- Integrating care around the person

As Manchester is a diverse city, MHCC support the continued focus on promoting equality of access and improving outcomes for service users from all equality groups. In future quality accounts, it would be good to see examples of how the Trust is undertaking targeted work across each of its services, to improve access and outcomes for people from the different equality groups.

We look forward to continuing to work with the trust in delivering high quality services for the people of Manchester.

Ian Williamson,
Chief Accountable Officer, Manchester Health and Care Commissioning
May 2019.

Feedback from HealthWatch, one narrative provided on behalf of HealthWatch Bolton, Manchester, Salford and Trafford

healthwatch Salford

Local Healthwatch Comments regarding GMMH quality account

Thank you for sending Quality Account 2018/19. Local Healthwatch are pleased to see the range of quality strategies and approaches introduced for 2018/19. The Trust has set up a sub-committee to set the strategy for quality and we would welcome any appropriate involvement in its deliberations.

We support the developments around PARIS, the clinical information system, as without reliable data, the constituent parts of GMMH cannot be effectively evaluated, or benchmarked against other Trusts' results. It is also reassuring to note that the reports of 114 local clinical audits were reviewed and that service user involvement is central to strategy and is a key deliverable for all Research Units. The experimentation with new, modern ways to engage with service users, such as an online web survey is impressive.

We continue to expect that NICE quality standards are complied with and where they are not, we would wish this to be made explicit to commissioners so that in the event of adverse occurrences risks are shared. However, we are very satisfied that the above demonstrates an organisation with a learning culture.

Regarding National Indicators; the focus on Improving the health and wellbeing of staff is welcome. The wellbeing of staff is essential to the delivery of high-quality services especially in view of the pressures on frontline services which has been reported to Local Healthwatch. Healthwatch commend those staff who have received accolades for exceptional work and those involved in research be they staff or service users and carers. GMMH appear to be working towards improving things for their staff. Some roles – e.g. frontline clinical roles – can be very challenging and stressful for the staff, especially given the nature of the work.

In contrast though, we have noted that according to comparison of national staff survey results for GMMH, the Trust scored less favourably in lower reporting of staff receiving directorate feedback from patients/service users, and lower reporting from staff on how such feedback is used to make informed decisions. This surprises us and contrasts with what we have come to understand as the importance of user/patient engagement in the business of the Trust. We look forward to seeing this improved.

Local Healthwatch have received comments about people who access to A&E in crisis. The 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 are offered integrated service experience is timely.

Physical health for service users is paramount and this will only be achieved by close working relationships with GPs. We are heartened to learn of all the initiatives in relation to introducing smoke free cessation support as much effort has gone into this potentially difficult area.

healthwatch Salford

Healthwatch is very concerned about the recent HSIB report on poor levels of satisfaction nationally regarding transition from Children and Young People's Services to adult services and note that this will be a feature of GMMH work in 2019/20. We would hope to work with GMMH in this regard.

We remain concerned about the number of out-of-area placements across the age range. We have heard accounts of the trauma this causes the individuals and their carers. We do acknowledge that there has been a significant reduction, partly as a consequence of GMMH's efforts in this regard, but we do consider that it is an important quality measure that nobody is placed far away from their family and carers and we look forward to this being totally eliminated by 2021.

We have faith that the Trust will continue to support diversity in all its forms to enable easy and welcoming access to those who need it.

We wouldn't ever expect that a Trust could always prevent the death of a patient. However, the number of deaths across the GMMH is concerning. 511 out of 815 were unexpected deaths. This high number cannot be explained by the fact that some could have been the result of an underlining condition. A more detailed description is required, and we note that only 158 investigations have been carried out. The introduction of a structured judgement review tool to monitor unexpected deaths is welcome and we would urge early implementation and, where possible, benchmarking with other Trusts to take place. We feel that the emphasis on this aspect of care in the Quality Account is measured and appropriate.

