Cumbria Partnership NHS Foundation Trust

Annual Report and Accounts
2017/18

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Annual Report, Quality Report and Supplementary Material 2017/18

Contents

Chair and Chief Executive Welcome

It's been a year of much change within Cumbria Partnership NHS Foundation Trust and for both of us, this is our first year of writing the introduction to the annual report. This year, we have made some great progress towards integrating health and care services locally to continue our journey towards our vision for happier, healthier and more hopeful communities.

We have passed some key milestones in achieving this, particularly within our community care group. We have worked with our partners and our communities to develop alternative health and care models where inpatient beds are closing, developed comprehensive plans to integrate services in our eight integrated care communities in North Cumbria, and on the 1 April 2018 our community services in South Cumbria transferred to University Hospitals of Morecambe Bay NHS Foundation Trust. This has unlocked the potential for further integration to happen at a local level to join up services for patients.

These are all really big pieces of work and it's not always been easy, but everyone has been focussed on the fact that we are doing this for our patients.

In the north of the County we have been bringing together the work of our Trust with that of North Cumbria University Hospitals NHS Trust, and Stephen's appointment as Chief Executive across both organisations has been instrumental in doing this. We now have a joint executive leadership team across both organisations which has brought considerable savings, reduced duplication and enabled us to join up our plans, which has inevitably seen a number of changes in executive leadership. During March 2018, we also appointed our first new joint Non-Executive Director and held our first joint board meeting in April 2018.

We are very grateful to the magnificent contribution from all of our executive and non executive directors over the course of the year, and to our Governors Council who have quite rightly held us to account during some of these key changes.

Next year we will be addressing the future of some of our countywide services and in particular mental health, child and adolescent mental health, and learning disability services and we appreciate that some of the uncertainty is difficult for our staff and communities. It's important that there is an increasing focus on working together, or co-production, to agree what is in the best interest of our patients and staff and that means that unfortunately, we can't provide absolute certainty for the future. Once thing is clear, whatever we do, it must be better for our patients and must be able to be delivered locally into Cumbria wherever possible.

Although a year of much change, our dedicated staff continue to provide excellent care to our patients day in day out. This year, we have experienced some of the worst widespread

snow for some time, with our staff across the Trust showing our resilient community spirit to reach patients and keep our services going. We also experienced our first cyberattack and our e-health team worked round the clock to minimise the impact on our patients.

Next year, we plan to bring you more progress towards building our integrated health and care system together, using our collective capabilities for a healthier and happier population.

Professor Robin Talbot
Chair
24 May 2018

Stephen Eames
Chief Executive
24 May 2018

Performance Report

Overview

The purpose of the Overview is to give the user a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Throughout the year the Trust has continued to work closely with its partners as we move towards a plan for the health and care systems in West, North and East Cumbria, and South Cumbria and North Lancashire, in line with the national drivers for more integrated care and organisations collaborating more strongly to achieve this.

Since September 2017, the Trust shares a Chief Executive, and a joint Executive Director leadership team with North Cumbria University Hospitals Trust (NCUHT). These changes reflect and demonstrate the Trust's commitment in moving toward an Integrated Health and Care System (IHCS), but do not diminish the Trust's responsibilities and accountabilities as a NHS Foundation Trust.

Thoughout the year the Trust has maintained its placement in segment 2 of NHS Improvements Single Oversight Framework. The financial climate continued to be challenging during 2017/18. The need to maintain safe staffing levels combined with recruitment difficulties has led to the continuing need for high cost agency staff.

The Annual Staff Survey showed positive improvement for the Trust, many of the scores were above the sector average and in the top 20% of all trusts surveyed, with just a few question scores that are in the bottom 20% of similar trusts. At a local level, compared to last year, there is only one question that has significantly declined and that is staff satisfaction with pay.

In Autumn 2017 the Care Quality Commission (CQC) carried out an inspection on six of our core services. Overall the Trust was rated as Requires Improvement.

We, along with our partners in the Cumbria health and social care system, continue to face significant challenges in the ability to recruit people into Cumbria with the right skills and experience to fill vacancies in our specialist roles. We continue to work together with our local partners and with leaders in the regional major transformation programmes to find workable solutions to this challenging problem.

The Organisation

Cumbria Partnership NHS Foundation Trust provides over 60 community and mental health services to a population of half a million people. We employ around 4000 staff and, every year, a fifth of the population use our services. We have been a Foundation Trust since 2007. This means that we are part of the NHS but have a significant amount of freedom in the way we deliver our services. Decision-making is done at a local level, which

means we can be more responsive to the needs of the people of Cumbria. We have members and governors who are local people that input into how we shape our services.

We have a longstanding history of working in partnership and we participate as a formal partner with other statutory services on issues of resilience (civil contingency planning), safeguarding, and in the provision of services to children and other groups with specific health needs such as people with mental health problems or learning disabilities. You can find out more about the Trust, its services and how to contact us on the Trust's website: www.cumbriapartnership.nhs.uk.

During 2018/19 the Trust will be increasingly integrating governance arrangements with NCUHT. This includes the establishment of integrated support services and wherever practical and appropriate, holding joint meetings, including Board-level meetings. It is anticipated these arrangements will lead to more efficient working and enable both Trusts to make best use of their resources, whilst also recognising the statutory duties of both Trusts as separate legal entities.

Our Trust exists to ensure people in Cumbria have Happier, Healthier and more Hopeful lives. We are working to achieve this vision by delivering quality and best value for our patients. Our four strategic goals define how we will do this:

- Consistently delivering the **highest possible quality of service** we can achieve
- Realising the **full potential** of everyone we work with and the **talent of all our staff**
- **Transforming our services** to improve them for the people we serve
- Being relentlessly **efficient and effective** to ensure we are financially sustainable

Our core values, as follows, underpin how we work and what we expect from everyone who works for us and in partnership with us.

Kindness
We always remember we are here for our patients

Ambition
We never stop improving

Fairness
We strive to bring about social equity

Spirit
We are energetic and determined

Our business model is to provide the above services within block contracts, working in partnership with providers in primary and social care. We work with our commissioners to inform and support commissioning strategies and intentions being developed with input from our expert clinicians and stakeholders. In a block contract model, the Trust is paid an agreed fixed sum of money for a broad range of services, as opposed to being paid based

on the level of activity that is undertaken. The Trust is exposed to risks when activity levels exceed the value of block contract payments.

We are determined for our services to be safe, efficient and financially sustainable for the long term, and we are striving towards this with our communities, partners and staff.

Working closely with patients, General Practitioners (GPs) and a wide range of other health and social care agencies across Cumbria, including Adult Social Care and the voluntary sector, we deliver community-based healthcare through 4 Care Groups as follows:

- Children and Families
  - Children's Community Nursing
  - Health Visiting
  - Public Health and Wellbeing Nurses
  - Child and Adolescent Mental Health Services (CAMHS)1
  - Physical health team
  - Children Looked After
  - Community Paediatrics
  - Children's Audiology

- Mental Health

- Community Health
  - Community Nursing (e.g. District Nursing)
  - Community Hospitals
  - Allied health professions such as physiotherapy and podiatry

- Specialist Services
  - Learning Disability
  - Community Dentistry
  - Palliative Care
  - Neurology
  - Diabetes Care
  - Physical Health Psychology
  - Sexual Health
  - Autism
  - Acquired Brain Injury Team

(Reference 1: The Trust's CAMHS services are a specialist tier within wider countywide CAMHS services that are provided by a network of other providers that together work towards a comprehensive model)

Under the new CQC inspection framework, introduced in April 2017, the Trust received inspections to six core services (during September and early October 2017) and an overall Trustwide inspection of the Well Led domain. Overall the Trust was rated Requires Improvement. During their inspection, the CQC received lots of positive feedback from people who use our services and their families, and they highlighted some areas of good

practice within the Trust. In particular the attitude of staff was praised and the Trust received an overall rating of Good for providing caring services with two services being rated as Outstanding for their care provided to patients in Cumbria. Further details about the CQC inspection can be found in our Quality Report.

Other key actions and achievements during 2017/18 include as follows:

- ✓ We have continued to formally develop our close working relationship with NCUHT, including key leadership appointments and integrated roles. For more information please see the Annual Governance Statement.
- ✓ In the South of the county through our role in Bay Health and Care Partners we have worked throughout the year to deliver the integration of community services, with the transfer of community staff from the Trust to University Hospitals Trust Morecambe Bay from 1 April 2018. The aim of this change is to create one system, promoting self-care and disease management and to simplify local health services so people in the future will experience more consistent care.
- ✓ The Strengthening Families Team launched in April 2017 with the aim to deliver a holistic health service to families including parents/carers, children and/or young people, aged pre-birth to 18 and in some instances to age 25, that according to the Cumbria LSCB multi-agency threshold guidance require a statutory intervention. This service was jointly commissioned by Cumbria County Council and Cumbria Clinical Commissioning Group.
- ✓ As part of greater integrated working, the 'Reach Out' delirium service was launched in Carlisle Infirmary, Carlisle and West Cumberland Hospital, Whitehaven. This innovative service developed by Memory & Later Life services in partnership with North Cumbria Health & Care system, aims to prevent and detect delirium earlier, reducing distress and providing effective intervention. Commencing in January 2018, the service has quickly been established and has already been welcomed within the acute hospital setting- with noted impact on reducing length of stay.
- ✓ Following the successful bid for transformational funding from the NHS Diabetes Programme we have launched the Multi Disciplinary Foot service which aims to reduce amputations by improving the timeliness of referrals from primary care for people with diabetic foot disease.
- ✓ We have developed and implemented the North Cumbria Musculoskeletal Service which provides a review, assessment and treatment service for direct referrals from GPs and health professionals with the aim of reducing waiting times for orthopaedic services.
- ✓ In October 2017, the care group launched the Children's Community Learning Disability and Behaviour Support Service which offers support to manage the behaviour of children with learning disabilities, global developmental delay and autism. The service is made up of a team of experienced learning disability nurses, trained specifically to support children and young people who have health needs arising from their learning disability or autism. This is delivered via parent programme or individual support pathways.

- ✓ Our Diabetic Eye Screening service continued improved performance across all metrics and have been recognised both regionally and nationally for their engagement work with the traveller community

Key risks and associated controls

Key risks to the delivery of our objectives and associated controls are set out in our Board Assurance Framework. The key risks are as follows:

- Patients or service users do not receive high quality care because either safety, outcomes or experience are compromised.
- Unable to sustain the cultural change needed to improve the quality of care for all patients and service users.
- High quality and sustainable care is compromised by inability to implement improvement strategies for hard and soft infrastructure (facilities, estate, applications, IT).
- Unable to deliver and sustain senior leadership workforce capability and capacity improvements to deliver modernised and transformed services.
- Inability to balance financial sustainability with maintaining high quality, safe services whilst balancing workforce, quality and financial challenges across multiple Sustainable Transformation Partnership (STP) footprints.
- Inability to maximise partnership working to achieve safe and sustainable system and service transformation, particularly of services delivered countywide, within the community, and across multiple care models due to the complexities and constraints of current regulatory frameworks.
- Failure to influence the shape and delivery of future care models (Integrated Health and Care Systems (IHCSs)).

Significant operational and clinical risks currently affecting the Trust include the following:

- Challenges of recruiting into specialist posts due to a shortage of suitably qualified people either locally or nationally. This has multiple impacts including a reliance on bank and agency staff to cover essential posts and to ensure safe staffing levels. We are not alone in facing these challenges: with our healthcare system partners in Cumbria's major transformation programmes, we continue to work on workforce planning and recruitment strategies to address these.
- Operating within a challenging health and social care environment means that the Trust's inpatient beds have continued to be affected throughout the year by delayed transfers of care. These arise when a patient is medically fit for discharge but their discharge is delayed for a non-medical reason such as availability of a social care placement. The Trust is working closely with health and social care partners to deliver sustainable solutions which ultimately reduce delays.
- The financial climate continued to be challenging during 2017/18. Savings from vacancies and additional non recurrent income offset the fact that saving from system working did not happen as planned. The net deficit for the year was £3.1m, improving to £1.6m due to incentive Sustainability and Tranformational fund income.

- Risks to our data quality have been recognised by the Trust for some time. Issues with our data quality arise in part from operating multiple electronic clinical systems whilst at the same time operating manual reporting systems. This can result in inconsistencies between electronic and paper-based systems. We also have some issues with the quality of the information we record. Details of the steps we are taking to address data quality are provided in the Data Quality section of this report.

Statement on going concern

The Trust delivered its full £5.5m Cost Improvement Programme (CIP) for 2017/18 and achieved a deficit of £3.1m against its 2017/18 £3.2m deficit Control Total. Control Totals are set by NHS Improvement to measure the Trust financial performance and exclude items such as revaluations, impairments, gains/losses on disposal and donations. The Trust has a planned deficit of £2.1m in 2018/19 and this agrees to the 2018/19 NHS Improvement Control Total. The financial plan for 2018/19 is dependent upon whole "system" transformation programmes as well as internal CIP's to achieve the control total. The Board is focussed on the risks within the 2018/19 plan, in particular those relating to the significant system benefits assumed therein. NHS Improvement continues to support the Trust to work closely with local stakeholders and partner organisations to mitigate the system based risks to the plan.

The Trust was in receipt of £0.4m of revenue support loan from the Secretary of State for Health and Social Care during 2017/18. The 2018/19 plan submitted to and accepted by NHS Improvement includes a requirement for an additional revenue loan support. As such, the Directors consider it reasonable to expect cash support to continue and for the Trust to continue to be able to meet its liabilities as they fall due.

After making enquiries, the Directors have adopted a going concern basis in preparing these accounts as they do not intend to apply to the Secretary of State for Health and Social Care for the dissolution of the NHS Foundation Trust without the transfer of services to another entity nor do they believe there is no realistic alternative but to do so.

Performance Analysis

Measuring performance

The Trust measures its performance through a mix of key performance indicators and metrics relating to quality, safety, financial performance, and compliance. Board-level performance reports include metrics relating to compliance against the former Monitor risk assessment framework and current NHS Improvement's Single Oversight Framework, and also metrics that enable the Trust to monitor its quality governance. Performance is monitored and managed through the Performance Group as a sub group of the Trust Management Board and overseen by the Board committee, Finance Investment and Performance Committee.

We measure our performance against our Outcomes Framework, which consists of a balanced scorecard of twenty high level performance indicators framed around four strategic domains: Quality, People, Services and Efficiency (QPSE).

Quality

- Preventing people from dying prematurely as a consequence of suicide
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- Building health resilience in children and young people
- Ensuring patients have timely and appropriate access to services based on need
- Ensuring people have a positive experience of care through better use of feedback and patient involvement

People

- Everyone is focussed on continually improving the services and care we deliver
- Leadership is modelled from the top, is visible and nurtured at all levels
- Everyone feels valued, engaged and confident in their role and in contributing to the Trust's future
- Everyone understands what is required of their role and is supported to identify and access learning, development and qualifications to enable them to deliver now and in the future
- Our working environments, systems and processes are safe and supportive of everyone to maintain their health and well-being
- We work as a team; locally, across the Trust and across the Cumbria health and social care system
- We understand the current workforce and plan for the future based on developing talent and new roles

Services

- Seamless care; by working in primary care communities
- Most appropriate setting of care
- Maximise rehabilitation and recovery to enable people to be as independent as possible
- Proactive care and support for people with long term conditions to optimise their health and wellbeing

Integrated care that addresses both mental and physical health needs holistically

- Efficiency
- Be a going concern by maintaining our liquidity
- Achieve our income and expenditure plans
- Improve levels of efficiency and productivity

The Outcomes Framework has been developed in conjunction with clinical leads and the senior management team. The Outcomes Framework is the tool we use to frame our performance reports and dashboards at Board, service and team level.

We use the following performance indicators within our Board level performance reports

Quality			
6 Weeks referral to diagnostics	First Step - Nos Waiting for 1st Treatment- Step 1	Medication errors causing serious harm	Patient Access: Period between referral and initial assessment (working days/hours): MH CMHT A
A&E Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	First Step - Nos Waiting for 1st Treatment- Step 2	Meeting MRSA objective	Patient Access: Period between referral and initial assessment (working days/hours): MH CMHT OA
Access to healthcare for people with a learning disability	First Step - Nos Waiting for 1st Treatment-Step 3	Number of Never Events	Patient Access: Period between referral and initial assessment (working days/hours): MH LD Children
Children Looked After (CLA) initial health assessment	First Step - Referral Received to First Treatment (Entered Treatment in Period)- 18 weeks	Patient Access: Period between referral and initial assessment (working days/hours): ALIS A& E 2 Hour Response	People followed up within 7 days of discharge
Children Looked After (CLA) over 5 years review health assessment	First Step - Referral Received to First Treatment (Entered Treatment in Period)- 6 weeks	Patient Access: Period between referral and initial assessment (working days/hours): ALIS Acute & Other Wards	Period between referral and initial assessment
Children Looked After (CLA) under 5 years review health assessment	Hand Hygiene Compliance	Patient Access: Period between referral and initial assessment (working days/hours): MH ABI	Reduction in the number of new avoidable pressure ulcers
Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE	Improved access to psychological therapies	Patient Access: Period between referral and initial assessment (working days/hours): MH ALIS 24hr	Referral to treatment for incomplete pathways

approved care package within two weeks of referral.			
Falls resulting in harm within inpatient areas (rate per 1000 bed days)	Individuals who have had a delayed transfer	Patient Access: Period between referral and initial assessment (working days/ hours): MH CAMHS routine	Referral to treatment for non-admitted patients
First Step - Access Target	Individuals who have had a delayed transfer-MH	Patient Access: Period between referral and initial assessment (working days/ hours): MH CAMHS triaged	Serious Untoward Incidents reported to the CCG
First Step – GP Letters sent	Infections identified: Reportable (excludes C.Diff & MRSA)	Patient Access: Period between referral and initial assessment (working days/ hours): MH CAMHS urgent	StEIS Reportable Investigations Completed Within 60 Days
People		**Services**	
Appraisal Compliance (12 months)	Tier 2 training completed in the last 12 months	Admissions to inpatient services had access to crisis teams	Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral
Appraisal Compliance (since February 2016)	Total number of vacancies in process of recruitment for 3 months or more	Bed occupancy (excluding ward leave for MH)- CS	Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral
Average number of days lost per WTE	WTE number of leavers in the month	Bed occupancy (excluding ward leave for MH)- MH	People on CPA who have received a care review in the last 12 months
Sickness rate against total staff	WTE number of starters in the month	Bed occupancy excluding ward	Percent of complaints responded within 35

(WTE)		leave for MH SP	working days
Tier 1 Mandatory training completed in the last 12 months	WTE staff on long term sick	Community Hospitals- Average Length of Stay	Reported medication errors
		Compliments received by the Trust	Units of Dental Activity
		Dataset complete: demographic domain	
Efficiency			
Cumulative achievement of budget	Financial Variance- Month	Financial Variance- YTD	

Performance during 2017/18

NHS Improvement's Single Oversight Framework (SOF) targets

From the 1 October 2016, the Monitor Risk Assessment process was replaced by the NHS Improvement's Single Oversight Framework (SOF). The SOF is designed to enable segmentation of the provider sector to identify where providers may benefit from, or require, improvement support across a range of areas. In November the Trust received notification that it has been placed into Segment 2, which is defined as 'providers offered targeted support'. For more detail on the SOF see section 3.5 of this report. The indicators within the Trusts balanced scorecard and operational performance reports were re-profiled in line with these changes, specifically moving access standards from Quality to Services, and introducing the new financial metrics used by NHS Improvement (NHSI).

Also new in 2016/17 was the Sustainability and Transformation fund (STF) which is designed to support providers in achieving financial balance whilst improving performance. Receipt of the Sustainability and Transformation Fund allocations is contingent on successful achievement of a combination of financial and operational factors with some in year tolerances. The Trust achieved these standards in all quarters of 2017/18.

Throughout the year we have sustained performance or made notable improvement against a number of our performance indicators including;

- ✓ 6 Weeks referral to diagnostics paediatric audiology
- ✓ Referral to treatment for incomplete pathways
- ✓ Patient Access: Period between referral and initial assessment (workingdays/hours) for Adult and Older Adult Mental Health Services
- ✓ Tier 1 Mandatory training completed in the last 12 months
- ✓ Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral
- ✓ Appraisal compliance (12 month)

We have consistently met key performance standards set out within the NHS Improvement Single Oversight Framework, with the exception of the following, where performance has fluctuated across the year:

- ✓ Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral

Performance against this target is closely related to recruitment difficulties. Our IAPT Service has developed and implemented a robust recovery plan which has delivered improvements towards the end of the year with full recovery forcecasted by the end of Quarter 1 of 2018/19.

Data quality risks have also impacted on our ability to accurately measure and report on some key performance indicators. Details of how we are addressing issues relating to data quality can be found in the Data Quality section of this report.

We have informed our Regulators of our progress against their performance frameworks throughout the year, and have provided them with details of our improvement plans and trajectories for compliance.

Internally improvement plans are managed through the Performance Group as a sub group of the Trust Management Group, and are closely monitored at Board level through the Finance Investment and Performance Committee. Details of our performance against the key performance indicators can be found in the Quality section of this report.

Workforce performance

Recruitment and the use of temporary staff

The Trust has continued to drive efficiencies in the recruitment process to reduce timescales for recruitment and compare favourably to the national benchmarking data available.

We, along with our partners in the Cumbria health and social care system, continue to face significant challenges in the ability to recruit people into Cumbria with the right skills and experience to fill vacancies in our specialist roles. We continue to work together with our local partners and with leaders in the regional major transformation programmes to find workable solutions to this challenging problem.

Examples of initiatives in the last year include:

- Attendance at various national recruitment fayres with partners including attendance the British Medical Journal (BMJ) careers fayre
- Local recruitment events
- Use of social media to promote specialist vacancies
- International recruitment for clinical posts

The Trust has actively sought to recruit into vacant posts during the year, but where vacancies exist we ensure safe staffing levels by first looking to use bank staff, before approaching a recruitment agency. During the year the Trust have worked closely with a neutral vendor to minimise agency spend. As at 31 March 2018, our spend on agency was above the ceiling spend set by NHSI. There has been an overall increase in agency usage in the last year particularly, although non-clinical usage as significantly reduced. There continues to be a reliance of agency workers particularly medical and nursing workers.