The Freedom to Speak initiative is also welcomed and should feature in future Quality Accounts as well as the resulting impacts. All Dragons' Den initiatives are worthy of consideration. We have already downloaded 'Health Matters' and would encourage others to do so also!

Local Healthwatch also provide guidance on what people consider areas to be improved. Healthwatch have found that some people think the way that the services communicate with people needs to improve.

Local Healthwatch have received adverse comments about waiting times and there is further evidence of this in feedback from our engagement on the NHS Long Term Plan. Not only are people experiencing problems with waiting times, they also report that there is a lack of any form of contact between assessment and referral which causes much distress for a significant number of people. Nevertheless, we accept that GMMH is meeting national targets for waiting times for its IAPT services which is encouraging.

We welcome the focus through the strategy on broader issues and not just on clinical issues but also looking at contributory factors such as social isolation, housing, long term health conditions and employment.

healthwatch Salford

We thank GMMH for their collaboration with us during this period and look forward to further partnership work to achieve the intensions outlined in this Quality Account.

Yours sincerely,

Delana Lawson
Chief Officer Healthwatch Salford
and on behalf of Healthwatch Trafford, Healthwatch Bolton 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.

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 2019 / 2020.

Councillor Margaret Morris, MBE
Chair of the Health and Social Care Scrutiny Panel
Salford City Council

Health and Adults Scrutiny Panel – Trafford City Council

On behalf of the Trafford Health Scrutiny Committee, I would like to thank GMMH NHS Foundation Trust for their report. The work of the trust is starting to ensure that mental health is becoming a priority within Greater Manchester and is starting to receive the media and official focus that has been lacking for far too long. It is important that a clear and robust infrastructure be in place for assisting individuals with mental health issues and it is clear that GMMH are committed providing that infrastructure at both a local and Greater Manchester level.

The Trafford Health Scrutiny Committee have received updates from GMMH over the course of the year and the Committee looks forward to continuing to develop this relationship in 2019/20 through regular updates on the work of the trust, including any service alterations.

Kind regards,

Cllr Rob Chilton
Chair of Trafford Health Scrutiny Committee

Manchester City Council Health Scrutiny Committee

Councillor John Farrell
Chair of the Health Scrutiny Committee

MANCHESTER CITY COUNCIL

Telephone +44 (0)161 234 3376
Fax +44 (0)161 274 7017
cllr.j.farrell@manchester.gov.uk

Governance and Scrutiny Support Unit
Chief Executive's Department
3rd Floor, Town Hall Extension
Manchester
M60 2LA

28 May 2019

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 2018/19

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 Account for 2018/19. Copies of the draft quality account were circulated to members of the committee for consideration and comments received have been included below. We would like to submit the following commentary to be included within your final published version.

The Committee note that the Welcome statement provided by the Chief Executive sets a tone of directness and transparency in the Quality Account, providing a summary of achievements over the previous year, and we were pleased to note the range of initiatives that have been implemented to support both patient and staff experience. The key quality priorities for the coming 2019/20 period referred to are described in detail within Part 4 of the report, and we support that these had been agreed following consultation with a range of stakeholders, staff, service users and carers.

The Committee fully support the priorities the Trust has identified for the coming year. In particular, we endorse the work to eliminate out of area placements across GMMH, an issue that has been raised as a concern by this Committee previously. We welcome the continued improved integration of effective links between community services to ensure patients have easier access to sources of appropriate support and we further welcome the reported progress being made to improve transition planning, patient and carer involvement and the experience of, and outcomes for those patients moving from inpatient CAMHS services to adult services.

The report clearly describes to the reader how the Trust is performing against national standards and a useful narrative is provided to assist the reader. Part 3 of the report clearly describes the progress and delivery of the actions identified for the previous year. The Committee further commented that the inclusion of a glossary of terms that had been provided within the report is useful to assist the lay reader to understand the document.

The inclusion of identified actions for 2019/20 across a range of activities, including responding to findings arising from the staff survey, patient survey and the Friends and

Family Test that are clearly described throughout the report are useful as this will allow for chronological and organisational comparisons to be made in future Quality Accounts.

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 the domain of Well Led, and we welcome the information provided that describes the actions identified to ensure that accurate, complete and timely information is collated across the organisation to ensure the safe delivery of care for all patients. The Committee further welcome the inclusion of the many positive comments received from service users regarding their experience of the care they had received.

The Committee welcomes the reported broader success of the Trust, noting the substantial achievements of both individual staff members and teams that has been recognised both locally and nationally. We also acknowledge the significant contribution the Research and Innovation Service is making to clinical research and we were pleased to note that the audit of 2018/19 research showed a 72% involvement of service users and that there is a stated commitment to service user involvement in the work of the research unit.

The Committee welcomes 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 a complex organisation that serves and responds effectively to service users, patients, their carers and families in an efficient and compassionate manner.

The Committee would like to take this opportunity to express our gratitude and appreciation to all staff at the Trust for their continued hard work and dedication to improving the health outcomes of Manchester residents.

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 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority 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; and
- 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 2018/19* ('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 Guidance.

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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 22 and 24 May 2019;
- feedback from governors, dated 6 February 2019;
- feedback from local Healthwatch organisations, dated 28 May 2019;
- feedback from Overview and Scrutiny Committee, dated 24 and 28 May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 May 2018;
- The latest National Patient Survey published November 2018;

- the 2018 national staff survey, dated March 2019;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated March 2019; 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the 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.

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 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have 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

28 May 2019

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 2018/19 and supporting guidance

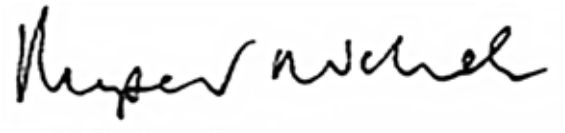
The content of the Quality Report so that it is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2018 to March 2019
- Papers relating to quality reported to the board over the period April 2018 to March 2019
- Feedback from Manchester Health and Care Commissioning dated 24th May 2019
- Feedback from Bolton, Salford and Trafford Clinical Commissioning Groups (CCG's) dated 22nd May 2019
- Feedback from governors dated 6th February 2019
- Feedback from local Healthwatch organisations dated 28th May 2019
- Feedback from Manchester Health Scrutiny Committee dated 28th May 2019
- Feedback from Salford City Council Health and Social Care Scrutiny Panel dated 24th May 2019
- Feedback from Trafford Council Health Scrutiny Committee dated 24th May 2019
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31st May 2018
- The 2018 National Patient Survey published November 2018
- The 2018 National Staff Survey published March 2019
- The Head of Internal Audit's annual opinion of the Trust's control environment provided in April 2019

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
The performance information reported in the Quality Report is reliable and accurate
There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
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
28 May 2019

Neil Thwaite
Chief Executive
28 May 2019

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:**		***Please see comments below***
	Age	NO	N/A
	Disability	NO	N/A
	Gender Re-assignment	NO	N/A
	Marriage and Civil Partnership	NO	N/A
	Pregnancy and Maternity	NO	N/A
	Race	NO	N/A
	Religion or Belief	NO	N/A
	Sex	NO	N/A
	Sexual Orientation	NO	N/A
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?**	NO	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 2018/19**