Sickness absence

Sickness absence is monitored through the Trust Management Group and is routinely reported at Board level. The Trust's sickness absence level has been above our internal stretch target level of 4% throughout the year. Sickness absence rate is consistently higher in clinical roles than in non-clinical roles; whilst long term sickness absence accounts for the majority of the overall days lost through sickness. Anxiety/stress/ depression or other psychiatric illness is the top reason for sickness absence.

Staff survey

We know that when staff are happy and engaged in their work they provide the best care; we would like all our staff to have the best experience of working within the Trust and we are committed to listening to staff feedback to understand where we can make improvements.

The NHS Staff Survey is an annual survey that asks staff a number of questions that relate to nine key themes which impact on their experience of work. Of 32 key findings 13 have improved and none have deteriorated.

The results from the 2017 National NHS Staff Survey show that our staff engagement score (3.84) and staff recommending the Trust as a place to work or receive treatment (3.78) is better than average when compared to trusts of a similar type.

The Trust continues to implement the People and Organisational Development strategic plan to support improvements in the culture within the organisation. Last year a focus on appraisal meant that all staff were encouraged to have a meaningful appraisal conversation with their manager and managers were offered training in coaching conversations and objective setting. The 2017 NHS staff survey results indicate an improvement in both appraisal compliance and quality of appraisal.

Staff health and wellbeing is also a priority. The Trust is working towards a bronze health and wellbeing at work award and has trained 23 health champions, from a range of professions, to promote healthy workplaces. The Trusts first health needs assessment identified mental health as being the top concern for staff and a series of campaigns have been undertaken to promote staff wellbeing and all staff have access to personal resilience and mindfulness based intervention programmes.

Some results in the survey show no statistical change yet are below average whent compared to similar trusts.

Results from the 2017 National NHS Staff Survey are included here for the key findings of:

- KF24. (% reporting most recent experience of violence)
- KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- KF15. % satisfied with the opportunities for flexible working patterns

KF24. % staff / colleagues reporting most recent experience of violence

		Trust improvement /deterioration
2017	78%	Statistically no change
2016	83%	

Whilst the percentage of staff reporting incidents of harassment, bullying or abuse from staff through the survey has improved overall reporting of violence has remained unchanged. The Trust has an active Freedom to Speak up Guardian and staff are encouraged to raise concerns and report any incidents they see.

KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

		Trust improvement /deterioration
2017	3.72	Statistically no change
2016	3.65	

The Trust continues to implement its values of kindness, fairness, spirit and ambition but there is room for improvement in staff perceived fairness and effectiveness of incident reporting.

KF15. % satisfied with the opportunities for flexible working patterns

		Trust improvement /deterioration
2017	56	Statistically no change
2016	53	

This key finding remains low and is reflected in other forms of staff feedback including the quarterly staff pulse check and exit interviews. In 2018-19 work will be done to understand the issues behind flexible working.

In 2018/19 we will continue to deliver on our programme of activity to support the People and OD plan, working more closely with our partners in NCUHT. Key pieces of work planned are:

- Continue to implement our staff the health and wellbeing programme
- 'This is us' face to face staff engagement programme linked to staff appraisal

You can find further details about the staff survey results, and other ways we engage with our staff, in the Staff Report.

Training

Performance against the Trust's mandatory training programmes is managed and monitored by the Board and committees. We set ourselves a target of achieving 80% compliance against our Tier 1 mandatory training which is training that is mandatory for all staff. Compliance against this target is measured and reported upon on a monthly basis. We achieved above the 80% target consistenly month on month with a compaince rate of 86.6% at the end of March 2018.

Appraisals

Our Values based approach to appraisal's and the training offered to support this was launched in 2016 with the aims of:

- All staff to have a meaningful appraisal that is linked to our values and translates the work of the Trust to individual objectives.
- All staff to have a Personal Development Plan (PDP)
- Supporting performance though a coaching culture.

An appraisal window was also introduced in 2016 with the purpose of improving compliance and linking with the business planning cycle. The Trust achieved its target of 80% of staff to have an appraisal within the appraisal window April – September 2017 and the staff survey results demonstrated that the quality of appraisals has also improved.

Delivery of 2017/18 Annual Business Plan

Our 2017/18 Annual Business Plan, which was developed in accordance with NHSI requirements covering a two year contract period, sets out 14 priorities for delivery across 2017/18 and 2018/19. The Board of Directors received quarterly updates on delivery against the plan, at the end of Year 1 of the plan the majority of the business plan objectives are on target. The few that were not were largely as a result of slippages outside of the Trust's direct control, and will continue to be managed throughout year 2 of the plan. Performance against the milestones for year one of the plan is summarised as follows:

Qtr	CH 1	CH 2	CS 2	CS 6	MH 4	SP 5	CG 1	CG 3	EH 6	EF 1	EF 2	QN 2	WF 6	WF 7
1			N S	N										
2			N S	N										
3			N S	N										
4			N S											

See legend for table on next page

RAG Rating:	Achieved	In progress	Some Delays/ Issues	Slippage/Not commenced	Not applicable	Not yet defined

CH – Children and Families	EH – eHealth
CS – Community Services (N-North S-South)	EF – Estates and Facilities
MH – Mental Health	QN – Quality and Nursing
SP – Specialist	WF – Workforce
CG – Corporate Governance	

The detail of Year 2 of the plan has been developed in conjunction with NCUHT as part of the increasingly joint arrangements between both Trusts and recognition that many of our priorities require joint approach.

Financial performance

The financial climate continued to be challenging during 2017/18. Due to continued strong budgetary control, non recurrent income and efficiency savings, the Trust net deficit for the year was £3.1m against a control total of £3.2m. This position improved to £1.6m due to incentive Sustainability and Transformational Funding income, a benefit of achieving the 2017/18 control total set by NHSI.

The financial challenge will continue during 2018/19 and for the foreseeable future. This is common to all health and social care partners. The Trust has accepted NHSI's control total for 2018/19 and plans to incur an income and expenditure deficit of £2.1m.

Achievement of this plan and delivery of sustainable services in the long term will be challenging and will require significant efficiencies from both internal programmes and system wide transformational change.

In recent years the Trust has utilised revenue support loans from the Secretary of State for Health and Social Care to fund its operating deficits. Further such loans will be required until the Trust is able to stabilise its financial position.

A summary of 2017/18 actual and 2018/19 plan is set out below.

£ million	**2017/18 Actual**	**2018/19 Plan**
Income & expenditure		
Income	180.2	156.5
Operating expenditure	176.0	152.3
EBITDA	**4.2**	**4.2**
Depreciation, dividend & interest	(5.7)	(5.7)
Net surplus/(deficit) before exceptional items	**(1.5)**	**(1.5)**
Exceptional items	(0.1)	(0.6)
Net surplus/(deficit)	**(1.6)**	**(2.1)**

£ million	2017/18 Actual	2018/19 Plan
Capital expenditure	4.3	8.9
Closing cash balance	8.1	5.6
Revenue support loan balance	1.8	2.5

Details of our financial performance for 2017/18 are set out in the annual accounts that accompany this Annual Report.

Environmental considerations

The Trust continues to be committed to being an environmentally friendly and socially responsible organisation and recognises that some of our activities can have a significant impact on the environment. We continue to take action to ensure these activities are managed effectively to minimise any impact and to ensure that we comply with, or exceed, relevant statutory requirements.

The Trust has continued to implement measures during 2018/19 to reduce greenhouse gas emissions and drive forward opportunities for cost savings.

Social, community and human rights issues

As a public sector organisation we have to comply with public sector equality duty, which is part of the Equality Act 2010. Our policies, particularly mental health policies and safeguarding policies, reflect social, community and human rights issues, for example Deprivation of Liberty (DOLS), prevention and management of violence and aggression, information governance and safeguarding of vulnerable persons. Our Participation Strategy informs how we will work with community groups on the development and implementation of our services. We also have an equality and diversity policy and procedures for assessing impacts of significant change to our services on all those affected or vulnerable groups. In 2017/18 we have taken steps to ensure we meet the Trust's responsibilities under the Modern Slavery Act 2015, further detail can be found under Voluntary disclosures.

You can find out more about the measures we have taken, and our achievements during the year, in the Directors' Report.

We have systems in place to identify whether any incidents or complaints have occurred relating to human rights, equality, and diversity issues, and for initiating investigations accordingly. Board level reports include information around reported incidents and complaints as part of the QPSE reporting framework.

Significant events since the end of the financial year

There have been no significant events affecting the performance of the Trust since the end of the financial year.

Overseas operations
The Trust does not have any overseas operations.

Signed..... Date: 24 May 2018
Stephen Eames
Chief Executive for CPFT and NCUHT

Accountability Report

This comprises the following reports:

- Directors' Report
- Remuneration Report
- Staff Report
- NHS Foundation Trust Code of Governance – Disclosures
- NHS Improvement – Single Oversight Framework
- Statement of Chief Executive Officer's Accounting Responsibilities
- Annual Governance Statement
- Voluntary Disclosures comprising:
- Equality and Diversity
- Modern Slavery Act 2015

Signed..... Date: 24 May 2018

Stephen Eames
Chief Executive for CPFT and NCUHT

Directors' Report

Directors' Report

As an NHS Foundation Trust, we are required to comply with the arrangements set out by our independent regulator, NHS Improvement (NHSI), in Monitor's NHS Foundation Trust Code of Governance (2010, revised 2014). The Code of Governance requires us to have a comprehensive framework in place to ensure the Trust is managed and governed properly. We strive to comply with the provisions of the Code and will continue to observe the spirit of the Code in everything we do.

The business of the Trust is managed by the Board of Directors (the Board), which exercises all the powers of the Trust subject to any contrary provisions of the National Health Service Act 2006 and Health and Social Care Act 2012. The Board of Directors is responsible for approving the Annual Report and Accounts. In preparing the Annual Plan, they take into account the views of the Governors Council which contains information about the Trust's forward planning.

The Board of Directors gives specific attention to:

- Active monitoring of quality indicators
- Assurance based on evidence
- Contact with frontline services
- Formal consideration of our compliance with NHSI's Well Led Framework and Code of Governance

The Quality Report describes our quality plans in more detail and outlines our achievement of quality over a number of specific areas. You can find out more about our quality governance, the challenges encountered and action taken during 2017/18 in the Annual Governance Statement.

The balance between Executive and Non-Executive Directors on the Board of Directors remains in line with the Code of Governance for NHS Foundation Trusts and with the Trust's Standing Orders. For a short period of time between 22 December 2017 and 5 March 2018, the balance between Executive and Non-Executive Directors was in favour of the Executive Directors in terms of voting rights. Whilst during this time the Board of Directors did not have a requirement to undertake a vote, it continued to make any necessary decisions and operated in line with its Standing Orders.

There were a number of changes to Board membership during the year which can be found in the Remuneration Report. You can find out more about the background and experience of all individual Board members as at 31 March 2018 later in this report.

All NEDs, the Chief Executive and a maximum of six other Executive Directors were able to exercise one full vote in 2017/18. The Chair has a second, casting vote on occasions where decisions are tied.

The Board meets formally in public at least every quarter, and monthly in private. There were no extra-ordinary meetings of the Board were held during the year in addition to scheduled meetings. A summary of decisions made by the Board is provided at each public Board of Directors meeting. The Board is responsible for:

- Exercising powers and the performance of the Trust
- Providing active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed
- Compliance with the NHS Provider Licence issued by NHSI, the sector regulator for health services in England
- Compliance with the Trust's Constitution
- Providing high quality and safe healthcare services, education, training and research
- Implementing effective governance measures
- Ensuring the Trust exercises its functions effectively, efficiently and economically
- Setting the Trust's vision, values and standards of conduct and ensuring that its obligations to its Members, service users and other stakeholders are understood and met
- Setting Trust policy
- Setting strategy for service development and improvement
- Preparing a statement of accounts for each financial year
- Managing performance.

The Board has a schedule of matters reserved for it that is detailed within Trust Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions. This clarifies which type of document requires approval by the Board and which can be approved and executed by executive management, under a delegated authority. The Board may also delegate executive powers to committees or through the Chief Executive to individual officers.

To undertake detailed consideration of specific areas of operation, the Board utilised the following committees throughout the reporting period:

- Audit Committee (re-named to Audit & Risk (A&R) Committee in February 2018)
- Quality and Safety (Q&S) Committee
- Finance Investment and Performance (FIP) Committee
- Charitable Funds Committee
- Remuneration Committee

All NEDs are members of at least one Board level committee. Executive Directors' involvement in Board level committees relates to their particular operational responsibilities.

As a unitary board, all Executive and NEDs have joint responsibility for every decision of the Board and share the same liability. This does not impact upon the particular responsibilities of the Chief Executive as Accountable Officer to Parliament, for ensuring that the Trust operates consistently within national policy and public service values.

All Directors have responsibility for the preparation of the financial statements. The Directors consider whether the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for service users, regulators and stakeholders to assess the Trust's performance, business model and strategy.

With the exception of one NED appointment which is a joint-NED with NCUHT, all NEDs of the Trust are considered to be independent in character and judgement and have no cross directorships or significant links which could materially interfere with the exercise of their independent judgements . Arrangements are in place to manage any potential conflicts associated with the joint NED appointment. The Chair had no other significant commitment during the year and therefore there was no requirement to report on this issue to the Governors Council.

As part of our increasingly collaborative working arrangements with NCUHT in March 2018, following necessary approvals by both Trust Boards, NHSI and our Governors Council, a Non-Executive Director was appointed to the Board of NCUHT and CPFT and functions as a 'joint' NED across both Trusts. You can find out more about our collaborative working with NCUHT in the Annual Governance Statement section of this annual report.

All Directors on the Board and the Lead Governor on the Governors Council are required to meet the 'fit and proper persons' test as described in the NHS Provider Licence issued by NHSI. You can view the updated Register of Board of Director Interests on the Trust website - https://www.cumbriapartnership.nhs.uk/the-trust/board-of-directors.

Table 3.1 shows members of the Board, their roles and attendance at Board and Governors Council general meetings during the year. Regular attendance at meetings of the Governors Council provides the opportunity for members of the Board to gain an understanding of the views of governors and Members. The Board and Governors Council undertake a programme of joint visits to Trust services. This programme enables NEDs and governors to listen to the views of staff and observe service delivery.

The Chair of the Trust is responsible for ensuring that NEDs have the necessary skill set and experience for the Trust. The Chief Executive is responsible for the performance appraisals of Executive Directors. The performance of the Chief Executive and NEDs is reviewed by the Chair, and the performance of the Chair is reviewed by a combination of the NEDs, governors and Executive Directors. The Senior Independent Director leads the Chair process with the arrangements agreed by the Governors Council.

All NED vacancies are managed by the Governors Council Nominations Committee to ensure the Board has the necessary skills and experience required and that the Board is well balanced. The terms of office for both Chair and NEDsis reviewed regularly to ensure succession planning is adequate and effective.

All Executive Director positions, covering issues of recruitment, accountability and performance, are managed by the Chief Executive in line with the Trust's organisational policies.

The current appointment terms of Non-Executive Directors, and the contract start dates of Executive Directors, are also shown in Table 3.1. The appointment of a NED may be terminated in line with guidance issued by our regulator NHSI. You can find out more about the appointments and/or departure and remuneration of Executive Directors in the Remuneration Report. The accounting policies for pensions and other retirement benefits are set out in note 1.8 to the accounts.

Table 3.1 Board of Directors and attendance at Board and Governors Council General meetings 1 April 2017 – 31 March 2018

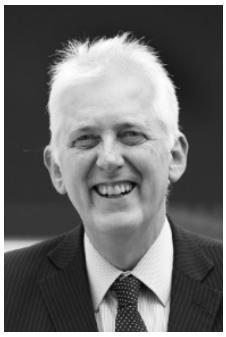
Name	**Attendance – Board of Director meetings (max 10) (actual/potential)**	**Attendance – Governors Council General meetings (max 5) (actual/potential)**
Current Non-Executive Directors		
Robin Talbot PhD, BA, Cert Ed	6/6	3/3
Alan Moore BSc (Hons), CEng, MIMechE, MBA, FAPM	8/10	4/6
Heike Horsburgh MBE, MSc International Development, MSC Human Resource Management, Diploma Community Education, Teaching in the Lifelong Learning Sector, Honorary Fellow: University of Cumbria	8/10	3/6
Brian Hetherington BSc(Hons) MSc MBA(Comm) CEng FIMechE DipIM FCMI MIoD	7/10	3/6
Dr Louise Nelson PhD	1/1	0/0
Current Executive Directors		
Stephen Eames Adv. Dip.in Sen. Exec Coaching, Degree in Prof. Coaching Practice	6/6	2/3

Name	Attendance – Board of Director meetings (max 10) (actual/potential)	Attendance – Governors Council General meetings (max 5) (actual/potential)
Dr Andrew Brittlebank MBBS, MA, FRCPsych	9/10	2/6
Clare Parker RNMH, DipNursing, MSc	9/10	3/6
Michael Smillie BSc (Hons), FCPFA	9/10	3/6
Prof. John Howarth MBBS, DTM&H, FRCGP, FFPH	10/10	0/6
Helen Ray Professional nursing qualifications, Executive MBA	4/4	1/3
Other Non-Executive Directors in post during 2017/18		
Mike Taylor CBE TD DL	3/4	2/3
Jill Stannard BSc, CQSW	6/7	3/5
Jane Fretwell FCCA	6/6	1/5
Helen Bingley - RMN,DMS,GIPM,MIM, MBA,PGDip,MH Law,PGCert in Action Learning	3/4	0/3
Other Executive Directors in post during 2017/18		
Claire Molloy MSc	4/4	2/3
Joanna Forster Adams MBA	2/3	0/1
Lynn Marsland MA, FCIPD	4/7	1/5

Attendance reflects the number of meetings they attended in the year, out of the total number that they could have attended, based on their appointment or departure date.

Director profiles

Non-Executive Directors



Robin Talbot
Chair PhD, BA, Cert Ed
Robin has spent over 26 years working in Higher Education and the NHS across Cumbria and Lancashire. Robin's previous NHS roles include chairing the Doncaster Family Practitioner Committee, the Lancaster and Morecambe Community Health Council, the Lancaster Primary Care Group and the Cumbria and Lancashire Workforce Development Confederation. Until 2004 Robin chaired the Morecambe Bay Primary Care Trust and since has had roles within the NHS including; Governing Body positions at Cumbria Partnership NHS Foundation Trust; and more recently from 2009-16 at Calderstones Partnerships NHS Foundation Trust. In addition, Robin has maintained his special interest in workforce development by Board positions until summer 2017 on the Lancashire and South Cumbria Workforce Action Board and Health Education England (North).

At St Martin's College and the University of Cumbria Robin was Executive Dean with a particular focus on Health, Social Care and Wellbeing. Outside the NHS and Higher Education, Robin is a member of the Lakes College Board at Lillyhall, the Progress Housing Group Board (social housing organisation specialising in rented accommodation for clients with a learning disability), and an Independent Monitoring Board for HM Prisons. He chairs the Health and Education Co-operative (a social enterprise hosting/producing online learning materials for universities and the Health Service).

Heike Horsburgh MBE
Vice Chair/Senior Independent Director
Heike has more than 30 years' experience in third sector and charitable community services and her work for young people has earned her an MBE. She is currently a

consultant to services requiring business and sustainability planning support. Heike received an Honorary Fellowship from the University of Cumbria in 2014. Heike is a member of the Finance, Investment & Performance and A&R Committees, Chair of the Charitable Funds Committee, Trust Vice Chair and Senior Independent Director. Heike's qualifications include; MSc International Development, MSC Human Resource Management, Diploma Community Education.

Alan Moore BSc (Hons) CEng, MIMechE, MBA, FAPM
Non-Executive Director

Alan has extensive experience in the nuclear industry including strategy development, management of complex programmes and major projects, nuclear operations management, commissioning and decommissioning, business change experience and Board Director experience in specialist transport environments. Alan has had a number of roles with the Nuclear Decommissioning Authority including Director of Operations, Head of Operational Performance and overall Portfolio Assurance. Alan is currently Chair of Cumbria County Holdings, and provides support to the Cabinet Office reviewing major projects and Programmes. Alan is Chair of the Finance, Investment & Performance Committee.

Brian Hetherington BSc(Hons) MSc MBA(Comm) CEng FIMechE DipIM FCMI MIoD
Non-Executive Director

Brian has been employed at BAE SYSTEMS, and its predecessor companies in Barrow for over forty-one years, where he is now Head of Capability for the Engineering Function.

In addition to his BAE role, Brian was a Non-Executive Director of the University of Cumbria for six years, Chairman of Cumbria Business Education Consortium for 11 years, Non-Executive Director of Morecambe Bay NHS PCT for four years, Director of Young Enterprise North West and Chairman of Cumbria Young Enterprise for six years, and is

currently a Member of the Common Purpose Advisory Board for Cumbria and sits on the Management Board of the Marine Technology Education Consortium.

Brian has an Honours Degree in Mechanical Engineering, a Masters Degree in Project Management and an MBA in Commercial Management. He is a Chartered Engineer, Fellow of the Institution of Mechanical Engineers, Fellow of the Chartered Management Institute and Member of the Institute of Directors. Brian is Chair of the Audit & Risk Committee and a member of Quality & Safety Committee.

Louise Nelson PhD
Non-Executive Director
Dr Louise Nelson trained as a mental health nurse 33 years ago and over the past 13 years has worked in higher education as a senior lecturer/programme leader for mental health nursing, a principal lecturer and, for the past two years, as head of nursing with the University of Cumbria.
Louise is involved in education-focused meetings with all local provider Trusts in Cumbria.

Executive Directors

Stephen Eames
Chief Executive Adv. Dip. in Sen. Exec. Coaching
Public service leader with 25 years' experience as a Chief Executive.
In 2012, Stephen was drafted in to Mid Yorkshire Hospitals where he spent 3 years overseeing major changes and improvements to services. Before this, Stephen was CEO of County Durham and Darlington NHS Foundation Trust where he successfully led a substantial multi-site hospital reconfiguration, secured a major acquisition of community services and ensured sound clinical and financial performance. In 2007 Stephen was awarded public service turnaround leader of the year by the Society of Turnaround

professionals. In 2013 Stephen was awarded 'Turnaround performance of the year' by the Management Consultants Association for his work in Mid Yorkshire.

Stephen has a wealth of experience in top level leadership activities and in partnership working with NHS Institutions, Local Authorities, the private sector and a variety of other agencies. Stephen has worked in a coaching capacity as a consultant for the NHS Performance Support Unit and the Leaders UK programme sponsored by the National School of Government.
Professional Qualifications: Advanced Diploma in Senior Executive Coaching for the Oxford School of Coaching and Mentoring and a Degree in Professional Coaching Practice from Middlesex University.