TRUST CLINICAL AUDITS	
	CQUINS/LOCAL QUALITY IMPROVEMENT REQUIREMENT
1	Collaboration with Primary Care Clinicians
2	CPA Risk Assessment/Risk Management Plans
3	Audit of Physical Health - Diabetes
4	Audit of Employment and Wellbeing
	PATIENT EXPERIENCE/SAFETY AUDITS, HEALTH AND SAFETY AUDITS
5	Annual Ligature Audit
6	Audit of Care Planning
7	Thematic Review – Audit of RCA Reviews following a Serious Untoward Incident
8	Improving Dementia Care: Memory Assessment and Treatment Service Team audit of case notes for carers views
9	Improving Dementia Care MATS Patient care and Experience
10	Audit of Antipsychotic Prescribing for People with Dementia at Point of Discharge
11	Infection Prevention Hand Hygiene Audit
12	Infection Prevention Annual Audit
13	Audit of under 18's admitted to Adult Wards
14	Safeguarding Children Audit
15	Safeguarding Adults Audit
16	Accuracy of Service User Data
17	Handover Audit
	MENTAL CAPACITY/MENTAL HEALTH ACT AUDITS
18	Mental Capacity Act Awareness
19	Consent to Treatment
20	Patient's Rights
	MEDICINES MANAGEMENT AUDITS
21	Antibiotic Prescribing
22	Prescribing Valproate
23	Medicines Handling (Duthie Audit)
24	Prescription Card Audit

DIVISION SPECIFIC AUDITS	
	MULTI-SITE
25	Manchester, Salford and Trafford - Compliance and escalation of NEWS and MEWS scores on inpatient psychiatry wards by Dr Adam Moreton ST5, Dr Griffin FY1, Dr Irogeme Specialty Dr, Dr Harris Trainer FY1, Dr Rachael Dunn GPVTS2, Dr Louise Harrison FY1 and Dr Rifat Rashid.
	BOLTON
26	Smoking Cessation advice on admission by Dr Nafisa Darod
27	Treatment of BPSD by Dr Umar Patel and Dr Alice Shelton
28	Review of Medical Seclusion Reviews by Dr Reshmi Nijjar and Dr Asif Mir
29	Are appropriate documents available in LD psychiatry clinic by Dr Gupta, K Beerman and E Riley
30	Offering Psychological Interventions to Adults with Psychosis and Schizophrenia in CMHT by Dr J Nazimek
31	Dementia Diagnosis in Acute Inpatients by Catherine Symonds
32	An Evaluation of Depression in Later Life Training with Clinical Members by Dr K Dykes and M Mawson
33	Protocol for Rapid Tranquillisation (Bolton Patients) by Bijo Jose and Dr Alice Seabourne
	SALFORD
34	Recognition of childhood Trauma and Management of PTSD in Early Detection and Intervention Team by Dr Alison Yung
35	Audit on High Dose Antipsychotic Medication at Braeburn House by Dr Neeti Singh and Dr Sunita Amarjeet Patil
36	Review of ACE-III screening measure in Salford Older Adult CMHT 1 April 2017-31 March 2018 by Dr Lee Harkness
37	Anticholinergic burden in patients admitted at Woodlands Hospital in the period of 14-18 May 2018 by Shumaila Hasmi CT1 and Dr Benjamin Shaw
38	Prescribing Valproate to Women of Child Bearing Age in CMHT by Dr Aaron Low
39	Audit to review 5 (2) section outcome by Dr Saba Nazir
40	Safe use of atypical antipsychotic medications by Dr Riz Ahmed, Dr Rabeena Lepcha and Dr Caroline Martin
41	Review of Quality of Mental Health Act Section Papers by Dr Ashokkumar Shishodia
42	Psychiatric Old Age Diabetes Audit by Dr Subhanna Chaudhry
43	An Audit into Prescribing Practices Using FP10's at Ramsgate House by Dr Jennie Lau
44	Establish why Physical Health Examinations are being completed but not recorded in PARIS or not done at all by Dr Khalid Kareem and Dr Anthony Baynham