Dr Andrew Brittlebank MBBS, MA, FRCPsych
Medical Director
Andrew is a Consultant Psychiatrist by background and has worked in this capacity since 1994. He has significant experience of working with dispersed, rural communities and in medical leadership and education; with a passion to improve patient safety and quality and develop greater integrated care.

Professor John Howarth MBBS, DTM&H, FRCGP, FFPH
Deputy Chief Executive
Professor John Howarth is a senior clinician with 35 years experience. He is Deputy Chief Executive of both CPFT and NCUHT. He is also Professor of Primary Care at UCLAN and works clinically in the small Cumbrian town of Millom.
John has had a varied career including clinical director for community services, medical director of Cumbria's GP Out of Hours cooperative, chairing the primary care research group, a GP trainer for over 10 years and medical adviser to the local hospice at home charity. During the 1990s John worked in 13 different conflicts and natural disasters initially

for MSF then becoming medical director and head of operations of Merlin, an international disaster relief charity. He led the health response to the floods in Cockermouth in 2009. He was a runner up in the first national NHS Leadership Awards in 2010 and received a Fellowship in Public Health through distinction in 2011. John is a senior clinical leader in the Integrated Health and Care System in North Cumbria.

Michael Smillie BSc (Hons), FCPFA
Executive Director of Finance CPFT and and Interim Joint Executive for Strategy, IM&T, Estates, Workforce and Organisational Development
Michael joined the Trust in January 2007 and has over 23 years' experience working in the NHS. He has held posts as the Director of Finance, Director of Commissioning and Director of Business Development in both commissioning and provider organisations. Michael lives in Cumbria and leads on financial stewardship and forward planning for the Trust and is working with our partners to improve the health and care system overall. Michael also leads on ensuring the Trust's estate, facilities and information management and technology are all fit for purpose and developed to support clinical care effectively.

Clare Parker RNMH, DipNursing, MSc
Executive Director of Nursing for CPFT & NCUHT
Clare qualified as a Learning Disability Nurse in 1996 and also gained a Masters in Management in 2005. Clare joined Cumbria Partnership NHS Trust in February 2015, initially as Associate Director of Nursing for the Specialist Care Group until her Interim appointment to Director of Quality & Nursing in August 2016. Clare moved up to Cumbria from Greater Manchester, where she was a Governing Body Nurse on a Clinical Commissioning Group (CCG) Board as well as the Head of Mental Health, Learning Disabilities and Children & Families. Clare has a wealth of experience working in both commissioning and provider services.

Helen Ray
Executive Managing Director of Operations for CPFT & NCUHT
Helen has worked for the NHS for 35 years, starting her career as a student nurse in 1983. Her management career started in 2001 when she moved from a senior clinical role in orthopaedics to be an assistant divisional manager. She has held a number of executive positions and has a breadth of experience in operational management that covers clinical and non-clinical services, business development and risk and compliance. Helen has a particular interest in service redesign and continuous improvement and sees operational services management as a key element of support across the organisation. As the executive lead for operational services across North Cumbria she will be focussed on making sure clinical teams have the right tools to deliver services that are safe and sustainable.

As well as her professional nursing qualifications, Helen has an Executive Masters in Business Administration and is active in pursuing new ideas and knowledge which can be applied to service developments.

Annual Reporting Manual and Companies Act disclosures

Cost allocation and charging

As a Public Sector Information Holder and where appropriate in accordance with the Data Protection Act 1998 (Fees and Miscellaneous Provisions) Regulations the Trust levies charges for the provision of information. The charges levied are compliant with the Re-Use of Public Sector Information Regulations 2005.

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

Political or charitable donations

The Trust has not made any political or charitable donations during 2017/18.

Better payment practice code

In July 2015, the Trust renewed its signatory to the Prompt Payment Code. The Prompt Payment Code sets standards for payment practices and best practice and is administered by the Chartered Institute of Credit Management. Compliance with the principles of the

code is monitored and enforced by the Prompt Payment Code Compliance Board. The Code covers prompt payment, as well as wider payment procedures.

As a signatory of the code, the Trust undertakes to pay suppliers on time and in accordance with agreed terms; to give clear guidance to suppliers advising them promptly if there is any reason why an invoice will not be paid to the agreed terms; and to encourage good practice.

During the year, the Trust was not required to pay any interest under the Late Payment of Commercial Debts (Interest) Act 1998.

Quality governance

During the year the Trust has built upon the work described in previous years' annual reports to improve our governance structures and quality governance arrangements. This has included refreshing our meetings structures to allow greater focus on balancing financial sustainability with quality improvements and further developing our quality and safety dashboards so that managers throughout the Trust have access to virtually real-time risk and safety related information which aids effective clinical and quality governance.

Following our self-assessment, and external review by Deloitte, of our quality governance arrangements in 2015/16, which led to Monitor lifting our Enforcement Undertakings in December 2015, the Trust has adopted a three year cycle to undertaking reviews against Monitor's Well-led framework for Governance Reviews. The cycle is as follows:

- Year 1 (2016/17)- a desktop based self-assessment review
- Year 2 (2017/18) - a desktop review plus in-depth review on certain framework elements by internal audit
- Year 3 (2018/19) - an external review by an appropriately qualified external body (procurement rules will apply)

The Trust undertook a self-assessment against the 2015 edition of Monitor's Well Led framework during quarter 4 of 2016/17. The outcome of that self assessment was formally considered and agreed by the Board of Directors during quarter 1 of 2017/18. Delivery of improvement actions has been monitored through relevant governance forums, with board level oversight of many actions through the Quality & Safety Committee and Finance Investment & Performance Committee.

The 2017/18 internal audit programme considered aspects of quality governance such as risk management, board assurance framework, learning from serious incidents, complaints, mandatory training and clinical audit, all of which are intrinsic to the well led framework. Progress with improvement actions identified from audits are monitored by the Audit Committee.

In June 2017 NHSI published an updated edition of the Well Led framework which had been jointly developed with the Care Quality Commission (CQC) and is framed around the Care Quality Commission's key lines of enquiry (KLOE). In response, we updated our tools used as part of our annual assessment of CQC compliance and conducted a self assessment against the new Well Led framework during Quarter 4 of 2017/18. Further details how the Trust has regard for NHSI's Well Led framework can be found in the Annual Governance Statement.

In 2015/16 we developed our Governance Accountability and Assurance Framework (GAAF) in response to the outcome of our self-assessment against Monitor's Well-led framework. The GAAF demonstrates how the Trust's quality systems and organisational learning is overseen and supported by an effective committee structure. The framework also links to NHSI's Well-Led framework. Key areas within the GAAF are:

- Strategy and Objective Setting
- Performance Information flows
- Risk and Issue Management (Operational and Strategic)
- Accountability Processes
- Governance Structures

Throughout 2017/18 the Board received quarterly updates on progress against the 2017/18 annual business plan. The Board also received integrated performance reports on a monthly basis, which compared and analysed information relating workforce, finance and quality.

Throughout the year we have reported compliance against NHSI's Single Oversight Framework, in accordance with NHSI's reporting requirements. Where required, we have supplemented routine reports to NHSI through exception notifications, such as an issue identified during quarter 4 relating to scheduling within one of our electronic patient record systems (EMIS).

You can find out more about our quality governance in the Annual Governance Statement. Details of our performance in relation to key health targets, our financial position, use of resources, achievement of CQUIN (Commissioning for Quality and Innovation) and other locally agreed targets, and progress against our business plan objectives for 2017/8 can be found in the Performance Report. Details of how we are improving information for patients and carers and how we handle complaints, and also how we have responded to patient and staff surveys can be found in the Quality Report.

The Board agreed the 2016/17 annual report, including annual accounts and quality report at its meeting in May 2017. The 2016/17 annual report was submitted to NHSI and laid before Parliament within the required timeframes, and was presented to Members and the general public at our Annual Members Meeting in September 2017.

There are no material inconsistencies between our Annual Governance Statement, the corporate governance statement, the Quality Report and Annual Report, reports arising from CQC planned and responsive reviews and action plans we have developed in response to the CQCs's reports.

In November 2017 the Trust underwent a formal inspection by the CQC under the new Well Led Framework. The report of that inspection was published by the CQC in January 2018. All of the services inspected were assessed as 'Good' for Caring. Overall the Trust was rated as Requiring Improvement. Immediately following the inspection the Trust implemented an improvement plan to respond to the issues raised by the CQC, which included 22 must-do actions and 51 highly recommended actions to improve our quality governance arrangements. One of the must-do actions related to the Well Led key line of enquiry. The Board of Directors receive monthly updates on progress against these actions. In the Quality Report, you can find out more about CQC inspections, details of any new or significantly revised services, and how we have used information from internal and external sources, such as complaints, patient and staff surveys, and inspection reports, to improve our services.

Strategic partnerships

The Trust is a partner in the two major transformation programmes covering the Cumbria geographical footprint: Better Care Together in the south of the county; and the West, East and North Cumbria Integrated Health and Care System (IHCS) in the north of the county and throughout 2017/18 we have worked with our partners on the development of plans for the Cumbria health economy.

In collaboration with our system partners and communities, during 2017/18 plans were developed to redesign services delivered in the community through the introduction of Integrated Care Communities (ICCs). The plans, which were approved by our Commissioners in April 2018, involve removing or reducing the number of overnight beds in some of our community hospitals in order to deliver care in an improved and different way to enable patients to be cared for at home and avoid admission to hospital as much as possible. We have worked closely with Alston, Wigton, and Maryport Alliances on plan development to ensure the communities were fully involved and engaged as much as possible in this service transformation.

As a provider of health services across the whole of Cumbria, we continue to work closely with our commissioners and partners to ensure our county-wide specialist services, such as mental health and children's services, are appropriately represented and involved in service planning across both STPs. During the latter part of Quarter 4 of 2017/18 our commissioners confirmed that countwide services need to be delivered into the IHCSs covering North and South Cumbria from April 2019. During 2018/19 we will be working closely with our commissioners to enable this transition to happen safely and in the best interests of patients and staff.

Through the implementation of our Participation Strategy, which was approved by the Board in February 2016, we will inform, engage, involve and where appropriate, consult with internal and external stakeholders on our service improvement and transformation plans. This includes local groups and third sector organisations, as well as the Local Authority's Health Scrutiny Committee. We will also continue to hear patient and staff stories at our Board of Directors meetings to ensure that the patient voice is at the heart of everything we do.

System-wide care

The Trust is one of the Bay Health and Care Partners – who are delivering the Better Care Together (BCT) strategy across Morecambe Bay. In the past 12 months, we have made progress with:

- Implemented plans that were developed during 2016/17 and 2017/18 for a system-wide health and care service which has involved transferring some of our community-based services operating in the south of Cumbria to University Hospitals Morecambe Bay NHS Foundation Trust. The transfer took place on 1 April 2018.
- Implemented improvements in people's care that crosses traditional boundaries by improving integrated care.
- Created local partnerships to ensure that people have a greater say over their health.

During 2017/18 we have been working increasingly closely with North Cumbria University Hospitals Trust (NCUHT) as part of the developments of the West East North Cumbria IHCS. Following consultations with NHSI, and with the agreement of both Boards and CPFT's Governors Council, Stephen Eames, was appointed as the Trust's Chief Executive in September 2017 meaning the Trust shares its Chief Executive with NCUHT. Most of our Executive Director leadership team, the Company Secretary and one NED also have roles spanning both Trusts. Many of the Trusts support services such as Estates and Facilities, Communications, and IM&T are now delivered to both Trusts as part of a shared service arrangement.

During Quarters 3 and 4, work was undertaken in consultation with NHSI and through close collaboration between both Boards, to introduce aligned corporate governance arrangements across both Trusts. These arrangements took effect in April 2018 and align Board-level meetings in both Trusts which are held at the same time in the same place. Throughout all these changes to Board level leadership and governance, legal advice has been sought to ensure that statutory requirements continue to be met in terms of Accountable Officer responsibilities and requirements of CPFT as a Foundation Trust and NCUHT as an NHS Trust.

During 2018/19 we will introduce shared services for all support services, and where appropriate to do so, align clinical services and pathways across both Trusts.

Integrating care
We are developing Integrated Care Communities – which see the existing primary, community health and care practitioners working together with their local communities as an integrated team to reduce duplication, build healthier communities and offer more care closer to home.

Creating local partnerships
Over the course of the year we have participated in a number of events and community conversations with the population of Morecambe Bay to help ensure that the NHS is aware of local health priorities and can work support them where possible.

West, East and North Cumbria Integrated Health and Care System (IHCS)
We are committed to working collaboratively with our partners and local communities to shape workable solutions to the significant sustainability challenges facing the NHS in Cumbria. As a partner in the IHCS we actively participated in the Healthcare for the Future public consultation during 2016/17 and liaised with stakeholder groups including the Alston, Maryport and Wigton Alliances to develop plans for how consultation outcomes could be implemented. In April 2018 the North Cumbria Clinical Commissioning Group Governing Body agreed those plans and we are now working with our system partners on their implementation.

Disclosure of information to auditors
The Directors who held office at the date of approval of this report confirm that, so far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware.

Each Director has 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 Trust's auditors are aware of that information.

Income disclosure – provision of goods and services for the purposes of the health service in England
During 2017/18, income from the provision of goods and services for the purpose of health services in England was greater than the income from the provision of goods and services for other purposes.

Other income
Other income is 0.46% of total income in 2017/18 (0.65% 2016/17) and as such, has no material impact on the provision of goods and services for the purposes of the health service in England.

During the year the Trust has not generated additional income by levying fees and charges for its services where the full cost of providing those services exceeds £1 million or where the income generated has not been material to the accounts.

Other disclosures
The Trust is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. In line with the Modern Slavery Act 2015, the Trust has published a statement on its website which sets out the actions taken and also where further improvements can be made. Further information can be found later in the report.

Remuneration Report

Section One – Annual statement on remuneration

The Trust has a Remuneration Committee whose purpose is to develop, apply and monitor the policy on Executive terms, conditions and remuneration.

The aim is to ensure that there is a transparent process for determining pay for the Chief Executive and other Executive Directors. The Committee also recommends and monitors the level and structure of remuneration for the first layer of management below Board level, albeit that these roles are remunerated within the terms and conditions for Agenda for Change or the Medical and Dental contract terms and conditions. The remit covers salary (including any performance-related elements/bonuses or additional payments), benefits (e.g. lease cars, pensions) and contracted terms of employment (e.g. service contracts, terminations).

Executive team changes
In September 2017 arrangements were formalised putting in place a Joint Executive Management Team for the Trust and North Cumbria University Hospitals NHS Trust (NCUHT). These joint arrangements will enable the oversight of the next phase of the development of the IHCS in the locality of West, North and East Cumbria (WNEC). Each Trust has unique service delivery challenges and it is the role of the Joint Executive Management Team to ensure that each 'base' is well governed whilst the developing health and care picture in the context of the IHCS model is addressed. All roles are transitional for an initial period of 18 months, until 31 March 2019, unless otherwise stated.

Stephen Eames formally took up the role of Chief Executive across both Trusts on 1 September 2017, a change from his previous role as Chief Executive at NCUHT. Stephen is on secondment from Mid Yorkshire NHS Hospitals Trust. This followed the departure of Clare Molloy who left her role of Chief Executive in September 2017 to take up a role with Pennine Care NHS Foundation Trust.

Professor John Howarth was appointed into a new role as Deputy Chief Executive/Executive Director for Integration, Partnerships and Population Health across both Trusts from 1 September 2017.

For the remainder of the Executive team where appropriate 'single' leadership roles were created operating with a mandate across relevant organisations, however for governance

purposes, some posts were maintained as separate positions in each Trust. Specifically, Board level posts carrying statutory accountabilities. These are Finance, Medical and Nursing Directors.

Clare Parker, Executive Director of Quality and Nursing took on Executive lead for operations in addition to her existing portfolio following the departure Joanna Forster Adams, Executive Director of Operations, at the end of June 2017. Joanna left the Trust to take up a post at Leeds and York Partnership NHS Foundation Trust. From September 2017 this was re-viewed as part of the integrated arrangements with responsibility for North Community Services moving to the Executive Managing Director at NCUHT.

The implementation of the new joint executive structure resulted in a reduction in the overall number of posts. The post of Director of Workforce and OD for CPFT held by Lynn Marsland was removed and as a result Lynn left the Trust in December 2017.

Michael Smillie, Executive Director of Finance has taken up the interim Executive lead for Workforce and Organisational Development across both Trusts until the new Joint Executive Director is in post.

The above has been supported by the move to a single Company Secretary operating across both Trusts with effect from 1 September 2017.

Changes to Executive Remuneration

The Remuneration Committees of the Trust and NCUHT agreed a joint approach to the remuneration for the Joint Executive Team at the remuneration Committee in January 2018. The new remuneration arrangement provides a transparent and consistent approach to the remuneration of the Executive Team across both Trusts. Chief Executive remuneration is subject to separate Remuneration Committee provisions; Medical Director remuneration was also excluded from the new arrangements. The new arrangements came into effect from 1 September 2017.

Non-Executive Directors

Following the departure of the Chair, Michael Taylor at the end of at the end of July 2017 Professor Robin Talbot was appointed as Chair from 1 September 2017. This was for an initial period until March 2018 which following consideration by the Governors Council in November 2017 was extended until 31 March 2019.

Dr Louise Nelson was appointed as Non-Executive Director to both the Trust and NCUHT in March 2018.

Helen Bingley, Jane Fretwell and Jill Stannard resigned from theirs positions of Non-Executive Director leaving the Trust in August, November and December 2017 respectively.

An extension of office until 31 March 2019 for Alan Moore was agreed at the Governors Council in November 2017.

Section Two – Senior managers remuneration policy

Future Policy Table
Directors

Element	Purpose and Strategy	Operation	Maximum
Salary	To attract and retain high calibre individuals and reflect level of responsibility.	All the Executive Directors are remunerated based on a local VSM scale system which is reviewed annually.	£225,981
Taxable Benefits	To attract and retain high calibre individuals.	This covers the provision of a lease car.	There is no specific maximum set but costs including fuel and insurance excess in the event of an accident are met by the director.
Pension Related Benefits	To attract and retain high calibre individuals.	Directors are eligible for membership of the NHS pension scheme.	In line with the NHS pension scheme.

There is no link between individual performance and salary. However should individual performance fall below the expected standard it would be addressed through performance management. All Directors have clear objectives based upon the Trust business priorities No Director received any annual or long term performance-related bonuses in 2017/18.

Non-Executive Directors:

Fees Payable	Additional Fees Payable	Purpose and Strategy	Operation	Maximum
NEDs: £12,000 per annum Chair: £45,000 per annum	£2,000 per annum for role as Senior Independent Director £3,500 for Chair of Audit Committee	To attract and retain high calibre candidates	Reviewed by the Nominations Committee and any changes are approved by the Governors Council	No maximum is specified but market rates are considered

Service contract obligations

Executive Directors' contracts do not have a specific duration and reflect notice periods and associated payments for loss of office as detailed in the following sections. Service contracts incorporate the following remuneration aspects:

- Annual Leave entitlement: 33 days plus 8 bank holidays
- Sick pay entitlement: 6 months full pay, 6 months half pay

Eligibility for a lease car in line with Trust policy on contribution, usage and associated mileage costs.

Policy on payment for loss of office

Should a redundancy occur, payment to the Executive Director will be made in line with the national Agenda for Change terms and conditions as stated in their written service agreement. Details of how these payments are calculated can be found in section 16 of the Agenda for Change terms and conditions. Performance is not taken into consideration when calculating payment.

Executive Directors are entitled to receive 3 or 6 months' written notice of termination of employment as stated in their individual service contracts. The Trust may exercise its discretion to pay them in lieu for all or part of the notice period.

Statement of consideration of employment conditions elsewhere in the foundation trust

This information can be found in Section One - Annual Statement of Remuneration.

Section Three – Annual report on remuneration

Service Contracts

Executive Directors				
Name	**Date of appointment or departure**	**Contract**	**Notice Period from Trust**	**Notice period from individual**
Claire Molloy Chief Executive	Appointed 17 June 2013 Left 10 September 2017	Permanent	6 months	3 months
Stephen Eames Chief Executive for CPFT and NCUHT	Appointed 1 September 2017	Secondment	3 months	3 months
Dr Andrew Brittlebank Medical Director	Appointed 14 July 2014	Permanent	3 months	3 months

Executive Directors				
Name	**Date of appointment or departure**	**Contract**	**Notice Period from Trust**	**Notice period from individual**
Michael Smillie Director of Finance and Strategy	Appointed January 2007 Appointed: Director of Finance & Joint Director of Strategy, IMT & Estates - Sept 2017 Took on additional interim responsibility as Executive lead for Workforce and OD across both Trusts from 1 February 2018	Permanent	6 months	3 months
Professor John Howarth Deputy Chief Executive/Executive Director for Integration, Partnerships and Population Health	Appointed January 2012 Appointed:Deputy Chief Executive/ Executive Director for Integration, Partnerships and Population Health across both Trusts 1 September 2017	Permanent	3 months	3 months
Clare Parker Director of Quality and Nursing	Appointed August 2016 Appointed: Director of Quality & Nursing - April 2017 Appointed: Executive Director of Nursing & Operational Lead For Mental Health, Childrens, Specialist and South Community Services – Sept 2017	Permanent	6 months	3 months
Joanna Forster-Adams Director of Operations	Appointed 23 Dec 2013 Left 2 July 2017	Permanent	6 months	3 months
Lynn Marsland Director of Workforce and Organisational Development	Appointed 22 Sept 2014 Left 31 December 2017	Permanent	6 months	3 months

NEDs and Chair		
	Date Term of Office Commenced*	**Date term of Office Ends/Ended**
Mike Taylor (Chair)	November 2016	July 2017
Professor Robin Talbot (Chair)	September 2017	March 2019
Jill Stannard	April 2017	December 2017
Heike Horsburgh	February 2016	January 2019
Jane Fretwell	April 2015	November 2017
Alan Moore	December 2017	March 2019
Helen Bingley	January 2017	August 2017
Brian Hetherington	February 2017	January 2020
Dr Louise Nelson	March 2018	February 2020

***** This is the start date of their current term of office.
For details of their initial appointment dates, please refer to the Directors' Report.