	MANCHESTER
45	Women's Wellbeing - women who are admitted to mental health wards offered contraceptive counselling by Dr Golawska, Dr Ramita Udupa, Dr Hayley Foster and Dr Mirza Beg
46	Audit of practice of 15 Democratic Therapeutic Community against Royal College of Psychiatry Community of Communities Core Standards regarding reviewing, setting and maintaining community rules and boundaries by Dr Adam Dierckx and Elizabeth Hudson
47	Clinical Audit on Initial Assessment for Psychiatric Assessments by Dr Judy Harrison, Dr Hina Rehman and Dr Mary Jane Dodd
48	CMHT Out-Patient Department Clinical Letters Audit by Dr Sesan Ajayi , Ruth Young and Andrew Hill
49	Audit of clinical supervision for Occupational Therapy Staff in MAN Services by Jane Lee
50	To assess the quality of antipsychotic prescribing for the mental health treatment of later life patients in hospital by Dr Ross Dunne and Natalie Kaklugin -
51	Documentation of physical health screening for new adult psychiatry outpatients who are prescribed antipsychotics or mood stabilisers by Dr Aaron McMeekin and Dr Eleanor Swift
52	Central East MAN Home Treatment Team compliance with multi-disciplinary team meeting documentation guidance by Dr Amanda Poynton, Dr Omair Husain and Dr Madhumanti Mitra
53	Compassionate Healthcare for Excellence in Nursing – CHEN by Graeme Donald, Ian Wilson, Jodie McCarthy and Trish Dwyer
54	Appropriateness of physical assessment of service users on SAFIRE unit, Park House by Dr. Saika Rahuja and Dr Kofi Antwi
55	Are we adhering to the local policy on DNAs in psychotherapy appointments? By Dr Adam Dierckx, Consultant Psychiatrist and Dr Paul Culatto - ST5
56	Use of ECGs in informing decision-making for treatment in later-life Psychiatry by Dr Mahesh Gopakumar
57	Prescribing Sodium Valproate to Women of Childbearing Age - an audit at GMMH by Dr Sarah Jones and Dr Ipshita Mukherjee
58	Prescribing Sodium Valproate to Women of Childbearing Age - Community Audit by Dr Angelika Wieck and Dr Ipshita Mukherjee - ST6
59	Exploring how health care professionals inform their hospitalized service users about medication for mental health problems in Greater Manchester Mental Health NHS Foundation Trust by Chaamili Prahalathan, Undergradaute, Dr Richard Keers and Joanne Nguyen
60	An Evaluation of the Physical Health Monitoring received by Inpatients Prescribed Antipsychotics in a Mental Health Trust by Louise Anderson, Final year Pharmacy Student, Dr Richard Keers and Joanne Nguyen
61	Audit of physical health monitoring for patients on clozapine in a catchment area of the South Mersey CMHT by Dr Regine Blattner, Consultant Psychiatrist and Dr Amy Squire, ST4 Psychiatry
62	Monitoring of cardio metabolic health in patients with severe and enduring mental illness by Dr Richard Jones, Dr Tahzid Ahsan , ST6 doctor and Dr Muqathas Javed, LAS Doctor