Remuneration Committee
The Remuneration Committee operates in accordance with documented Terms of Reference, as a subcommittee to the Board. This is chaired by the Chairman and comprises the other NEDs. It is usual for the Executive Director of Workforce and Organisational Development to attend, accompanied by other Executive Directors if required. Papers are also made available to the Chief Executive.

In addition to oversight and agreement of Executive remuneration, the Committee also has oversight of any requests for redundancy payments which either total above £100k or apply to staff of band 8 or above; or both. Similarly the Committee also has oversight of any Mutually Agreed Resignation Scheme (MARS) requests from staff of band 8 or above should the Trust decide to offer such a scheme.

The Committee may meet monthly should there be business tabled, or as and when there are decisions to be made. The Committee is however required to meet at least every six months.

Remuneration Committee meetings and attendance details 2017/18

Name	Position (e.g. Chair, Deputy Chair, member or other)	Committee Attendance (total of 7 meetings held during 2017/18)
Remuneration Committee members		
Mike Taylor	Trust Chair – Committee Chair	0/1 Left the Trust July 2017
Robin Talbot	Trust Chair – Committee Chair	6/6 Appointed September 2017
Heike Horsburgh	Non-Executive Director – Committee Member	6/7
Jill Stannard	Non-Executive Director – Committee Member	4/5 Left the Trust December 2017
Alan Moore	Non-Executive Director – Committee Member	4/7
Jane Fretwell	Non-Executive Director – Committee Member	4/4 Left the Trust November 2017
Helen Bingley	Non-Executive Director – Committee Member	0/1 Left the Trust August 2017
Brian Hetherington	Non-Executive Director – Committee Member	5/7

In attendance (Executive Directors and Senior Managers)		Committee Attendance (based on requirement)
Lynn Marsland	Director of Workforce and Organisational Development	Left the Trust Dec 2017 0 attendances
Claire Molloy	Chief Executive	Left the Trust Aug 2017 0 attendances
Daniel Scheffer	Joint Company Secretary	All 7 meetings – May, Sept, Oct, Nov, Dec, Feb and March
Lyn Moore	Associate Director of Operations	1 attendance in May 2017
Stephen Eames	Chief Executive for CPFT and NCUHT	6/6 attendances Sept 2017 – March 2018
Julie Hull	HR Advisor	Left the Trust Jan 2018

Disclosures required by the Health and Social Care Act
Expenses of the Governors and Directors

	Total Number		Number claiming expenses		2016/17	2017/18
	2016/17	2017/18	2016/17	2017/18	£00s	£00s
Non Executive Directors	9	9	7	7	79	120
Executive Directors	9	8	7	4	108	43
Governors	45	47	23	23	112	81

The information below is subject to audit.

Remuneration for each senior manager who served during the last financial year - Single Total Figure Table

		Salary & fees (in bands of £5k)		All taxable benefits (total to the nearest £100)	Annual performance-related bonuses (in bands of £5k)		Long-term performance-related bonuses (in bands of £5k)		All pension-related benefits (in bands of £2.5k)		Total (bands of £5k)	
Name of senior manager	**Job title (and period of office if relevant)**	**£000s**		**£s**	**£000s**		**£000s**		**£000s**		**£000s**	
Mrs C Molloy	Chief Executive (to Sept 2017)	55	60	1,500	0	0	0	0	82.5	85.0	140	145
Mr S Eames	Joint Chief Executive (from Sept 2017)	75	80	6,300	0	0	0	0	0	0	0	0
Mr M Smillie	Director of Strategy & Support Services and Interim Executive Lead for Workforce and OD (from Feb 2018)	120	125	0	0	0	0	0	17.5	20.0	140	145
Prof. J P Howarth	Director of Service Improvement (to Sept 17) Joint Deputy Chief Executive (from Sept 17)	150	155	2,700	0	0	0	0	0.0	2.5	150	155
Dr A Brittlebank	Medical Director	185	190	0	0	0	0	0	35.0	37.5	220	225
Mrs L Marsland	Director of WF & OD (to Dec 2017)	230	235	5,600	0	0	0	0	17.5	20.0	255	260
Mrs J Forster-Adams	Director of Operations (to July 2017)	25	30	0	0	0	0	0	117.5	120.0	145	150
Mrs C Parker	Director of Quality & Nursing	120	125	4,200	0	0	0	0	142.5	145.0	270	275

		Salary & fees (in bands of £5k)		All taxable benefits (total to the nearest £100)	Annual performance-related bonuses (in bands of £5k)		Long-term performance-related bonuses (in bands of £5k)		All pension-related benefits (in bands of £2.5k)		Total (bands of £5k)	
Name of senior manager	**Job title (and period of office if relevant)**	**£000s**		**£s**	**£000s**		**£000s**		**£000s**		**£000s**	
Mrs H Ray	Executive Managing Director of Operations	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mr M Taylor	Chair (to July 2017)	15	20	0	0	0	0	0	0	0	15	20
Prof. Robin Talbot	Chair (from Sept 2017)	25	30	0	0	0	0	0	0	0	25	30
Ms H Horsburgh	Non Executive Director	10	15	0	0	0	0	0	0	0	10	15
Ms J Stannard	Non Executive Director (to Dec 2017)	10	15	0	0	0	0	0	0	0	10	15
Mr A Moore	Non Executive Director	10	15	0	0	0	0	0	0	0	10	15
Ms J Fretwell	Non Executive Director (to Nov 2017)	10	15	0	0	0	0	0	0	0	10	15
Dr L Nelson	Non Executive Director (from March 2018)	0	5	0	0	0	0	0	0	0	0	5
Mr B Hetherington	Non Executive Director	10	15	0	0	0	0	0	0	0	10	15
Mrs H Bingley	Non Executive Director (to Aug 2017)	0	5	0	0	0	0	0	0	0	0	5

Notes:

- There are no performance- related bonuses or long term performance related bonuses.
- Dr Howarth is Joint Deputy Chief Executive for the Trust and NCUHT. He is employed by CPFT who met his full salary costs under the Joint Trust Board arrangements in place during 2017/18. Dr J Howarth during 2017/18 commenced claiming his NHS Pension and therefore there is no transfer value.

- Dr A Brittlebank's remuneration includes an element from the Trust that relates to his clinical role. This amounts to £87,244 in 2017/18 and £76,979 in 2016/17.
- Mr Smillie is Director of Strategy & Support Services and Interim Executive Lead for Workforce & Organisational Development for both NCUHT and CPFT. He is employed by the Trust who met his full salary costs under the Joint Trust Board arrangements in place during 2017/18.
- Mrs Ray is Executive Managing Director of Operations for both NCUHT and CPFT. She is employed by NCUHT who met her full salary costs under the Joint Trust Board arrangements in place during 2017/18.
- Dr Nelson was appointed as a Joint Non-Executive Director for NCUHT and CPFT. She is employed by the Trust but her salary costs are shared equally between the two organisations.

Fair pay multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

Median remuneration of staff

	Year ended 31 March 2018	**Year ended 31 March 2017**
Median Total Remuneration £	27,804	27,269
Mid-point of the Highest Paid Director £	283,775	178,411
Ratio	10.2	6.5

Notes:

- The banded remuneration of the highest paid director in the financial year 2017/18 was £280k-£285k (2016/17 was £175k-£180k).
- This was 10.2 times (2016/17, 6.5) the median remuneration of the workforce was £27,804 (2016/17 £27,269).
- The highest paid director in 2017/18 was the Chief Executive and in 2016/17 was the Medical Director.
- In 2017/18 nil employees (2016/17, 13) received remuneration in excess of the highest paid director. In 2016/ 17 the remuneration ranged from £179k to £215k.
- Total remuneration includes salary, severance payments and lease car benefits in kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
- The median total remuneration is based on the workforce in post at 31 March including bank and agency staff and reflects the annualised full-time equivalent remuneration.
- The median total remuneration includes staff on maternity leave at 31 March at their pre maternity remuneration level.
- The banded remuneration of the highest paid director in the financial year 2017/18 was £280k-£285k (2016/17 was £175k-£180k).

Total Pension Entitlement

Pension benefits 2017/18	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018
Name and Title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mrs C Molly, Chief Executive (to Sept 17)	2.5-5	7.5-10	45-50	145-150	893	90	1,001
Mr S Eames, Joint Chief Executive (from Sept 17)	0[A]	0[A]	0[A]	0[A]	0[A]	0[A]	0[A]
Mr M Smillie, Director of Strategy & Support Services and Interim Executive Lead for Workforce and OD (from Jan 18)	0-2.5	2.5-5	30-35	95-100	467	62	537
Prof. J Howarth, Director of Service Improvement (to Sept 17) Joint Deputy Chief Executive (from Sept 17)	0[B]	0[B]	0[B]	0[B]	0[B]	0[B]	0[B]
Dr A Brittlebank, Medical Director	0-2.5	2.5-5	60-65	195-200	1,402	95	1,525
Mrs L Marsland, Director of WF & OD (to Dec 17)	0-2.5	2.5-5	15-20	55-60	0	0	0
Mrs J Forster-Adams, Director of Operations (to Jul 17)	2.5-5	12.5-15	30-35	110-115	555	123	689
Mrs C Parker, Director of Quality & Nursing	5-7.5	0	25-30	0	279	98	383

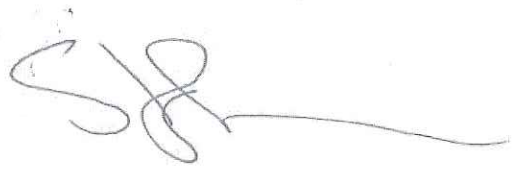
Notes:

- A: Mr S Eames does not contribute to the NHS Pension scheme.
- B: Prof. J Howarth commenced claiming his NHS Pension in 2017/18.
- There was no employer's contribution to stakeholder pensions.

Payments for Loss of Office

Following the implementation of the new joint executive structure across Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust there was a reduction in the overall number of posts. The post of Director of Workforce and OD for the Trust held by Lynn Marsland was removed. Payment was made for loss of office.

Calculations were made in line with national Agenda for Change terms and conditions. The value of the redundancy payment was a £106,667 lump sum payment.



Signed..... Date: 24 May 2018

Stephen Eames, Chief Executive for CPFT and NCUHT

Staff Report

We would like all our staff to have the best experience of working within the Trust because we know that when staff are happy and engaged in their work they provide the best possible care for our patients, they are also healthier and more likely to want to remain working with us. As a Trust we are committed to 'creating the right culture and environment within which people can be the best they can be' through offering staff access to a range of initiatives to support their wellbeing and personal development and involve them in making improvements.

Staff engagement is a measured by the annual National NHS Staff Survey. The results for 2017 show that our overall staff engagement score is above the national average when compared to other similar mental health/learning disability and community trusts. The percentage of staff recommending the organisation as a place to work or receive treatment is also above average.

Staff have opportunity to provide feedback on their experience of work throughout the year by completing our Great Teams Great Care pulse survey. The survey highlights areas where satisfaction is low and this, together with the national staff survey results drive the improvement work that we do. Staff have told us that they do not always feel valued and the introduction of 'Our amazing People' awards and weekly 'Glimpse of Brilliance' message provides us with opportunity to share and recognise the great work that they do.

Engaging for Improvement (formerly known as LiA) is a structured approach that enables teams to identify and carry out service improvements. This year a number of improvements have been led by staff including:

- Piloting a new referral process for patients with diabetic foot problems which reduced patient waiting times.
- Developing an End of Life care self-assessment tool for services to help assess how well they are meeting the needs of people who are in the last 12 months of life.
- Enabling earlier discharge for patients by creating better ways of working between acute hospital services and Eden Community therapy teams.
- A one stop assessment for specialist dental care which reduced waiting time from referral to treatment by more than 50% and made financial savings relating to radiographs.

Analysis of staff costs

			2017/18	2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	100,892	7,179	**108,071**	107,206
Social security costs	9,336	663	**9,999**	10,106
Apprenticeship levy	480	39	**519**	-
Employer's contributions to NHS pensions	13,131	933	**14,064**	13,989
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	239	-	**239**	839
Temporary staff		5,482	**5,482**	6,216
Total gross staff costs	**124,078**	**14,296**	**138,374**	**138,356**
Recoveries in respect of seconded staff	(728)	-	**(728)**	(686)
Total staff costs	**123,350**	**14,296**	**137,646**	**137,670**
Of which:				
Costs capitalised as part of assets	73	63	**136**	**-**

Average number of employees (WTE basis)

			2017/18	2016/17
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	98	30	**128**	130
Ambulance staff	-	-	**-**	-
Administration and estates	705	66	**771**	784
Healthcare assistants and other support staff	656	72	**728**	769
Nursing, midwifery and health visiting staff	1,016	64	**1,080**	1,214
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	640	60	**700**	586
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	1	-	**1**	1
Total average numbers	**3,116**	**292**	**3,408**	**3,484**
Of which:				
Number of employees (WTE) engaged on capital projects	1	2	**3**	-

Male/female staff numbers as at 31/03/18

Role	Female Headcount	Male Headcount
Directors (Executive and NEDs)	3	7
Other Senior Managers	0	0
Employees	3536	498

Sickness absence data

The table below shows the Trust's wte days lost in 2017/18 with a comparison for the previous financial year:

Figures Converted by DH to Best Estimates of Required Data Items				Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE		Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
2017	3,294	34,572	10.5	1,202,223	56,084
2016	3,349	33,953	10.1	1,222,563	55,079

Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse

Period covered: January to December 2017

Staff policies and actions applied during the financial year

Policies relating to staff continued to be reviewed and updated throughout 2017/18. The Trust also commenced a joint consultation process with North Cumbria University Hospitals NHS Trust to agree a Joint Organisational Change Policy across both Trusts. This will go to the first Joint Partnership Forum in 2018 for approval and once agreed will be implemented across both Trusts. All revised policies went through local Equality Impact Assessment processes, and the HR team work in conjunction with the occupational health provider and line managers to ensure any reasonable adjustments which are required to either sustain a staff member in post, or assist a return to work are put in place as quickly as possible.

The Trust continues to operate an equal opportunities policy, and has maintained its two tick 'Positive about disabled people' status. In addition, the Trust is also applied for the 'Disability Confident – Employer' and was successful. This is a scheme that further enhances career opportunities for disabled people.

During the financial year 2017/18 staff consultation, engagement and involvement has continued through the well-established and well attended monthly Partnership Forum.

Significant staff consultation and engagement has been targeted around the transfer of approximately 500 community based staff in South Cumbria which was brought about as a result of Better care Together (Vanguard in South Cumbria). This engagement has been led by Union Representatives and Executive Directors.

Another key area where there was significant staff engagement and involvement was in relation to the development of Integrated Care Communities with various place based events taking place throughout the last year on developing the model and the workforce plans which will be implemented in the coming financial year.

Due to the dispersed nature of the staff within the Trust, engagement took place through various means including slide decks which were cascaded through the leadership teams, the development of an animation video to describe why we need Integrated Care Communities and what the plans are. This was shared through our various communication channels including the use of social media.

A robust approach to staff performance and development was embedded during 2017. Supported, by the appraisal policy and associated documentation we continued to embed our Trust values and reflect on these during all appraisals. Comprehensive training to provide managers with an understanding of the process and also skills in coaching to enhance staff performance, development and engagement continued through 2017. The appraisal process continues to support the roll out of objectives linked to the Trust Annual Business Plan through an appraisal 'window'.

Staff survey results

Summary of performance – NHS Staff Survey

The 2017 National NHS Staff Survey was administered by Quality Health, a national independent contractor with long standing NHS experience to all staff. Unlike the previous year a full survey was undertaken with 80% of surveys administered electronically and 20% of surveys posted to staff homes. The response rate was 51% which was higher than in 2016 (43%) and above the national average (45%).

Response rate				
	2016	**2017**		**Trust Improvement**
	Trust	Trust	National average	
Response Rate	43%	51%	45%	8% increase

The 2017 survey results show a positive improvement since last year with no scores deteriorating and 13 scores showing improvement.

The Trust continues to score well in areas relating to equality and diversity and there have also been improvements in the percentage of staff experiencing physical violence or bullying and harassment from patients or relatives.

Last year the Trust particularly emphasised the importance of staff appraisal and offered training for appraisal conversations, as a result improvements have been seen in the quality of appraisal and the number of staff receiving an appraisal within 12 months, which is now above the national average when compared to similar Trusts.

The Trust leadership and development programmes have evaluated well and the survey results show an improvement in both the support from immediate line managers and managers recognising and valuing their staff.

Although the Trust results have not deteriorated this year it benchmarks less well than other similar organisations in perceived fairness of procedures for reporting errors and incidents and also in reporting recent experience of violence. The Trust continues to encourage staff to report incidents and to feel they can be open and able to speak up. Our Freedom to Speak Up Guardian provides access to an independent person to listen to staff concerns and has direct access to the Chief Executive.

It is possible to access the full staff survey results on the CQC website https://www.cqc.org.uk/files/2017-staff-survey-results-cqc-overall

Top 5 ranking scores				
	2016	**2017**		**Trust improvement/ deterioration****
	Trust	**Trust**	**Benchmarking group average***	
KF16. Percentage of staff working extra hours	72%	65%	71%	(Decrease) better than 2016
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	9%	7%	11%	No change
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	41%	36%	40%	No change
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	17%	12%	14%	(Decrease) better than 2016
KF14. Staff satisfaction with resourcing and support	3.31	3.40	3.33	(Increase) better than 2016
Bottom 5 ranking scores				
	2016	**2017**		**Trust improvement /deterioration****
	Trust	**Trust**	**Benchmarking group average***	
KF24. Percentage of staff / colleagues reporting most recent experience of violence	83%	78%	88%	No change
KF6. Percentage of staff reporting good communication between senior management and staff	24%	30%	34%	(Increase) better than 2016
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	53%	56%	58%	No change

KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.65	3.72	3.76	No change
KF19. Organisation and management interest in and action on health and wellbeing	3.62	3.68	3.70	No change

*Benchmarking group (mental health/learning disability and community)
****** The NHS Survey results are analysed nationally, results showing no significant statistical change from the 2016 survey are classified as 'no change'.

In 2017-18 the Trust continued to implement the People and Organisational Development (OD) Strategic Plan which aims to create culture change and support our staff to "be the best they can be".

Work continued to embed the Trust values and behaviours and this was recognised in the CQC inspection report (February 2018).

Staff wellbeing is important to us and last year the Trust began working towards a bronze health and wellbeing at work award. The Trust has undertaken its first health needs analysis and worked with staff to identify its top priorities for improving health. This year the Trust will focus on Mental Wellbeing, including stress, sleep and work life balance, promoting physical activities and introducing a health and wellbeing MOT. Staff are able to access personal resilience training and also a mindfulness based intervention programme.

Future priorities and targets
The Trust is committed to supporting transformational change across the health and care system and is working closely with partner organisations to improve patient care and to attract and retain staff to work in Cumbria.

Our priorities for 2018/19 are to build on the improvements that we have made to culture change and staff engagement. We will work collaboratively with our colleagues in North Cumbria University Hospitals identifying ways to work better together to make improvements to patient care and enhance team working. The Great Teams Great Care pulse survey will be rolled out to acute services.

Health and wellbeing will remain a priority as we continue to implement a range of health campaigns and introduce a single Occupational Health Provider with North Cumbria Hospitals.

The Trusts leadership programmes have evaluated well and the learning has been shared with our partners in the health and care system. From April 2018 leadership development

will be delivered through the Cumbria Learning and Improvement Collaborative (CLIC) enabling leaders to learn together with peers from other organisations.
In response to the CQC report we will maintain our focus on ensuring that all staff have access to a good annual appraisal and also receive the mandatory training they require to do their job.

Expenditure on consultancy
The total consultancy fees for 2017/18 were £332k.

Off-payroll engagements

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

	2017/18 Number of engagements
Number of existing engagements as of 31 Mar 2018	7
Of which:	
Number that have existed for less than one year at the time of reporting	2
Number that have existed for between one and two years at the time of reporting	1
Number that have existed for between two and three years at the time of reporting	1
Number that have existed for between three and four years at the time of reporting	2
Number that have existed for four or more years at the time of reporting	1

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

	2017/18 Number of engagements
Number of new engagements, or those that reached six months in duration between 1 Apr 2017 and 31 Mar 2018	1
Of which:	
Number assessed as within the scope of IR35	1
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	1
Number of engagements reassessed for consistency/assurance purposes during the year	1
Number of engagements that saw a change to IR35 status following the consistency review	1

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

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

Exit packages 2017/18

The information in the tables that follow shows the number and values of exit packages in the last two financial years. This information is for all staff including senior managers. The Trust has policies and procedures in place to ensure that any expenditure on exit payments is in line with the appropriate terms and conditions of the individual and that the Trust meets its legal obligations. Whenever there is a risk of redundancy, all staff are appropriately supported and every effort is made to redeploy where possible.

Reporting of compensation schemes - exit packages 2017/18

		Number of other departures agreed	**Total number of exit packages**
	Number	**Number**	**Number**
Exit package cost band (including any special payment element)			
<£10,000	-	7	**7**
£10,001 - £25,000	4	1	**5**
£25,001 - 50,000	3	-	**3**
£50,001 - £100,000	1	1	**2**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**9**	**9**	**18**
Total resource cost (£)	£356,000	£92,000	**£448,000**

The table above illustrates exit packages agreed during 2017/18. Exit packages within this disclosure were all made under nationally agreed arrangements. This note does not include the cost of ill-health retirements which falls on the relevant pension scheme, not the Trust. The costs disclosed below are based on agreements with specific individuals. The timing of these costs being recognised in the Statement of Comprehensive Income may therefore differ as restructuring provisions may be recognised in advance of specific packages being agreed.

Reporting of compensation schemes - exit packages 2016/17

		Number of other departures agreed	Total number of exit packages
	Number	**Number**	**Number**
Exit package cost band (including any special payment element)			
<£10,000	3	2	**5**
£10,001 - £25,000	7	3	**10**
£25,001 - 50,000	5	5	**10**
£50,001 - £100,000	-	1	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**16**	**11**	**27**
Total resource cost (£)	£423,000	£329,000	**£752,000**

Exit packages: other (non-compulsory) departure payments

	2017/18		**2016/17**	
	Payments agreed Number	**£000**	**Payments agreed Number**	**£000**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	5	201
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	9	92	6	128
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**9**	**92**	**11**	**329**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

NHS Foundation Trust Code of Governance – disclosures

Cumbria Partnership NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a 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.	Governors Council Report Directors Report
Board Nomination Committee Audit Committee Remuneration Committee	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.	Directors Report Nomination Report Audit & Risk Committee Report Remuneration Report
Governors Council	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.	Governors Council Report
Governors Council	FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Governors Council Report Directors Report

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
Board	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.	Directors Report
Board	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 to the requirements of the NHS foundation trust.	Directors Report
Board	FT ARM	The annual report should include a brief description of the length of appointments of the NEDs, and how they may be terminated.	Remuneration Report Governors Council Report Directors Report
Nominations Committee	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Nominations Report
Nominations Committee	FT ARM	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.	Nominations Report
Chair / Governors Council	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.	Directors Report

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
Governors Council	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.	Governors Council Report
Governors Council	FT ARM	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. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Governors Council Report
Board	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.	Directors Report Performance Report
Board	B.6.2	Where there has been external evaluation of the board, 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.	Directors Report

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
Board	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).	Directors Report AGS
Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	AGS
Audit Committee / control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Audit & Risk Committee
Audit Committee Governors Council	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.	Audit & Risk Committee
Audit Committee	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 statements, operations and compliance, and how these issues were addressed; an explanation of how it has assessed the	Audit & Risk Committee

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
		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.	
Board Rem Com	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.	Remuneration Report
Board	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 NEDs, 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.	Directors Report Governors Council Report
Board Membership	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.	Membership Report
Membership	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.	Governors Council Report
Membership	FT ARM	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	Membership Report

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
		assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	
Board Governors Council	FT ARM	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.	Directors report and Governors Council Report signposting to Register of Interests

Audit & Risk Committee Report

Composition

The Audit and Risk Committee consists of Non-Executive Directors and was chaired by Ms Jane Fretwell until October 2017. Other members of the committee during the year were Heike Horsburgh and Brian Hetherington. Following the resignation of Ms Jane Fretwell in November 2017, Mr Brian Hetherington was appointed Chair with effect from January 2018.

Meetings

This committee met on five occasions during 2017/18. The following table gives details of attendance by individual committee members at the meetings and includes details of attendance by Executive Directors.

Although not members of this committee, Executive Directors (or their nominated deputy) are invited to attend, particularly where specific risk discussions fall under the remit of that Director. For this the appropriate Executive Director attends for some or all of the meeting and this is shown in the table below. Furthermore, papers relating to Audit and Risk Committee meetings are issued to all Executive Directors and where they are not in attendance, they are able to provide input where appropriate. The Terms of Reference for this committee includes a requirement for the Chief Executive to attend at least one meeting during each reporting year. The Chief Executive commenced in September 2017 and was unable to attend the Audit and Risk Committee during 2017/18. He met with the Company Secretary in May 2018 to discuss the 2017/18 Annual Accounts, Quality Report and Annual Report and will be present at the Board of Directors in May 2018 as part of the approval process.

Table: Meetings of the Audit and Risk Committee 1 April 2017 – 31 March 2018

Name	Position	Attendance - (total of 5 meetings held during 2017/18)
Committee members		
Jane Fretwell	Non-Executive Director – Committee Member and Chair to November 2017	4/4
Heike Horsburgh	Non-Executive Director- Committee Member	4/5
Brian Hetherington	Non-Executive Director – Committee Member and Chair from December 2017.	5/5

Name	Position	Attendance - (total of 5 meetings held during 2017/18)
In attendance (Executive Directors)		**Audit and Risk Committee Attendance (partial or full attendance based on requirement)**
Dr Andrew Brittlebank	Medical Director	1
Joanna Forster-Adams	Executive Director of Operations	1
Lynn Marsland	Director of Workforce and Organisational Development	2
Clare Parker	Director of Nursing, Operational Lead for MH, Specialist Services, Children's Services and South Community Services	4
Michael Smillie	Director of Finance, Joint Director of Strategy, IM&T, Estates & Facilities	5

Role and responsibilities

The work of the Audit and Risk Committee is to: Seek assurances as to the adequacy and effectiveness of internal control, corporate governance, and financial and non-financial reporting arrangements, to support the delivery of safe and quality services for patients. This includes oversight of external and internal audit; and functions relating to the annual statutory accounts, standing orders, standing financial instructions and standards of business conduct.

The key activities undertaken by the committee in fulfilling its responsibilities for the year are set out below.

Risk management and internal control

Key items considered were as follows.

Internal Audit

The committee approved the Internal Audit Plan and monitored its delivery throughout the year. The committee ensured that Executive Directors were held to account for implementation of recommendations.

The role and structure of the internal audit function are detailed later in this report.

Counter Fraud

The committee received the Local Counter Fraud Specialist Annual Report 2016/17 and approved the Local Counter Fraud Specialist Plan 2017/18.

Raising Concerns
The committee reviewed and approved the Trust's Raising Concerns policy and received the annual report on Raising Concerns.

CQC Registration
The committee received assurance on the arrangements for ensuring compliance with CQC requirements and preparations for the inspection of core services.

Governance Statements and Declarations Process
The committee received assurance on the Trust's governance statements and declarations process.

Litigation and Claims Management
The committee received assurance on the management of litigation and claims.

Trust Annual Report
The committee reviewed the 2016/17 annual report and accounts and agreed to recommend to the Board that they be adopted.

Financial Reporting
During 2017/18, the committee considered key accounting issues and judgements relating to the accounts. The significant areas of judgement considered, in relation to the financial statements for the year ended 31 March 2018, were as follows:

- **Valuation of land and buildings** – During 2017/18, the Trust undertook an interim revaluation of its land and buildings based on professional advice. We considered and agreed the basis of this revaluation and its disclosure in the financial statements.
- **Contingent assets and liabilities** – As disclosed in note 19 to the financial statements, the Trust has contingencies in respect of a dispute with its PFI provider and employers' liability claims. We considered the available expert and legal advice and approved the accounting treatment of these matters.
- **Provisions** – The Trust has a number of provisions as set out in note 18 to the financial statements. We reviewed and accepted the judgements made by management in assessing provisions.
- **Going Concern** – We considered the financial position of the Trust and agreed that the accounts should be prepared on a going concern basis.

Quality Accounts
The committee considered the integrity and accuracy of the 2016/17 quality accounts and agreed to recommend to the Board that they be adopted. We received updates throughout the year on the implementation of improvement actions.

Standing Orders and Standing Financial Instructions (SFIs)
The committee reviewed activity and were satisfied that these were appropriately managed.

Data Quality
The committee monitored progress against the Data Quality Strategy to improve the quality of data underpinning key performance indicators, particularly those subject to external audit. For further details see the Quality Report.

Board Assurance Framework
The committee monitored the review and subsequent development of the Board Assurance Framework towards an outcomes-based approach and noted work to improve the connectivity between the BAF and the corporate risk register.

Risk Management
The committee reviewed the Trust's arrangements for monitoring and managing risk. The Risk Management Strategy and policy were considered and the committee noted ongoing work to revise the risk appetite statement. The Committee recommended consideration of the inclusion of risks associated with the Working Time Directive and budgetary control in relation to agency staffing.

Charitable Trust Funds
The committee reviewed the annual accounts of the Charitable Trust Fund and agreed to recommend to the Corporate Trustee that they be approved. The committee considered the management of the Charitable Trust Fund and approved changes to the Charitable Funds Policy. The Committee agreed that the Charitable Trust Funds should not be consolidated into the accounts of Cumbria Partnership NHS Foundation Trust.

External Audit
The committee engaged with External Auditors (KPMG) until 11 October 2017 when KPMG gave notice of their resignation as auditors of the Trust and the charitable subsidiary. The committee assessed the effectiveness of the external audit service. This was based on reporting by and communication with the External Auditor and the views of senior management. We concluded that we had no concerns. KPMG considered that there was no matter connected with them ceasing to hold office that needed to be brought to the attention of the Trust's members or creditors.

The Trust sought to appoint a new external auditor for the 2017/18 period through completion of a tender process and the committee agreed to recommend to the Governors that Mazars should be awarded the contract. The committee engaged with External Auditors Mazars from 12 October 2017, with at least one representative from Mazars in attendance at all meetings through the remainder of the year. Mazars have a contract for 2 years commencing with the 2018/19 audit. The value of the contract for 2018/19 is £40,000 including VAT.

The committee approved the External Audit Strategy Memorandum.

The committee reviewed and amended the Policy for Engagement of External Auditors to address new rules introduced by the National Audit Office in relation to non-audit services from 1 April 2017.

The committee considered if non-audit work undertaken by the Trust's External Auditor represented any conflict of interest. The Trust has a policy for appointment of External Auditors to undertake non-audit work approved by the Trust governors. The Trust sought confirmation that where External Audit staff were undertaking non-audit services, these staff were not involved in the external audit service. Non-audit services provided by the External Auditors during the year totalled £8,000 including VAT, which related to the assurance in respect of the Quality Report.

Internal Audit – Role and Structure

Internal audit provides an independent, objective assurance and consulting activity designed to add value and improve the Trust's operations. It assists the Trust to accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

The Trust continues to obtain internal audit and counter fraud services from Audit One. Audit One is a not-for-profit provider of internal audit, information systems assurance and counter fraud services, to the public sector in the North of England. Their work is based on a risk based plan; agreed and overseen by the Trust's Audit and Risk Committee. The committee receive summaries of all internal audit reports, including regular progress information on the status of agreed management actions arising from internal audit recommendations. All internal audit reports are provided to the Chair of the Audit and Risk Committee.

The Audit One Managing Director of Audit, as part of his requirements, provides the Trust's Chief Executive with an annual Head of Audit opinion. This supports the Annual Governance Statement and is based upon all internal audit work undertaken during the year, and the arrangements for gaining assurance via the Board Assurance Framework. All internal audit work is undertaken in accordance with the requirements of the Public Sector Internal Audit Standards.

Governors Council Report

As a NHS Foundation Trust, we are required to comply with the arrangements set out by our independent regulators, NHS Improvement, in the NHS Foundation Trust Code of Governance (2014). The Code of Governance requires us to have a comprehensive framework in place to ensure the Trust is managed and governed properly. We comply with the provisions of the code and will continue to observe the spirit of the code in everything we do.

The business of the Trust is managed by the Board of Directors which exercises all the powers of the Trust subject to any contrary provisions of the NHS Act 2006 and the Health and Social Care Act 2012. The Board of Directors is responsible for approving the Annual Report and accounts. In preparing the Annual Report they take into account the views of the Governors Council which contain information about the Trust's forward planning.

This section describes the composition of the Governors Council during the year, their roles and responsibilities, how they work together and the types of decisions taken during the year to develop the organisation and describes how disagreements between the Board of Directors and the Governors Council will be resolved.

Roles and responsibilities

The roles and responsibilities of the Governors Council, which are to be carried out in accordance with the Trust's Constitution and NHS Provider Licence, are as follows:

- To hold the NEDs individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the Members of the Foundation Trust as a whole and the interests of the public
- To appoint or remove the Chair and the other NEDs
- To approve an appointment (by the NEDs) of the Chief Executive
- To decide the remuneration, allowances and other terms and conditions of office of the NEDs
- To appoint or remove the Foundation Trust's auditor
- To be presented with the annual accounts, any report of the auditor on them and the annual report
- To provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning
- To undertake such functions as the Board of Directors may from time to time request
- To review at least annually the Foundation Trust's membership strategy
- To make recommendations to the Board of Directors for any amendments in this Constitution to the composition of the Governors Council
- To respond as appropriate when consulted by the Board of Directors on any proposed revision of this Constitution or any other matter.

On 31 March 2018 the Governors Council, chaired by the Trust Chair, Professor Robin Talbot, consisted of 47 governors representing the Public and Staff constituencies and representatives from the Local Authority and Partner Organisations as identified by the Trust's Constitution: 31 Public governors; 9 Staff governors and 7 Appointed governors. There are currently 13 vacancies on the Governors Council.

Information on governors who held office during 2017/18 is shown in Table 3.3 which includes details of their constituencies or organisations represented; whether they are elected or appointed; their term of office and attendance at meetings. In accordance with the Trust's Constitution and NHS Provider Licence, all governors are required to meet the 'Fit and Proper Persons Test' on appointment and on reappointment.

Lead Governor and Deputy Lead Governor

The Lead and Deputy Lead Governors are elected by their peers for a term of 3 years or until their term ends, whichever is the sooner.

- Lead Governor - Jane Smith, Staff Governor Allerdale and Copeland (Jan 2017 – Dec 2020) (current Staff Governor term ends 30 Sept 2020)
- Deputy Lead Governor – Keith Amey, Public Governor Copeland (July 2017 – June 2020) (current Public Governor term ends 30 Sept 2018)

Table 3.3: Governors Council – composition and meeting attendance record

Constituency	* No. of Governor positions	Name	Appointment	** No. of Mtgs
Public constituency (elected)				
Allerdale	5	Linda Vance	Oct 2015 - Sep 2018	4/6
		Rachael H Davies	Oct 2016 - Sep 2019	4/6
		Alinson McCourt	Oct 2017 - Sep 2020	0/2
		Mark Hayhurst	Oct 2014 - Sep 2020	3/6
		Linda Radcliffe	Oct 2016 - Sep 2019	6/6
		Paul Lee	Oct 2014 - Sep 2017	0/4
Carlisle	5	Elizabeth Freeman	Oct 2016 - Sep 2019	5/6
		Christine Logan	Oct 2012 - Sep 2018	5/6
		Jack Smith	Oct 2017 - Sep 2019	0/2
		Malcolm Nelson	Oct 2016 - Apr 2017	0/3
		Vacant	Oct 2015 - Aug 2018	0/0
		Garry English	Oct 2013 - Sep 2019	0/6
Copeland	5	Catherine McCreadie	Oct 2014 - Sep 2017	0/4
		Keith Amey	Oct 2012 - Sep 2018	5/6
		Vacant	Oct 2017 - Sep 2020	0/0
		Vacant	Oct 2016 - Sep 2019	0/0
		Kerry-Ann Lister	Oct 2013 - Sep 2019	2/6
		Vacant	Oct 2016 - Sep 2019	0/0

Constituency	* No. of Governor positions	Name	Appointment	** No. of Mtgs
Eden	5	Vacant	Oct 2015 - Sep 2018	0/0
		Mike Taylor	Oct 2017 - Sep 2020	2/2
		Tim Wilson	Oct 2016 - Nov 2017	2/4
		Ian Robb	Oct 2011 - Sep 2017	0/4
		Jacqueline Nicol	Oct 2017 - Sep 2020	1/2
		David Pollitt	Oct 2014 - Sep 2020	5/6
		Hilary Carrick	Oct 2014 - Sep 2020	4/6
Furness	5	Maggie Harrison	Jun 2013 - Sep 2018	4/6
		Tony O'Malley	Oct 2017 - Sep 2020	2/2
		Vacant	Jun 2013 - Sep 2018	0/0
		Stephen Newton	Jun 2013 - Sep 2019	5/6
		Vacant	Oct 2015 - Sep 2018	0/0
Lancashire	1	Derek Seber (Rev)	Oct 2017 - Sep 2020	1/2
South Lakeland	5	Patricia Turton	Oct 2016 - Sep 2019	4/6
		Lesley Flood	Oct 2007 - Sep 2017	2/4
		Patricia Davey	Oct 2017 - Sep 2020	2/2
		Stephen Johnson	Oct 2016 - Sep 2019	4/6
		Lorna Graham	Oct 2014 - Sep 2017	0/4
		Jim Ring	Oct 2017 - Sep 2020	1/2
		Catherine Gleeson	Oct 2015 - Sep 2018	4/6
Staff constituency (elected)				
Allerdale and Copeland	3	Leslie Blacklock	Oct 2017 - Sep 2018	2/2
		Jane Smith	Oct 2011 - Sep 2020	6/6
		Tricia Goldwater	Oct 2013 - Sep 2019	1/6
Carlisle and Eden	3	Peter Farrell	Oct 2016 - Sep 2019	2/6
		Pepe Shrinarine	Oct 2017 - Dec 2017	1/1
		Vacant	Dec 2017 - Sep 2020	0/0
		Robert Donlevy	Oct 2017 - Sep 2020	2/2
		Emma Hoyles	Oct 2014 - Sep 2017	1/4
Furness and South Lakeland	3	Vacant	Oct 2013 - Sep 2018	0/0
		Vacant	Oct 2015 - Sep 2018	0/0
		Kevin McVeigh	Oct 2015 - Sep 2018	4/6
Appointed Governors				
Cumbria County Council	2	Cllr Ian Stewart	Mar 2016 - Mar 2018	0/6
		Cllr Mark Wilson	Mar 2016 - Feb 2019	3/6
University of Cumbria	1	Alison Hampson	Apr 2017 - Apr 2020	5/5
Council for Voluntary	2	Michael Cassells	Sep 2014 - Nov 2017	1/4
		Barbara Cotton	Jun 2013 - Sep 2017	3/4

Constituency	* No. of Governor positions	Name	Appointment	** No. of Mtgs
Service		Helene Morris	Nov 2017 - Oct 2020	1/2
Leagues of Friends	1	Chris Mitchell	Apr 2014 - Mar 2017	4/6
UHMB	1	Declined	Apr 2017 - Feb 2018	n/a
	47			

***** Number of governor positions per constituency. Elections are held annually in September so the table shows governors that held a position at some point during 2017/18.

****** Number of Governors Council meetings that each governor attended, out of the total number they were eligible to attend, based on their Term of Office.

Details of company directorships of Governors

The register of interests for members of the Governors Council is available on the Trust's website https://www.cumbriapartnership.nhs.uk/the-trust/governors or from the Corporate Governance Team on **01228 603761**.

Supporting the role of Governor

The Health and Social Care Act s151(5) places a duty on Foundation Trusts to take steps to secure that governors are equipped with the skills and knowledge they require in their capacity as such. This duty is also included within the Trust Constitution at section 6.4.

In order to ensure governors are equipped with the skills and knowledge they require to fulfil their role, governors are provided with training and development opportunities throughout their tenure. The training and development programme continues to be adapted to meet the needs of the governors.

Communications between the Board of Directors, Governors Council and Members

The Board of Directors (the Board) and Governors Council work closely together. All members of the Board have an open invitation to attend the Governors Council meetings. Executive and NEDs are involved in making formal presentations at the Governors Council meetings (6 meetings in year) for the purpose of obtaining information on the Trust's performance of its functions and the Directors' performance of their duties and to hear the views of the governors, members and the public.

The Senior Independent Director (SID) attends the Governors Council meeting to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors. The SID also attends/chairs the Nominations Committee when considering the Chair appraisal or Chair appointment.

The Chair ensures that the views of governors and members are communicated to the Board as a whole through the Lead Governor sitting at the Board table and the Executive Directors and NEDs attending the Governors Council meetings. At Board meetings the Lead Governor is able to ask questions of Non-Executive and Executives Directors throughout the meeting and can escalate any good practice or concerns raised by the Governors Council or Members. The Board meetings include a quarterly standing item on the activities and views of the Governors Council presented by the Lead Governor. Governors and Members can attend Board meetings and ask questions on notice or about the agenda items at set times within the meeting.

The Governors Council meeting is held in public and advertised on the Trust website. The public has an opportunity at the meeting to give their views or ask questions on the agenda. NEDs feedback on progress of issues from the Board committees to the Governors Council to help governors fulfil their role in 'holding NEDs to account'.

The following information details the steps taken during the year by the Governors Council to engage with our members and the public on the Trust's forward plan, including its objectives, priorities and strategy, and their views are shared at the Governors Council meetings and included in the Governors Council Activity Report presented to the Board by the Lead Governor on a quarterly basis.

Trust Talk

Governors have a page in the quarterly magazine for members and the public which is available on the Trust website and is sent to staff and public members by email, with limited paper copies available in Trust premises.

Locality Groups

Locality groups have been re-established as two groups North and South to maintain communications with members and third sector organisations and to understand the impact of the STPs and ICCs. Both had their first meeting in April 2017 and met on a quarterly basis throughout the year.

Healthcare for the Future in West, North, East Cumbria

Governors have been involved in the significant work within their local communities on the re-provision of community hospitals. The Governance Special Interest Group was tasked by the Board and Governors Council to consider how to define the role of the Governors Council in the emergent partnership working to make sure the voice of the public and members is heard. This is ongoing.

Non-Executive Directors (NEDs) and Governors engage with staff - The purpose of the joint Non-Executive Director and Governor visiting programme is to provide members of staff from services the opportunity to openly discuss service developments and improvements, and to highlight any key issues/risks in their service that may prevent the service user from receiving high quality and safe care, and having the best experience

whilst using our services. The visits aim to promote transparency and to ensure that staff feel supported and are confident in fulfilling their day to day roles. The engagement team feeds back issues and good practice to senior managers at the end of the visit. Reports are provided to the relevant care group governance group for consideration and shared with the Quality and Safety Committee and the Governors Council.

Governors Special Interest Groups are a forum for the Trust's care groups to engage with governors and Members. Their purpose is to establish and maintain communication with Members and Third Sector organisations and to monitor and review the work of the Trust in the individual care group which includes the experience of service users, carers and vulnerable groups, good practice, safeguarding, unmet needs and co-operation between care groups which is reported to the Governors Council through the Advisory Committee. Members with a special interest/experience can be co-opted onto each group.

Annual Members meeting - was held on 28 September 2017. The meeting focussed on the strategic transformational programmes of care in the county and how the barriers between Trusts need to be broken down and ensure the positive culture of values and behaviours is not eroded. Members openly explained their concerns for the Trust and also their ideas of how things could be improved. In an open and frank round table discussion with Directors; Governors, Staff and Members asked questions, challenged and celebrated the work of the Trust. Executive and NEDs make themselves available during the break period and before the meeting for more informal discussions.

Patient Led Assessment of the Care Environment - Governors take part in this national annual programme of assessment of all inpatient areas.

Quality Peer Reviews

During 2017 Quality Peer Reviews were introduced across the Trust, and these are led by the care groups Associate Director of Nursing, and supported by the Governors. The reviews look at the criteria of the CQC five Key Lines of Enquiry (KLOE) and is a supportive process for services to identify areas of notable practice and any areas of improvement. The reviews importantly support shared learning across the Trust.

Governors Council - meeting governance

All formal meetings involving governors have Terms of Reference, minutes and action plans that include a section on issues to be escalated to the Governors Council and/or Board. The agenda and papers for the meetings of the Governors Council General meeting are published on the Trust website. This provides a clear audit trail of engagement and communication between Members, Governors and the Board.

Elections to Lead and Deputy Lead Governor

An election for the role of Deputy Lead Governor was undertaken in July 2017. There was one candidate nominated which led to the formal appointment of Keith Amey, Public Governor Copeland.