63	Re- audit of the availability and suitability of equipment for physical health assessment in an inpatient mental health unit B by Dr R Jones, Clinical Director, Dr Kathleen Serracino-Inglott and Dr Emmalene Fish
64	Review of attendance and management of DNAs at psychotherapy assessment appointments in Gaskell House by Dr Rosie Clarke, Dr Laura Nagle and Dr Emmalene Fish
65	Trainees access to adequate and appropriate office space in post by Dr Rosie Clarke, Dr Laura Nagle and Dr. Elena Nam
66	ECG in Memory Assessment by Lucy Smith FY2 and Dr Joy Ratcliffe, Consultant Psychiatrist
67	Assessment of physical observations prescription in newly admitted patients and their subsequent re-evaluation by Dr Hamid Zamani, Consultant Psychiatrist and Dr William Harris, FY1
68	Audit of the Use of Benzodiazepines and Z- drugs as Hypnotics (Insomnia) on Mulberry Ward by Dr Parishkrit Pandec and Dr T Mukherjee
69	Valproate in Women of Childbearing Age by Dr Hamid Zamani, Consultant Psychiatrist, Dr Anupam Verma, Consultant Psychiatrist, and Dr Muhammad Nasr
70	Psychotropic Medication in Adults who have a learning disability by Dr Steven Rowe
71	Re-audit of Medical equipment present on the ward vs the recommended equipment detailed by RCPsych by Dr Ashley Cooper, Dr Jemma Martin Supervisor: Dr Rajesh Dasi
72	Audit of physical health monitoring for patients on clozapine in a catchment area of the South Mersey CMHT by Dr Julie Jones and Dr Jennie Massie
73	The Park House Inpatient Pathway A Service Evaluation by Dr Richard Jones, Dr Brian Sweeney and Dr Neil Crossley
74	VTE Risk Assessment on an Acute Mental Health Ward by Dr Laura Bladon and Dr Rajesh Dasi
75	An Audit Of Physical Health Monitoring In Patients With Serious Mental Illness Prescribed Antipsychotics At Tesito House by Dr Shahzada Nawaz,
76	Central East Manchester Home Based Treatment Team Compliance with Multi-disciplinary Team meeting Documentation Guidance by Dr A Poynton, Dr Hussain and Dr M Mitra
77	Re-audit to assess the technical aspects of our blood test procedure by Dr Thomas Green and Dr C Moffat
78	Evaluating the prioritization of limited pharmacy team resource for pharmaceutical care provision to inpatients at GMMH by Man Lo and Ruby Lawson, Supervised by Dr Richard Keers
79	Re-Audit to assess the technical aspects of our blood test procedure Central Manchester Home Based Treatment Team: by Dr Thomas Green and Dr Claire Moffat
80	Medical equipment present at Park House vs the recommended equipment detailed by RCPsych – Re-Audit, Dr Rajesh Dasi, Dr Ashley Cooper, Dr Patwardhan (Service Evaluation Completed: January 2019)
81	Adherence to the Shared Care Protocol for the Initiation and Monitoring or Oral Atypical Antipsychotics in Home Based Treatment Team by Dr Wakil Ahmed and Dr Mirian Gent

	TRAFFORD
82	A study to examine current clinical performance of Step 4 care, against the Clinical Standards for Practice set out by Trafford Psychological Therapies Service by Luke Beardmore, Dr Hazel Bennett and Dr Kate Thomason
83	An Audit of Record Keeping for a Group Intervention within a North West IAPT Service by Rebecca Knight
84	Quality of Doctors Handover, Moorside unit, Audit and Re-Audit by Dr Cherry Lewin, Consultant Psychiatrist and Dr Francesca Latham, ST1.
85	The availability and suitability of content of emergency trolleys by Dr J Srivastava, Consultant Psychiatrist and Dr Aalia Bhatti, CT1
86	How and When to FP10 in a Home Based Treatment Team by Dr Pashyca Gill, Dr Emily Melling, Supervisor: Dr Sally Wheeler
87	Audit of patients medical review within 7 days of admission to the HBTT by Dr Emily Melling, Dr Pashyca Gill and Dr Sally Wheeler
88	A local clinical re-audit on 'Driver and Vehicle Licensing Agency (DVLA) guidance within the patient population of the Trafford Home Based Treatment Team' by Dr Wheeler, Dr E Slorach, CT3 and Dr L Black, FY2.
SPECIALIST NETWORK SERVICES	
	Adult Forensic Services
89	Quality of referrals received at AFS by Dr Pushpinder Sidhu
90	Lithium monitoring in GMMH medium & low secure services by Dr Mukta Bahuguna and Dr Scott Broadhurst
91	Prescribing of sodium valproate prescribing in women of child bearing age within AFS by Dr William Davis
92	VIT D supplementation in WOMEN'S Medium Secure Forensic service by Dr Cathy Gregory
93	Prescribing practices for long acting injectable antipsychotics by Dr Oliver Shorthouse
94	Audit of the understanding of mental health medical professionals of the Mental Health Act Code of Practice, as it applies to Mental Health Review Tribunals and Managers' Hearings by Dr Suhanthini Farrell
95	Response times for referrals to AFS by Dr Andrew Porter
96	Assess Specific Operational Practices and Correspondence between AFS and MAPPA by Dr Hany El-Metaal, Dr Ayesha Ali and Ellen Mae Coomber.
	Criminal Justice
97	An audit into the current practice of adult ADHD diagnosis and management within the HMP Risley Population by Dr Lucy Shaw, Dr Sandeep Mathews and Dr Andrew Fulton
	Child and Adolescent Mental Health Services
98	Rapid tranquilisation in Young people's directorate by Dr Adil Amin and Dr Shermin Imran
99	Melatonin prescribing Audit by Dr Ayesha Siraj
100	Audit of the transfer of information during inter hospital transfers to acute care by Dr Oliver Wilkinson and Dr Shermin Imran
101	Consent to Treatment by Dr Miriam Gent
102	CPA meetings on J17 - do they comply with standards? By Emma Williams, Bridie Gallagher and Fiona Varney