An election for the role of Lead Governor was undertaken in October 2017. There was one candidate nominated which led to the formal appointment of the existing Lead Governor, Jane Smith.

Dispute between the Governors Council and the Board of Directors
There were no disputes during 2017/18. In the event of any unresolved dispute between the Governors Council and the Board of Directors, the Chair will:

- Take such steps as the Chair considers appropriate to try to reach a common and clear understanding of the issues in dispute
- Consider whether independent advice will help to resolve the dispute and if appropriate arrange for independent advice to be made available to the Foundation Trust
- If the dispute continues to be unresolved, ensure that an appropriate record of it is made in the minutes of a Meeting of the Governors Council and in the minutes of a meeting of the Board of Directors.

Ensure that an appropriate record of any unresolved dispute is made in the annual report of the Foundation Trust for the relevant period including a summary of the issues in dispute and the action taken by the Board of Directors and the Governors Council to attempt to resolve the dispute.

Nominations Committee Report

The Nominations Committee's primary function is to ensure that the Board includes an appropriate number of independent, skilled, experienced and effective NEDs. The committee must also ensure that the levels of remuneration for the Chair and other NEDs reflect the time commitment and responsibilities of their roles.

The committee must work to ensure that appointments to the Board:

- Are made on merit, against objective criteria
- Meet the fit and proper persons test described in the NHS Provider Licence issued by NHS Improvement
- Have due regard for the benefits of diversity on the Board and the requirements of the Trust, and that appointees have enough time available to discharge their responsibilities effectively.

The committee should satisfy itself that plans are in place for orderly succession for appointments to the Board and also maintain an appropriate balance of skills and experience within the Trust and on the Board.

The committee was chaired by the Trust Chair, Mike Taylor until July 2017. Professor Robin Talbot, Interim Chair took over on 1 September 2017. The Vice Chair is the Senior Independent Director (SID) was Jill Stannard, Non-Executive Director until December

2017. Heike Horsburgh, Non-Executive Director/Vice Chair/SID started in February 2018. The SID is invited to attend when considering the Chair's appraisal and chairs the meeting when considering the Chair's appointment. The committee is attended by three Governors: Jane Smith (Staff Governor Allerdale and Copeland/Lead Governor), Linda Vance (Public Governor Allerdale) and Keith Amey (Public Governor Copeland/Deputy Lead Governor).

The committee, all in attendance, met eight times during the year to consider:

- Board succession planning
- NED appointments
- Chair appointment
- Amendments to the process for appointing/reappointing the Chair and NEDs
- Fit and Proper Person Annual Review

No Directors were invited to attend the Nominations Committee in the year.

Non-Executive Directors (NEDs) Appointment

The committee considered Non-Executive Director appointments, in line with the approved process for appointment/reappointment of the Chair and NEDs. In August 2017 the Nominations Committee considered the need to recruit a Non-Executive Director with clinical expertise following the resignation of Helen Bingley.

In the spirit of partnership and collaboration, the recruitment process was undertaken in conjunction with North Cumbria University Hospitals NHS Trust (NCUHT). This was agreed by the Governors Council Nominations Committee as both Trusts were looking for a NED with a strong clinical background. The process taken was approved by NHS Improvement who have responsibility for appointing NEDs to non-foundation Trusts and on this occasion, included Gina Tiller, Chair of NCUHT and an Independent Panel Member.

The Nominations Committee undertook the recruitment process in line the agreed procedure and identified a preferred candidate. Following the preferred candidate being offered the position, the candidate declined due to concerns on expected time commitment. The Chair advised the Governors Council at the meeting on 23 November 2017. Further discussions took place at the Nominations Committee in January 2018 on the proposed joint working of the Boards which had been agreed in principle and was approved by the respective Boards in January 2018. The Nominations Committee agreed that the Chair should contact the preferred candidate again with a new offer of 3 days per month to cover both Trusts, to which the candidate agreed. Dr Louise Nelson was appointed as Joint NED to both Trusts for a 2 year period from 5 March 2018 to 29 February 2020.

Non-Executive Directors (NEDs) Re-appointment

In November 2017 the Nominations Committee considered the re-appointment of Alan Moore, NED for 2 years to the 30 November 2019. The Governors Council approved the extension.

Chair Appointment
The Nominations Committee led a recruitment exercise for a new Chair which was paused, after shortlisting, by agreement with the Governors Council in June 2017. It was agreed to seek an Interim Chair with experience of the NHS and chairing a Board. The Job Description was amended to reflect this and one of the shortlisted candidates fully met the criteria and was interviewed in July 2017. The candidate, Professor Robin Talbot attended the Governors Council Extraordinary meeting in July 2017 to enable governors to ask questions before they approved the recommendation of the Committee. In November 2017 the Nominations Committee considered an extension of the Chair's appointment to 31 March 2019 which was approved by the Governors Council.

Appointment of Interim Chief Executive
The Board of Directors sought the views of the Governors Council on the appointment of Stephen Eames as Interim Chief Executive. The Nominations Committee considered the recommendation and agreed to recommend the appointment process undertaken to the Governors Council, subject to the agreement of a procedure to manage potential conflicts of interest. The Governors Advisory Committee met with Stephen Eames in July 2017 to seek points of clarity on how this interim joint role would work and in particular how he envisaged handling any conflicts of interest that would inevitably emerge in his dual role. This information was shared with the Governors Council in September 2017.

Non-Executive Director Remuneration Review
The committee agreed a recommendation of no change for a two year period to the Governors Council on 4 May 2017 which was approved.

Membership Report

What is membership?
All Foundation Trusts have a duty to engage with their local communities and encourage local people to become Members and to take steps to ensure that their membership is representative of the communities they serve. The Trust is committed to an engaged and vibrant membership community.

Anyone who lives in the area or who works for the Trust, and is 14 years or older, can apply to become a Member of the Trust (exclusions apply as detailed in our Constitution). They will be eligible to join one of two membership groups:
Public membership – divided into seven constituencies
Staff membership – divided into three joint constituencies

An individual cannot be a member of more than one group. You can find out more about the eligibility criteria and the process for membership application in our Constitution which can be accessed via our website

https://www.cumbriapartnership.nhs.uk/the-trust/board-of-directors or request a copy from the Corporate Governance Team on 01228 603761 or email AskYourGovernor@cumbria.nhs.uk

Public membership

The Trust has eight public constituencies which are open to all residents of Cumbria, Lancashire and North East England over the age of 14 years. The eight public constituencies correspond to the six district council areas within Cumbria County Council, Lancashire County Council and the North East of England (Cleveland, Durham, Northumbria and Tyne & Wear).

Staff membership

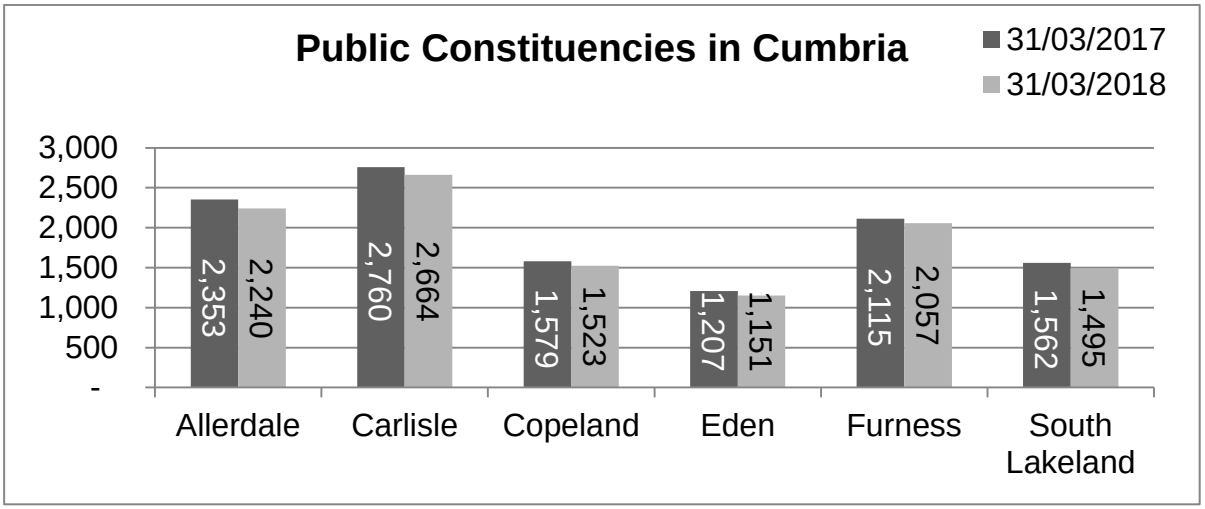
The staff constituency is divided into three classes that are geographically based according to where the member of staff works:

- West Cumbria (Allerdale and Copeland)
- North/East Cumbria (Carlisle and Eden)
- South Cumbria (Furness and South Lakeland)

We have adopted an opt-out scheme and all staff who are employed (including indirectly employed) by us for 12 months or more are included as Members. New employees who meet the criteria above are automatically included as Members.

Membership profile

Information on the total number of Members and the number of Members in each constituency at 31 March 2018 compared to last year is shown in the chart below.



In February 2018 the Governors Council and the Board of Directors approved extending the membership profile to include the North East England (Cleveland, Durham, Northumbria and Tyne & Wear). There are 2 Public members in North East England which have been attracted through links with North Cumbria University Hospitals NHS Trust and our general communications channels, primarily our website. The total public membership

figure at 31 March 2018 is 11,178, a reduction of 446 from the previous year following the annual data cleanse exercise, plus 25 new public members.

Membership Engagement Strategy 2015-2018

The Trust's ambition is to have a membership base which is engaged and actively involved in co-producing future service design and delivery, reflective of the needs of patients and the local community. This means our focus is less on recruiting Members and more on engaging with them.

The mission of the Trust is to improve the health and wellbeing of people of all ages in Cumbria. The Trust plans to achieve its mission through:

- Building better and stronger partnerships and collaborations with our staff, other providers of care and communities themselves.
- Growing a partnership with patients and communities in which they are valued partners in both the design and the delivery of care; a partnership where communities and patients play a larger part in promoting health and wellbeing.

This signals a clear opportunity for real engagement with our Members in communities, our patients and staff. Our strategy will harness that opportunity, enabling our Members to contribute to this as part of the Trust's developing Participation Strategy. The Governors Council has a duty to represent the interests of the Members of the Trust as a whole and the interests of the public and feed back to their communities. Our strategy sets out the ways in which the Governors Council and the Trust will engage with our membership.

The Trust has over 11,000 public Members, of which currently one third is active. The Trust aims to have as many actively participating Members as possible and with this in mind there is a drive to improve engagement. Engagement with Members is aligned with care groups and localities and opportunities for Members and the public to engage is communicated via digital media, the website and newsletters. Details of engagement this year can be found in the Governors Council Report.

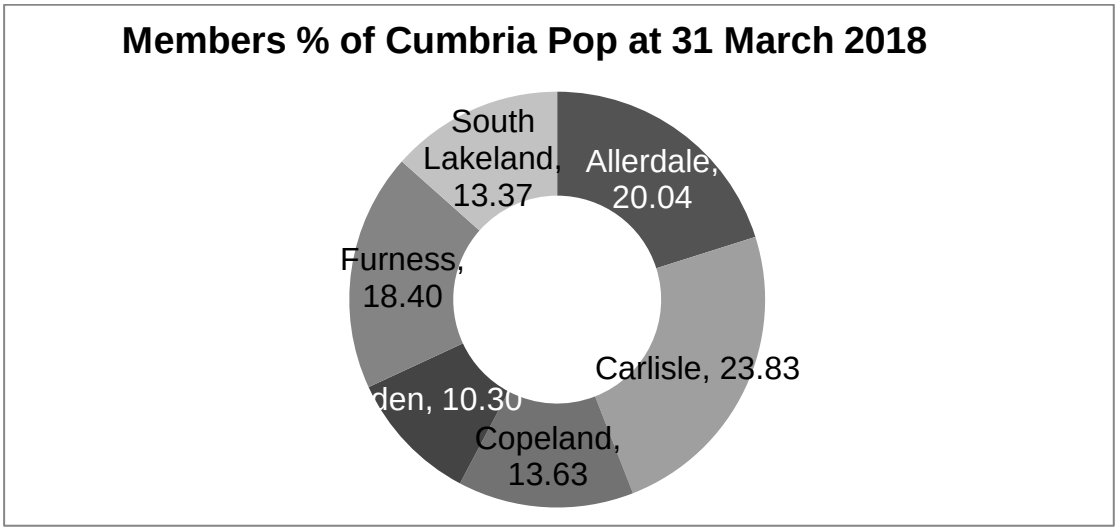
Membership monitoring

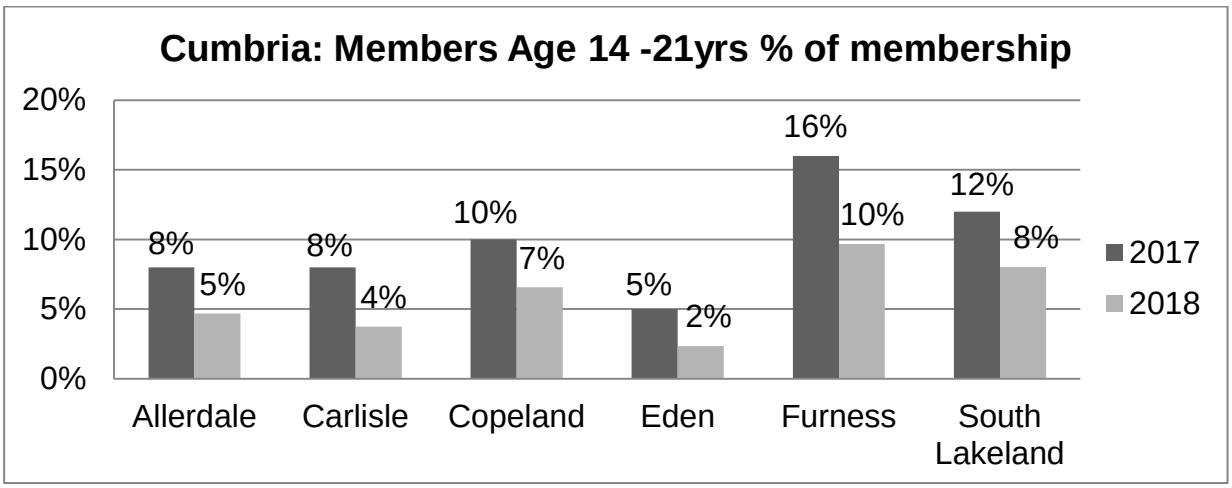
The Trust needs to ensure proportional representation of members from its local population in Cumbria. Targets for 2017/18 identified in our strategy are:

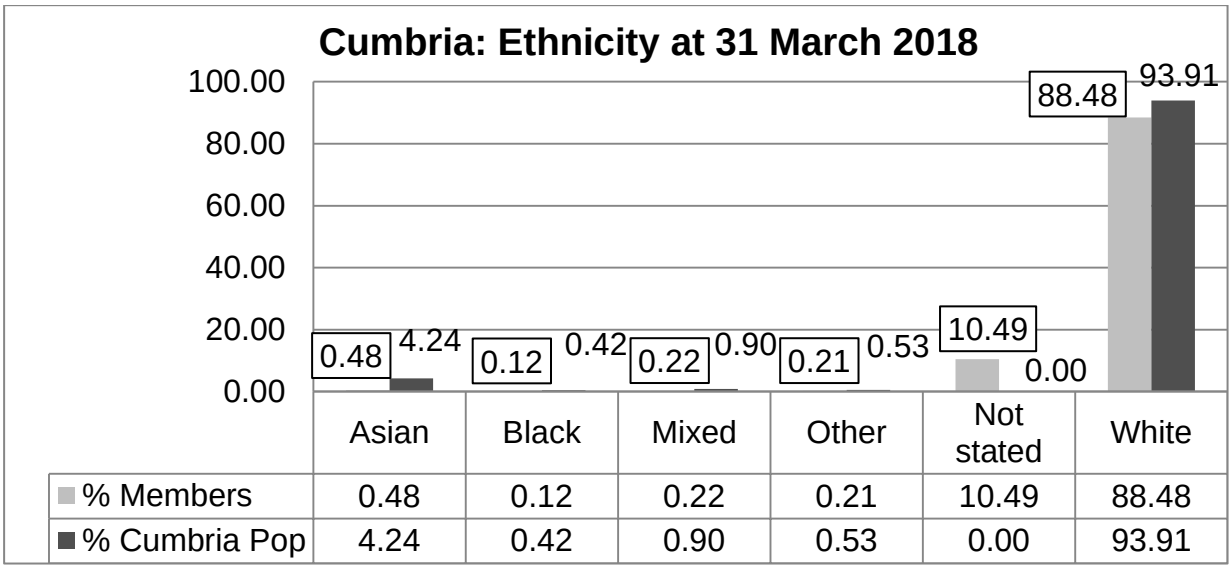
- maintain 2% of the population of Cumbria as Members
- to increase the proportion of male members by 1% by 2018 – no change
- increase representation of younger members by 1.5% by 2018
- increase representation of minority ethnic groups by 0.4% to reflect the population of Cumbria by 2018

The following graphs show how representative our current membership is against these targets. The graphs do not include the 46 members in Lancashire and 2 members in North East England. Limited membership recruitment was carried out this year at the LGBT

event in Carlisle and at the Westmorland Show in South Lakeland. The Governors Council's focus changed to increase engagement of members and the public. In 2018/19 the Governors Council is proposing to enhance its engagement role in the wider healthcare arena in support of the two STP arrangements within Cumbria.







	Asian	Black	Mixed	Other	Not stated	White
% Members	0.48	0.12	0.22	0.21	10.49	88.48
% Cumbria Pop	4.24	0.42	0.90	0.53	0.00	93.91

The Board monitors the level and effectiveness of membership engagement through the presentation of the Governors Council Activity Report on a quarterly basis by the Lead Governor.

There are no specific recruitment plans in place to increase the numbers of members in Lancashire and North East of England other than through the general communication routes mentioned above. Further consideration will be given when the three-year strategy is due for renewal later in 2018.

Contact a Director or Governor

If you wish to make contact with a Director please contact:
Engagement and Communications Team
Address: Trust Headquarters, Voreda, Portland Place, Penrith, CA11 7QQ
Telephone: 01228 603890
Email: communications.helpdesk@cumbria.nhs.uk

If you wish to make contact with a governor please contact:
Email: AskYourGovernor@cumbria.nhs.uk
Telephone: 01228 603761
Or use Contact Us on the Trust website for Directors or governors

You are welcome to attend our Annual Members meeting or Governors Council meetings which are held throughout the year – find out more at https://www.cumbriapartnership.nhs.uk/the-trust/public-meetings-and-events

NHS Improvement's Single Oversight Framework

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

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

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

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Comparative information relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvements guidance for annual reports.

Segmentation
Cumbria Partnership Trust has been placed in segment 2, which is defined as 'providers offered targeted support'.

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

Area	Metric	2017/18 Q1 score	2017/18 Q2 score	2017/18 Q3 score	2017/18 Q4 score
Financial sustainability	Capital service capacity	4	4	3	3
	Liquidity	4	4	3	3
Financial Efficiency	I&E margin	4	4	4	3
Financial Controls	Distance from financial plan	1	1	1	1
	Agency spend	2	2	2	2
Overall scoring		**3**	**3**	**3**	**2**

Statement of Chief Executive's responsibilities as the Accounting Officer of Cumbria Partnership NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Cumbria Partnership 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 Cumbria Partnership 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 Group Accounting Manual and in particular to:

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the 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…… Date: 24 May 2018
Stephen Eames, Chief Executive for CPFT and NCUHT

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 ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Cumbria Partnership 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 Cumbria Partnership NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive has overall accountability for risk management within the organisation and discharges that duty through the Executive Team and their respective portfolios. Senior clinical leaders are in place throughout each of our four care groups. They are responsible for driving improvements to quality and safety, and actively support our staff in the identification and management of identified risks. Care groups are supported by staff within Corporate and Support Service teams who are specialists in various aspects of risk management, and who are a central resource for training, advice and guidance.

Risk management is part of the Trust's training programme. In addition to subject-specific training and core skills training, which make up the overall training programme, we deliver risk management training for team leaders, which covers the essentials of risk management. This includes learning from incidents and complaints through appropriate level investigations, and duties as a manager under health and safety law. Policies and procedures to support and enable risk management are available to all staff via the Trust's intranet site.

The Trust benefits from good practice through a range of learning and improvement mechanisms, including:

- Robust investigation processes
- Peer review
- Clinical audits
- Professional and personal development
- The application of evidence-based practice
- Quality improvement tools, such as the Cumbria Production System

Investigation of complaints, incidents and near misses is overseen by our Director of Quality and Nursing, who, during 2017/18, saw their role widen to include Director level responsibility for Operations, Quality, safety and performance matters are cascaded and escalated through governance frameworks. Improving the quality of care and safety are the driving principles of our quality governance arrangements.

Our quality governance, clinical risk management and leadership frameworks, developed during 2014/15, have become embedded into routine practice and enable us to identify, manage, escalate and report risks, as appropriate to the scale and nature of the risk.

The Board of Directors has line of sight to the management of significant operational and strategic risks through the Board Assurance Framework and through the functioning of its committee and governance frameworks.

The Risk and Control Framework

Board Membership

There were a number of changes to Board membership during the year. Since September 2017 the Trust shares a Chief Executive, and since October 2017, three Executive Directors with North Cumbria University Hospitals NHS Trust (NCUHT). These changes reflect and demonstrate the Trust's commitment in moving toward an Integrated Health and Care System, but do not diminish the Trust's responsibilities and accountabilities as a NHS Foundation Trust.

As at 4 May 2018 the Trust has:

- Five Non-Executive Directors (the Chair plus four other Non-Executive Directors, one of whom is a joint appointment with NCUHT)
- Two Non-Executive Director vacancies
- Seven Executive Directors, five of whom have voting rights (including all of the designated Executive Director posts listed above)
- One Executive Director vacancy (Director of Workforce & OD (non-voting)

The balance between Executive and Non-Executive Directors on the Board of Directors remains in line with the Code of Governance for NHS Foundation Trusts and with the Trust's Standing Orders. For a short period of time between 22 December 2017 and 5 March 2018, the balance between Executive and Non-Executive Directors was in favour of

the Executive Directors in terms of voting rights. Whilst during this time the Board of Directors did not have a requirement to undertake a vote, it continued to make any necessary decisions and operated in line with its Standing Orders.

Further details about Board members and changes to Board membership during the year can be found in the Directors Report and the Remuneration Report.

During Quarter 4 of 2016/17 a review was undertaken of the corporate governance structures that support Board subcommittee effectiveness. The review identified some changes were necessary to strengthen quality governance around transformation, financial recovery and strategic planning. Those structures, which disestablished the Strategy Group, took effect in Quarter 1 of 2017/18. During quarters 3 and 4 of 2017/18, some further adjustments were made to Board-level meeting arrangements. Meetings that have been in place during the year, and any changes or adjustments to their arrangements, are set out below.

Board and Board level committee

The Board of Directors is supported by a governance structure as follows, which deals with various components of corporate governance and risk management:

- Quality and Safety Committee (Q&S) – the designated Board subcommittee which oversees quality and safety issues. It is chaired by a Non-Executive Director (NED) and has Executive and NED membership. The Q&S Committee monitored clinical risk management performance throughout the year and made recommendations to the Board as appropriate.
- Finance Investment and Performance Committee (FIP) - the designated Board subcommittee which oversees financial, corporate performance and investment issues. It is chaired by a NED and has Executive and NED membership. The FIP Committee monitored risks to operational and financial performance throughout the year and made recommendations to the Board as appropriate.
- Charitable Funds Committee – this designated Board subcommittee which oversees the management of Charitable Funds held by the Trust.
- Audit & Risk Committee (A&R) – an independent committee and senior Board subcommittee, with all members being NEDs. The A&R Committee has responsibility for overseeing risk management and internal control. The A&R Committee agreed audit plans with our internal and external auditors and received progress updates and audit opinions throughout the year. In January 2018 the Board of Directors agreed to amend the name of this Committee from Audit Committee to Audit & Risk Committee.
- Remuneration Committee – wholly NED membership.
- Executive Leadership Group – membership is Executive Directors, led by the Chief Executive. In practice, due to the joint roles held by the Chief Executive and a number of other Executive Directors across both the Trust and NCUHT, this meeting takes place as a joint Executive Team meeting. The Joint Company Secretary also attends these meetings.

High level governance meetings that support Board subcommittee effectiveness

- Trust Management Board (TMB) - the senior operational management group led by the Chief Executive and attended by Executive Directors, senior officers within care groups and Heads of Support Services. TMB monitors risks to operational and financial performance and provides updates to the FIP Committee.
- Trust Wide Clinical Governance Group (TWCGG) – the senior forum for clinical governance, led by the Director of Quality and Nursing (April 2017 – June 2017) and Deputy Director of Nursing & Quality (July 2017 – March 2018). This monitors risks to quality and safety and provides updates to our Q&S Committee. Representation at the meeting includes the Medical Director, senior clinicians within care groups and senior managers within support services. The change in leadership of this group part way through the year arose in recognition of increasing capacity impacts on the Director of Quality & Nursing associated with their widened role following the departure of the Director of Operations in June 2017 to take up post as Director of Operations at Leeds and York Partnership NHS Foundation Trust.
- Joint Leadership Development Group (April 2017 – August 2017) – led by the Chief Executive and including Executive Directors and senior managerial and clinical leaders, with a specific focus on the development and implementation of Trust strategy. This Group morphed into the Leadership Community Forum (September 2017 – March 2018) and, whilst it has the same target audience and serves the same purpose, it has membership from both Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals Trust.

During 2017/18 the effectiveness of our Board and committee was evaluated through a survey involving Board members and members of each Board sub-committee, and also through consideration of the Committees performance against their workplans. This evaluation indicated each Committee had met and fulfilled their functions in accordance with their Terms of Reference.

During 2018/19 the Trust will be increasingly integrating governance arrangements with North Cumbria University Hospitals Trust. This includes the establishment of shared support services and wherever practical and appropriate, holding joint meetings, including Board-level meetings. It is anticipated these arrangements will lead to more efficient working and enable both Trusts to make best use of their resources, whilst also recognising the statutory duties both Trusts as separate legal entities.

Risk Management Strategy

Our Board of Directors agreed the Trust's Risk Management Strategy in January 2017 and will be reviewing it again during Quarter 1 of 2018/19 as part of the alignment of governance and risk management processes with North Cumbria University Hospitals Trust. In setting out our appetite for risk, the Trust uses a risk appetite framework based upon that promoted by the Good Governance Institute but which it has expanded to include wider range of risk domains that reflect complex sustainability challenges currently

facing the NHS. The strategy also sets out our integrated approach to risk governance, which incorporates:

- Strategic planning activities
- Business planning activities
- Quality Governance Framework
- Assurance Framework
- Governance Assurance and Accountability Framework

The Director of Quality and Nursing is accountable for ensuring appropriate systems and processes are in place to enable the implementation of the Trust's Risk Management Strategy.

Our Risk Management Strategy is implemented through the Risk Management Policy which sets out the framework for how risks are identified, evaluated and controlled. Operational risks are managed on a day-to-day basis by staff throughout the organisation through the Trust's governance structures.

The Risk Management strategy is also delivered through other policies and procedures that support the activities mentioned above, including:

- Policies on specific risk areas, including policies and procedures with respect to countering fraud and corruption
- Policies for the reporting and investigation of incidents, complaints, concerns, and claims
- A risk-based training programme based on an annual analysis of skills and competencies required to support the delivery of safe and effective services
- Induction programmes for our staff and governors
- Training delivered by a combination of in-house experts and external partners, that gives the flexibility to provide tailored training to meet the needs of individuals with additional risk management responsibilities
- Reporting to the Board and its committee on quality governance matters, including patient safety, patient experience, performance against key performance indicators and other regulatory and compliance requirements.

Risk Management Policy

The Risk Management Policy, last reviewed during 2016/17, sets out our approach to the identification, evaluation, assessment, management, reporting and monitoring of risks. In addition, it also sets out how risks are to be escalated through the Trust's governance frameworks. Training on the Risk Management Policy was delivered to team leads during 2017/18 as part of the Trust's risk management training programme.

We are continually seeking ways in which to enhance the quality of information available to frontline services to support their decision making around risk management. Quality and safety dashboards, which have been developed in liaison with our clinical leads, enable

our leaders to actively identify and respond to quality and safety risks within their services. Further enhancements to the content, accessibility and functionality of dashboards were made during the year. Embedding the use of dashboards within governance forums is an ambition for 2018/19.

A continual improvement approach is taken to enhance the capabilities of our risk management information system (Ulysses). Our Quality and Safety Systems Group (formerly Ulysses systems group) meets regularly throughout the year to discuss improvement opportunities and to ensure the system enables us to meet our statutory obligations with accuracy.

Our Governance Accountability and Assurance Framework (GAAF) is the Trust's performance measurement and reporting framework. The GAAF sets out responsibilities and accountabilities of staff at all levels and complements the Trust's Risk Management Policy. It is framed around the four domains of our approach to quality improvement Quality, People, Service and Efficiency (QPSE) and is underpinned by performance indicators and metrics that inform our understanding of risks to performance and quality through our integrated performance reporting processes. During the year, the Trust's Governance Manual was updated and expanded to incorporate the GAAF, and also describes the Board Assurance Framework and business planning processes. It is now referred to as the Integrated Governance Manual.

Quality governance

Quality governance is a key activity of the Board of Directors to ensure essential levels of quality and safety are met.

External sources of assurance include:

- Internal and external auditors
- Care Quality Commission
- NHS Litigation Authority
- Other visits and inspections from regulatory agencies.

Internal sources of assurance include:

- Activities undertaken by Quality and Safety Leads within care groups, Clinical Governance Team within the Quality & Nursing Directorate, and the Corporate Governance Department
- Performance metrics
- Non-executive and governor joint visiting programme
- Incident reporting
- Patient and carer feedback, including patient stories at the Board

Over recent years the Trust has undertaken an annual self-assessment against NHS Improvement's (formerly Monitor's) Well Led Framework which informs our evaluation of

our quality governance arrangements. The self-assessment undertaken during quarter 4 of 2016/17 was agreed by the Board of Directors in July 2017.

Areas identified for improvement included strengthening arrangements for workforce planning, reviewing our arrangements for corporate risk management, evaluating the effectiveness of the integrated assessment tool at informing risk-based decisions on matters of financial and clinical sustainability and hold a Board development session on Equality & Diversity to include board responsibilities for setting and delivering E&D objectives. Delivery of improvement actions has been monitored through relevant governance forums and with board level oversight.

Our 2016/17 self-assessment was undertaken against the 2015 version of the Well Led framework, which at the time of the self-assessment was being reviewed jointly by NHSI and CQC who subsequently published a combined Well Led framework in June 2017. The Trust's internal process to support CQC inspection-readiness were updated and all clinical services were requested to update their Key Lines of Enquiry (KLOE) documents to recognise changes within the updated new framework.

In November 2017 the Trust underwent a formal inspection by the CQC and was one of first tranche of Trusts to be inspected under this new framework. The CQC issued their inspection report in January 2018 and assessed the Trust as Requires Improvement overall and stated 22 'must do' actions required immediate attention. Details of the outcome of the CQC's inspection and how we are responding to their recommendations can be found in the Quality Report. The Trust's 2017/18 self-assessment against the Well Led framework, which was conducted during Quarter 4 of 2017/18, takes into consideration the findings and recommendations from the CQC's inspection and our progress with improvement actions identified in our 2016/17 self assessment.

One of those 'must do' actions in the CQC's January 2018 inspection report related to improving the relationship between our operational and strategic risk management processes and strengthening our arrangements for how we gain assurances that risks are being effectively managed. These were areas that the Trust had identified that required attention as part of reviewing the effectiveness of corporate risk management arrangements and were making ready to implement improvement actions at the time of the inspection.

Actions taken during Quarter 4 of 2017/18 to strengthen our risk management arrangements include providing greater visibility of the Board Assurance Framework (the Trust's strategic risk register) to senior managers below Board level, improved scrutiny of the corporate risk register (which contains the most significant operational risks) at Trust Management Board. Other notable improvements achieved during Quarter 4 include a dramatic reduction in the number of risk assessments in our risk registers that are overdue for review (from (19.72% of the total number of open risks on the risk register on 12 January 2018 to 4.31% on 31 March 2018). This aspect of risk register management is

now incorporated into our performance management (GAAF) reports and is a regular aspect of quality governance within Care Group and Support Services'. Our risk management policy has also been reviewed to take into account findings of the CQC inspection.

Longer term actions which collectively will strengthen the quality of our risk management arrangements during 2018/19 include refreshing risk management training programmes and guidance documents, reinvigorating governance processes within our care groups and support services, further developing our performance and safety dashboards, and updating the Ulysses risk management system. The Q&S Committee oversees progress and effectiveness of initiatives to address the CQC's must do actions.

The care group model, which was introduced in 2014/15 to realign and refocus our clinical governance arrangements, is now embedded and quality continues to be the driving principle of our governance frameworks. Continual improvement and organisational development also continue to underpin our quality governance arrangements. In 2017/18, a full year's baseline data of our staff engagement activities became available through our Great Teams Great Care approach. This gives us rich information that we are now using to inform our development programmes such as leadership and staff recognition.

The Board receives performance reports on agreed safety and quality key performance indicators in accordance with the Governance Accountability and Assurance Framework (GAAF). The GAAF is framed around four domains: Quality, People, Services, Efficiency which represent the Trust's strategic objectives.

To comply with the governance conditions of the Provider Licence, the Trust is required to provide a Corporate Governance Statement to NHS Improvement (NHSI). The Corporate Governance Statement relating to 2017/18 was presented to the Board of Directors for formal acceptance in May 2018. The Corporate Governance Statement sets out any risks to our compliance with the governance conditions, along with the actions taken or being taken to maintain future compliance. The statement sets out a number of key questions essential for quality governance, with evidence gathered through self-assessment or review. The Chief Executive has overall responsibility for ensuring compliance with the Trust's Provider Licence conditions, which he discharges through the Executive Team. The FIP Committee seeks assurance on compliance with the licence conditions on behalf of the Board of Directors. Risks to performance are managed and monitored through the TMB.

Throughout the year we have maintained good working relations with NHSI and have ensured they have been notified of any significant risks to compliance or service continuity, such as an issue identified with the scheduling function one of our patient information systems (EMIS) during Quarter 4 of 2017/18 which required temporary work-arounds to be introduced whilst the supplier resolved the issues.

The Trust expects to comply with all of the Provider Licence conditions in 2018/19. Should there be any indications to the contrary we will ensure NHSI are notified as soon as they become apparent. NHSI is regularly appraised of the Trust's financial position. Further information on our quality governance arrangements can be found in the Quality Report.

Incident reporting

A positive approach to incident reporting is communicated through Trust policies and procedures. The Trust continues to be consistently within the top third of benchmark trusts in NHS Organisation Patient Safety Incident Reports, in respect of reports of patient safety incidents, with most of our incidents reported falling within the no/low harm categories.

Within the Trust the reporting of incidents or concerns is encouraged and is used as a tool to learn and improve. The Trust has a clear focus on open and honest reporting of incidents, with investigation into an incident proportional to the level of harm or potential harm, as detailed in the Trust's Being Open/Duty of Candour and Serious Incident policies.

A review of the Trust's Raising Concerns (Whistleblowing) Policy and supporting processes was undertaken by the Trust during the year which took into consideration recent national best practice guidance. The approved policy is published on the Trust's website. A designated Freedom to Speak Up Guardian was appointed during the year who provides regular updates to the Board of Directors. The trust's policy and arrangements for conflicts of interest were also updated during the year to reflect best practice.

Risk reporting

Risk management is fundamental to how the Trust operates. The Trust's risk appetite is articulated in our Risk Management Strategy. Risks are identified and evaluated using a 5 x 5 risk grading matrix, and recorded and reported in accordance with the Risk Management Policy.

Top strategic risks are managed through the Board Assurance Framework (BAF). Work activities of the Board and Board level committee are aligned to the BAF in order to enable line of sight to the management of strategic risks.

All operational risks are recorded in the Trust's risk management information system (Ulysses). Those risks recorded within Ulysses collectively form the Trust's risk register. The risks recorded on the Trust's risk register which scored 15-25 i.e. high risks, are also identified on the corporate risk register. An Executive Director or other senior manager is formally accountable for each recorded risk on the Trust's risk register. Individual responsibilities include ensuring appropriate arrangements are in place for effective risk management and mitigation.

The BAF is subject to formal review by the A&R Committee every six months and quarterly by the Board of Directors, Q&S Committee and FIP Committee. The TMB has responsibilities for risk management performance and receives monthly updates on the

management of risks on the corporate risk register. The BAF review process, which takes place on a quarterly basis, incorporates a review of the risks on the corporate risk register. The management of risks is a routine item for discussion at each of the care groups' clinical governance forums.

In February and March 2018 the Boards of Directors of CPFT and NCUHT agreed an aligned approach for the Board Assurance Framework and reporting of strategic risks as part of the collaborative working arrangements between both trusts.

The Q&S Committee receive annual reports from each care group about their clinical governance arrangements and Care Quality Commission (CQC) compliance. Any significant risks identified from these reviews are managed as per the agreed accountabilities and responsibilities framework. The Clinical Governance team within the Quality and Nursing Directorate coordinate arrangements for monitoring and overseeing CQC registration and compliance requirements.

Public stakeholders are involved in identifying and managing risks through membership of the Governors Council and by attending specific service users' and carers' groups throughout the Trust. The Governors Council is provided with performance information and is involved in the annual planning process. All service users, carers and visitors are encouraged to provide feedback on the service received and offer suggestions for improvement.

Data quality

Risks to our data quality have been recognised by the Trust for some time and have been highlighted by both our Internal and External Auditors over recent years. In July 2016, the Audit Committee endorsed a Data Quality Strategy for implementation over a three year period (2016/17 to 2018/19) through initiatives to systematically improve data quality across all of our information systems. The A&R Committee received updates on progress against the strategy throughout 2017/18 and the internal audit programme included audits on data quality which demonstrated positive improvements. Details of the steps we have taken to address data quality are provided in the Quality Report.

Top Strategic risks

We take assurance that our quality governance arrangements are effective from a range of sources including audits by our Internal Auditors, and reviews by external bodies such as the CQC. We recognise that balancing high quality care with long term financial sustainability and delivering integrated care are significant and challenging strategic risks. These are integral to our BAF. We are working with our STP partners on major transformation programmes which span the Cumbria footprint to find workable solutions to these very challenging strategic risks. Examples of transformational schemes include the development of Integrated Care Communities (ICCs) based around GP practice populations across the County, and as part of the integration of community services, the

transfer of community staff from the Trust to University Hospitals Morecambe Bay NHS Trust on 1 April 2018 to simplify local health services.

During Quarter 3 of 2017/18 the Board of Directors reviewed its top strategic risks and major operational and clinical risks. Our top strategic risks are as follows:

- Patients or service users do not receive high quality care because either safety, outcomes or experience are compromised
- Unable to sustain the cultural change needed to improve the quality of care for all patients and service users
- High quality and sustainable care is compromised by inability to implement improvement strategies for hard and soft infrastructure (facilities, estate, applications, IT)
- Unable to deliver and sustain senior leadership workforce capability and capacity improvements to deliver modernised and transformed services
- Inability to balance financial sustainability with maintaining high quality, safe services whilst balancing workforce, quality and financial challenges across multiple STP footprints
- Inability to maximise partnership working to achieve safe and sustainable system and service transformation, particularly of services delivered countywide, within the community, and across multiple care models due to the complexities and constraints of current regulatory frameworks
- Failure to influence the shape and delivery of future care models Integrated Health and Care Systems (IHCSs)

A further review of strategic risks will be undertaken during Quarter 1 of 2018/19 as part of the work to integrate the Board Assurance Framework arrangements across CPFT and NCUHT.

Significant operational and clinical risks

Risks are identified, managed and monitored through our governance frameworks, in accordance with the Risk Management Policy and the GAAF. Risk reporting and measurement are actioned through our Outcomes Framework, quality and safety dashboards, and via the risk management information system (Ulysses) - all of which enable line of sight to risk management performance at all levels throughout the Trust.

Examples of significant operational and clinical risks affecting the Trust include the following:

- ability to ensure service continuity in services that are fragile due to challenges in recruitment to specialist roles, such as in some of our district nursing services
- delays in patients accessing specialist dental services due to lack of availability in specialists to support the delivery of care during treatments
- ability to transfer patients out of community hospitals into alternative care settings

- suitability of some of our patient and staff environments, such as our Kentmere ward in Kendal. Oakwood ward on our Carleton Clinic site and Valley View in Whitehaven all of which have their own particular issues which are complex to resolve.

Policy Management

During 2017/18 we continued to see improvements in the number of policies which were due for review. Policies become due for review throughout the year and arrangements are in place to initiate timely review. The number due for review as at 31 March 2018 was 36. This is slightly increased from the position at 31 March 2017 when 30 policies were due for review.

Performance and Delivery Group monitors policy review performance throughout the year, with oversight provided by A&R Committee. Information on how we have responded to the CQC inspection relating to the management and implementation of some policies is provided within the Quality Report.

As part of our increasingly integrated working with North Cumbria University Hospitals Trust, both trusts are working together to implement aligned processes for policy management. Initial work commenced on this during Quarter 4 of 2017/18 and will continue throughout 2018/19. We are also identifying policies appropriate for alignment across both trusts during 2018/19, which may result in adjustments and extension to review timeframes for some policies.

Quality Impact Assessments

Our The Integrated Assessment (IA) approach to undertaking quality impact assessments, which takes a holistic approach to assessing the impacts of major change schemes, including those proposed within our efficiency programme, was applied throughout 2017/18. The IA approach enables decisions to be made based upon a balance of risks to quality, equality and the clinical and financial sustainability of services. The IA process is led by the Medical Director and overseen by the Q&S Committee. It is also integrated into the Trust's business planning process, which evolved during the yearto integrate and incorporate the trust's approach to workforce planning.

Board level assurance on the timely undertaking of impact assessments improved during the year through evidence provided to the Q&S Committee. As part of our collaborative working with NCUHT, an aligned approach to undertaking quality impact assessments was agreed by the Q&S Committee in April 2018 for immediate implementation across both trusts.

Cumbria Partnership NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

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.

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

Emergency preparedness
The Trust's emergency planning and business continuity consider organisational resilience and the Trust's ability to respond/recover from incidents and disruption. Very high and high risks in the current version of the Cumbria Community Risk Register are covered by either the Trust's contingency planning, or wider health or multi-agency planning to which the Trust contributes. The Trust works collaboratively and shares information appropriately with responder organisations in furtherance of multi-agency co-operation and co-ordination.
The Trust seeks to comply with the Civil Contingencies Act 2004 regime and align with the international standard for business continuity, BS ISO 22301:2012 and its guidance, BS ISO 22313:2012.

Under NHS England's Emergency Preparedness Resilience and Response (EPRR) guidance, the Trust must:

- have a suitable and up-to-date incident response plan which sets out how it would respond to and recover from a major incident/emergency affecting local communities or the delivery of its services; and
- adopt business continuity plans to enable it to maintain or recover the delivery of its critical services in the event of significant disruption.

The Trust complies with NHS England's requirements by providing an EPRR structure and implementing a business continuity management system through which the Trust will endeavour to respond to critical incidents (which may include so-called 'unusual' incidents) and emergencies as well as maintaining its critical functions, ordinary functions and contractual obligations as far as reasonably practicable.

Review of economy, efficiency and effectiveness of the use of resources
The Trust closely monitors budgetary control and expenditure through the Financial Delivery Group (formerly Financial Recovery and Transformation (FRAT) Group) and TMB. The FRAT group was established in April 2017 to strengthen the governance around financial recovery and to give focus to where small changes could make big differences to the Trust's overall financial efficiency efforts.

The Director of Finance and Joint Director of Strategy and Support Services presents finance reports to both the FIP Committee and the Board of Directors. Through the Trust's Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation the Board of Directors has created clarity regarding delegated authority levels across the Trust. Executive Directors and managers have responsibility for the effective management and deployment of their staff and other resources to optimise the efficiency of each area of the Trust's operations.

The Board receives both performance and financial reports at each of its public meetings in addition to reports from the chairs of its committee, to which it has delegated powers and responsibilities. When required, the Board receives further assurance provided by its internal and external auditors.