	Mental Health & Deafness (John Denmark Unit
103	Accessible reference material for medication in a MH & Deafness service by Dr Faye Strange
	Substance Misuse Services
104	Use of Antipsychotics in patients who died within Unity SMS by Dr Patrick Horgan, Dr M Nasr and Dr A Muller
105	Discover Opiate Prescribing Audit by Dr Jonathan Dewhurst and Dr Rebecca Lee
106	Re-admissions to Chapman Barker Unit by Dr Patrick Horgan
107	Prescribing for Substance Misuse: Alcohol Detoxification by Dr C Daly, Dr S F Badshah (ST6), and Dr A Abbas (ST6)
108	Audit of Management of withdrawal seizures on the CBU by Dr Alfred Cheung, Dr Ali Abbas and Dr Oliver Shorthouse
109	Assessment lung health in clients in Carlisle by Dr Patrick Horgan and Dr Ian Pritchard
110	Pulse oximetry in substance misuse in Carlisle by Dr Patrick Horgan and Dr Ian Pritchard
111	Offering BBV testing to new service users at St Wilf's Preston, Central Lancs Drug and Alcohol Recovery by Dr David Butterworth
112	Audit on the use of SROM for patients with opioid dependence at Bolton Achieve by Dr Jason Ip, and Dr Nazia Ahmad
113	Discover Drug and Alcohol Recovery Service Naloxone Interventions Audit by Anna Ashworth
114	Audit of current compliance with escalation policies for the MEWS-2 to GMMH, current compliance by Dr Ash Sishodia

ANNEX 6 – **Glossary of Terms**

A&E	Accident and Emergency hospital services
AC	Accreditation Committee
ACE 111	The Addenbrooke's Cognitive Examination are neuropsychological tests used to identify cognitive impairment in conditions such as dementia
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
BSL	British Sign Language
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
CG	Clinical Guideline
CMHT	Community Mental Health Team
CPA	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
GDPR	General Data Protection Regulation
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
MHSDS	Mental Health Services Data Set
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
NCSCT	National Centre for Smoking Cessation and Training
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
QIC	Quality Improvement Committee (formerly Quality Governance Committee)
QIP's	Quality Improvement Priorities
QPR	Questionnaire about Process of Recovery
R&D	Research and Development
R&I	Research and Innovation
RAG	Red Amber Green
RCA	Root Cause Analysis investigation
SQI	The Sustainability and Quality Improvement Group
STORM	Skills based suicide prevention training in risk assessment and safety planning for frontline staff

Contact us

For further details about the information contained in this Quality Account, please contact:

Patrick Cahoon
Head of Quality Improvement

Greater Manchester Mental Health NHS Foundation Trust
The Knowsley Building
Bury New Road
Prestwich
Manchester
M25 3BL

Telephone: 0161 357 1793
E-mail: patrick.cahoon@gmmh.nhs.uk