The 2-year financial plan for 2017/18 and 2018/19 was developed based on a number of assumptions about the degree of financial recovery that could be delivered over the two year period. We recognised there were risks to the delivery of the 2-year plan which we alerted NHSI of through caveats within the 2-year operational plan and through separate correspondence and routine contacts.
Through concerted efforts driving efficiencies during the year and through our collaborative working with system partners, the Trust exceeded its financial control total for 2017/18 and qualified for bonus and incentive STF of £1.34m. The financial plan for 2018/19 (year 2 of the 2-year plan) has been developed in conjunction with NCUHT and was agreed by both Boards of Directors in April 2018. There are significant risks to the delivery of the financial plan and many of the caveats notified to NHSI for the 2017/18 financial plan remain relevant into 2018/19.

The Trust was rated as being placed in Segment 2 under NHSI's Single Oversight Framework at 31 March 2018. You can find further details about ratings in the NHS Improvements Single Oversight Framework Report.

During 2017/18 the Trust has continued to reduce reliance on agency staff where possible and controls are in place to control expenditure on agency workers. Board-level oversight of expenditure on agency workers is undertaken by the FIP Committee as part of the Board level performance reports. Information is also readily available to front line managers through quality and safety dashboards.

Information governance (IG) and data security
The Trust reported two IG level 2 Serious Incidents Requiring Investigation (SIRIs) relating to IG during the year. Each of these incidents have been reported to the Information Commissioners Office. We are committed to learning from all incidents with a view to preventing recurrence in the future.

The Trust was affected by the international cyber security incident in May 2017 which affected a number of NHS Trusts in the UK. The Trust took swift action to secure its IT systems in response to the cyber-attack and experienced no breaches of its patient records or data loss. You can find further details about our Information Governance and data security arrangements in the Quality Report.

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

The Trust has arrangements in place to assure the Board that the Quality Report presents a balanced view and that there are controls in place to ensure the accuracy of data. Overseeing the Quality Report preparation and content was the responsibility of the Director of Quality and Nursing during 2017/18.

The Trust recognises that good quality data is essential for the delivery of safe and effective care to our patients as well as enabling us to manage services and performance. To support this, the Trust has in place a strategy with supporting policies and procedures which govern the accuracy, completeness and timeliness of data at the point of capture and when reporting either for internal or external purposes.

A governance framework is in place which oversees data quality performance from operational services through to Board level. Data quality performance is overseen by the Information Governance department. Key performance indicators (KPI) are subject to data quality and data validation processes. Performance is routinely reported and regularly reviewed at all levels within local and corporate governance structures in accordance with the Trust's Governance Assurance and Accountability Framework. This includes monthly review by the Board of Directors and review at each meeting of the Governors Council.

A balanced view of our data quality is obtained through comparing and analysing data accuracy from checks undertaken by front line staff and service managers, and through independent audits undertaken by our internal and external auditors.

The Trust currently uses a number of separate electronic and paper patient record systems to record clinical information and produce reports. This includes EMIS and RiO electronic patient record systems which are used in our Care Groups. Checks are in place to provide assurance that the data from these systems is accurate. Assurances have been provided during the year through the internal audit programme and our data validation checks and monitoring processes that our data quality has improved through implementation of our Data Quality strategy.

Our suite of policies and procedural documents are reviewed as part of an ongoing review programme to reflect changes to legislation and best practice and, more recently, to reflect aligned governance arrangements with NCUHT. The Clinical Policies sub group which was established during 2016/17 continues to meet regularly to ensure clinical policies are reviewed in a timely manner. The work to review policies is ongoing and is overseen by the A&R Committee. Our Governance Assurance and Accountability Framework sets out responsibilities and accountabilities for performance and governance at all levels within the Trust. This is underpinned by the Outcomes and Performance Framework, which comprises performance indicators and metrics by which the Trust measures and monitors its performance with local, regional and national standards and targets.

The Outcomes and Performance Framework populates a set of dashboards which enable our staff and managers to identify, monitor and improve the quality of data derived from patient information systems. The dashboards also provide the basis for assuring the Board of Directors of the quality, accuracy and completeness of data. Our quality and safety dashboards have been expanded during the year to enable triangulation of safety data. Developments will continue during 2018/19.

In Quarter 1 of 2017/18, as part of a refresh of our governance arrangements, the Performance & Delivery Group was formed to identify, monitor and manage risks to performance. Particular focus is given to those areas subject to key performance indicators, such as targets set by NHSI. The Performance & Delivery Group is a sub group of TMB. Our organisational development and service improvement functions, which are now embedded, support our leadership teams with implementing quality improvements. A suite of tools and training on quality improvement methodologies is also available to all staff throughout the Trust.

The Trust achieved a number of quality improvements during the year, including developing the approach to equality & quality impact assessments, building our capabilities around learning lessons from incidents, and use of quality & safety dashboards at network and team level to improve quality governance. Further details about these and other quality highlights, and also details about our performance and achievement of key performance indicators can be found in the Quality Report.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the 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 Report 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 & Risk Committee (A&R), Quality and Safety Committee(Q&S), and Finance Investment and PerformanceCommittee (FIP) and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Director of Quality and Nursing is responsible for developing and delivering the clinical audit programme and for ensuring the audit programme supports a process of continual improvement. The Trust Wide Clinical Governance Group (TWCGG), which reports into the Q&S Committee, oversees the clinical audit programme. The Q&S Committee receives monthly updates from the TWCGG on the management of risks to quality and safety.

The Q&S Committee, FIP Committee, Charitable Funds Committee and A&R Committee each have activity schedules framed around enabling the Board of Directors to have line of sight to any significant risks to internal control. An annual evaluation of committee effectiveness is undertaken for each of these Board committee. This is a self-assessment by committee members and regular attendees, the outcome of which is considered by the A&R Committee.

The Trust also has an active programme of internal and external audit. The audit programme, including recommendations from audits, is overseen by the A&R Committee which is a subcommittee of the Board of Directors. The focus of the internal and external audit programme is set to both support and complement the organisation’s objectives and provide an assessment for the Board of Directors on areas of specific risk. The internal audit programme is developed having due regard to the risks and risk controls set out in the Board Assurance Framework and corporate risk register. Audit recommendations are framed around improving internal control and also identifying opportunities for creating added value from our current systems and processes. Any significant risks to internal control identified through the internal audit programme are assigned to a nominated Executive Director to resolve, and are monitored through the Trust Management Group.

During the year the Trust’s external auditors changed from KPMG to Mazars. 2017/18 will be the first year Mazars will give their opinion on the Trust’s governance arrangements.

Our internal auditors awarded substantial, good or reasonable assurance on all audits they undertook during the year, with the exception of our arrangements for duty of candour and

procurement which were both awarded limited assurance during quarter 4 of 2017/18. We are actively working to improve and embed our arrangements for duty of candour and an improvement plan has been developed in conjunction with our system partners (NCUHT and UHMB) to strengthen our collective arrangements for procurement and get best value from the contracts we hold and manage. Progress is being managed and monitored through our governance frameworks, with oversight by the A&R Committee. Progress on implementing recommendations from audits is overseen by the A&R Committee.

The Head of Internal Audit has given an overall opinion of good assurance that the system of internal control has been effectively designed to meet the organisation's objectives, and that controls are being consistently applied.

Conclusion

As Accounting Officer and based on the review process outlined above, I conclude that no significant internal control issues have been identified during the year with the exception of our procurement arrangements which have been responded to through the implementation of remedial actions and an improvement plan that will be delivered in conjunction with our system partners during 2018/19.

Signed ..... Date: 24 May 2018

Stephen Eames, Chief Executive for CPFT and NCUHT

Voluntary Disclosure

Equality reporting

Introduction

This Equality, Diversity and Inclusion (EDI) report provides information on how Cumbria Partnership NHS Foundation Trust is meeting its legal duties set out in the Equality Act 2010, the Public Sector Equality Duty 2011 and the Human Rights Act 1998 which aim to:

- Eliminate unlawful discrimination, harassment and victimisation and other unlawful conduct
- Advance equality of opportunity between people of different groups; and
- Foster good relationships between people who share a protected characteristic and those who do not

The nine Characteristics which are protected by the Equality Act 2010 are:

1. Age
2. Disability
3. Gender reassignment
4. Marriage or civil partnership
5. Pregnancy and maternity
6. Race
7. Religion or belief
8. Sex
9. Sexual orientation

The people who use our services have diverse needs therefore to enable us to deliver quality care to every patient every time we must hear the voice of the patient and understand their individual need; creating the right culture and environment for quality care to flourish and all our staff to achieve their potential. Our equality goals and objectives provide a framework for this to happen:

Goal 1: Better health outcomes for all
Goal 2: Improved patient access and experience
Goal 3: Empowered, engaged and well supported staff
Goal 4: Inclusive leadership at all levels

This report provides an update on the progress the Trust has made towards these goals during 2017/18, and includes workforce and patient statistical information relating to specific protected groups.

The information within this report will inform improvements for joint EDI development within the Trust and in North Cumbria University Hospitals NHS Trust (NCUHT) in 2018/19.

Compliance

Equality Delivery System Objectives

The Equality Delivery System (EDS2) requires the Trust to develop and agree equality objectives. An annual self-assessment is undertaken to measure the Trust's progress against these objectives followed by a Community Stakeholder Engagement event to grade performance and collectively develop equality objectives for the following year.

The table below contains the Equality Objectives for 2018-19 the Trust which were agreed by the Quality and Safety Committee on 8 February 2018:

Goal	Description of Outcome	Achieved by	Equality Objective
Better Health Outcomes	Patient and staff stories from a range of different protected characteristics are heard at joint Board level meetings with identified impact/outcomes	November 2018	**1, 3 & 4**
Improved Patient Access and Experience	Workforce Disability Equality Standard (WDES) completed within the required standards and timescales, engaging with different community groups and partner organisations to ensure representation and promote equality of opportunity	December 2018	**1, 2 & 3**
	Work with BME community groups to understand barriers to recruitment and promote opportunities for attraction and employment of people from diverse ethnic backgrounds	December 2018	**1, 2 & 3**
Representative and Supported Workforce	Develop a Transgender Policy and implement across CPFT & NCUHT with a supported roll out and training plan	September 2018	**1, 2 & 3**
	Develop and implement Staff Networks across CPFT & NCUHT with a supporting communications plan and measurable outcomes	September 2018	**1 & 3**
Inclusive Leadership at all levels	Work closely with system partners to create joint Equality Objectives as North Cumbria Health & Care Partners	July 2018	**1, 2, 3 & 4**

The table below shows the grading achieved for the Trust following the EDS2 Stakeholder Grading event in November 2017:

GOAL	OBJECTIVE	SCORE
1.	Develop a single Equality Impact Assessment process, applied consistently across the Trust implemented with a supported roll out.	Achieving
2.	The Trust is represented at Strategic Refugee Meetings and Health Sub Groups to ensure the needs of Syrian refugees are identified with plans developed to identify their needs and promote access.	Achieving
3.	EDI networks developed to focus on different protected characteristics	Developing
4.	Workforce Race Equality Standard (WRES) completed within the required standards and timescales, engaging with different cultural staff groups to ensure representation and promote equality of opportunity.	Achieving
5.	Patient stories are included and heard at Board level meetings	Achieving
6.	Board Development session to consider how the Trust Board can demonstrate inclusive leadership, accountability and the impact of decisions upon people from protected groups.	Achieving

EDI incidents and Complaints

The EDI related incidents in the Trust are contained in the table below.

Incident	Type of Incident	Action
1	Unhappy with lack of disabled facilities on Yewdale Ward	Raised with Head of Facilities. Estates team exploring update of kitchen facilities at Yewdale
2	No wheelchair access to groups at CMHART Building in Carlisle	Raised with Head of Facilities. Discussions with Mental Health Team regarding access to building.
3	Lack of disabled facilities at Valley View. No suitable parking or toilet facilities.	Raised with Head of Facilities. Alternative provision being explored.

Equality Impact Assessments (EIA's)

An Equality Impact Assessment (EIA) should be undertaken for all proposed changes, to assess whether they may cause a detrimental impact upon people with protected characteristics. The Trust undertakes EIA's and a revised process has been developed to ensure a consistent joint approach and that assessments are undertaken as effectively as possible. In addition, all reports seeking Committee approval must attach the completed

EIA to ensure any potential detrimental impact upon people with protected characteristics or under-represented groups have been appropriately assessed.

Workforce Equality, Diversity and Inclusion related HR cases
During the 2017-2018 period the Trust had 25 grievances, disciplinary and capability cases raised, however, none were related to Equality, Diversity and Inclusion issues.

Policies and Procedures
The Trust has an EDI Policy; the Equality and Diversity policy is due for renewal in May 2019 and the Equal Opportunities Policy for NCUHT in 2026. A joint policy will be developed with NCUHT to ensure a consistent approach for our patients and staff.

A Transgender policy is being developed for both CPFT and NCUHT, with specialist advice received from a local Transgender Organisation, members of the Transgender Community plus discussion with EDI Representatives. Once approved, this joint policy will be launched on, or before, September 2018, together with a programme of engagement and awareness training.

Training, Development and Awareness Sessions
- The Trust requires all staff to compete mandatory e-learning training for Equality and Diversity. The Trust has recently introduced the core skills framework provided by skills for health, although there have been some compatibility issues, this went live in May 2018.
- The launch of the Transgender policy will be accompanied by a number of development sessions offered throughout Cumbria, commenced in April 2018.
- A full day of Equality, Diversity and Inclusion training was held on the 29 September 2017, attended by system-wide Health and Social Care colleagues. The day included interactive sessions around unconscious bias, transgender awareness and engaging with BME communities.
- An Accessible Information Training afternoon was also held on the 1 November 2017 including presentations from Cumbria Deaf Association and Sight Advice South Lakes.

Workforce Equality Standards
In accordance with NHS England's requirements the Trust completed the Workforce Race Equality Standard (WRES) for 2017, providing both data and narrative around race equality issues within the workforce. Although figures are increasing, the Black, Minority, Ethnic (BME) population of Cumbria is low, with an overall BME of 1.4%. This full WRES reports can be found on the Trust website.

The Disability Workforce Equality Standard (WDES) comes into effect in 2018 which requires Trusts to provide data and narrative around disability equality issues within the workforce. The Trust is working with NHS England on what is required.

Accessible Information Standard (AIS)
From the 1 August 2016 all publicly funded health and social care organisations are legally required to adhere to the standard requirements. These standards are to identify, record, flag, share and act on the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

A joint working group was established with staff, service user and partner involvement to progress a number of different workstreams. The project has made a number of significant achievements including the implementation of BrowseAloud, a Digital Patient Information library and a custom AIS training package for staff. As work continues, the emphasis for 2018 is upon system working and sharing best practice.

Culture, Communities and Partnership

EDI Representatives
EDI Representatives are employees and governors within both CPFT and NCUHT who are passionate about promoting equality, diversity and inclusion within their everyday work. The number of representatives is continually increasing and currently stands at 58. Joint Staff Networks are now being developed; the Armed Forces Network was launched September 2017, which will be followed by the LGBT Network in April, the Accessibility/Disability Network in May and the BME/Diverse Communities Network in June.

Community Events
The Trust works with a number of different community groups across Cumbria. Over the past 12 months they have both sponsored and attended community events including the Unity Festival, Cumbria Pride, Culture Bazaar, IDAHOT day, and the Diverse Cumbria Awards, attending as “NHS in Cumbria”.

The Trusts are working closely with a local BME organisation to understand how to better engage with people from BME and under-represented communities, to promote work opportunities and understand barriers experienced by different communities, ethnic and cultural backgrounds. The Trusts also work with national and local partners to support the County’s Military Veterans in accessing services and promoting work opportunities when transitioning into civilian life and supporting the Step into Health Programme.

Public Sector Partnerships and Integrated Working
The Trust is represented at regional and national EDI events, working together with NHS employers, NHS England and the North West Leadership Academy. Regional and local EDI groups also include the Carlisle Equality & Diversity Partnership and the EDI Network Group for Cumbria and the North East.

The Trust is also a member of the Employers Network for Equality and Inclusion (ENEI) and joint membership will be explored for 2018.

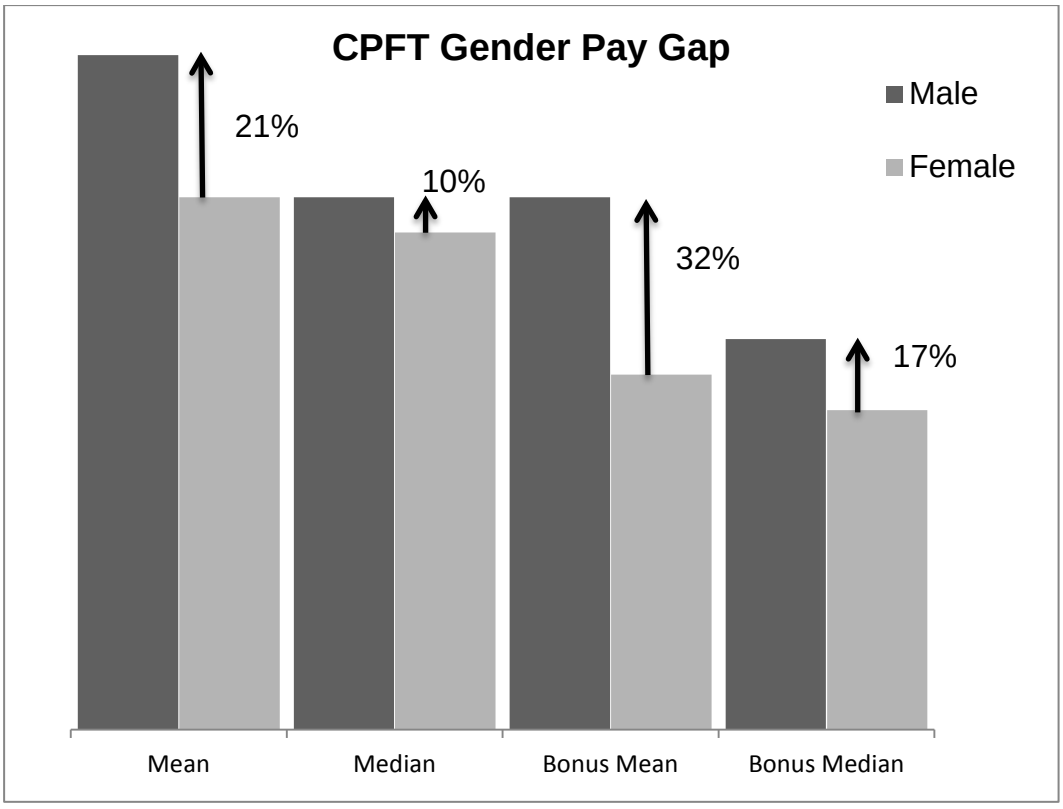
The Trust is a key member of the Cumbria Public Sector Partnership, together with NCUHT, Cumbria Constabulary, Cumbria Clinical Commissioning Group and Cumbria County Council. Working together with shared equality objectives to identify, understand and meet the EDI needs of public, patients and service users within the County. Membership of the Group has been extended to include other public sector partner across the County.

Gender Pay Gap Analysis

Following government consultation, it became mandatory as of 31 March 2017 for public sectors organisations with over 250 employees to report annually on their gender pay gap. The Trust has published the data on both the Government website and their public website to ensure compliance.

The gender pay gap describes the difference between the average earning of all the women in an organisation compared to the average earnings of all the men in that organisation. This is not the same as equal pay, which is about ensuring men and women doing the same or comparable jobs are paid the same. In our organisations, Clinical Excellence Awards apply to consultant level medical and dental staff, these are defined as a bonus within the gender pay definitions. As a healthcare provider a high proportion of the workforce is female, this is reflected in the national NHS workforce with 77% being female.

The graph below shows the gap analysis for each organisation between the mean, median, bonus mean and bonus median hourly rates of pay by gender.



Workforce EDI Data

Gender
The NHS workforce is made up of 23% Male and 77% Female, when the Trust figures are compared they are within a 10% margin. 93% of our Nursing and Midwifery Staff are female and 44% of the Medical and Dental Consultant staff are also female.

Age
The Trust workforce information shows that we have an ageing workforce with 55%being over the age of 45 and 22% of which are over 56. When compared with 2017 this has increased by 4% for over 45's and 3% for over 56.

Ethnicity
The Trust currently employs in the region of 3900 staff, 94% of which described themselves as White UK. As the BME rate within the county is low the Trust figures correspond with the county statistics.

Religion
A large majority of employees have chosen not to disclose their religion currently 28% with Christianity ranking highest within the Trust at 51%. Other religions and cultures are represented within the organisation, however the numbers are very sparse.

Sexual Orientation
As previously seen within the religion statistics a large majority of have chosen not to disclose at 24%. There are very low indication rates of gay, lesbian and bisexual with the highest disclosing rate being heterosexual at 75%.

Bisexual	0.30%
Gay	0.60%
Heterosexual	74.56%
Lesbian	0.40%
Undefined	0.08%
Not Disclosed	24.06%

Disability – Existing Staff
The not declared rate has decreased by 2% from last year to 20% and only a minor number of the workforce declare themselves as having a disability currently 4%. This leaves us with a 76% majority of the workforce that consider they do not to have a disability.

Ethnicity
The ethnicity profile of patients within the Trust's services includes both Community and Mental Health Inpatient and Outpatient. The data shows a high proportion of patients from

White-British backgrounds and a small number from a range of different backgrounds. This is in line with the counties ethnicity profile of a majority White – British population at 96.5% (2011 census).

Ethnicity - Inpatient	**%**
White - British	88.38%
Not stated	9.55%
White - Any other White Background	1.17%
White - Irish	0.45%
Asian/Asian Brit - Any other Asian background	0.09%
Other Ethnic Group - Any other ethnic group	0.09%
Unknown	0.07%
Mixed - Any other mixed background	0.05%
Any other White background	0.05%
Other Ethnic Groups - Chinese	0.05%
Mixed - White and Black African	0.02%
Black/Blk Brit - African	0.02%
Mixed - White and Black Caribbean	0.02%

Ethnicity - Outpatient	**%**
White - British	41.94%
Unknown	37.85%
Any other white background	8.01%
Not stated	5.65%
White - Any other White Background	1.62%
Not Mapped	1.07%
White - Irish	0.69%
Other Ethnic Group - Any other ethnic group	0.58%
Mixed - Any other mixed background	0.49%
Asian/Asian Brit - Any other Asian background	0.26%
Mixed - White and Asian	0.24%
Mixed - White and Black Caribbean	0.17%
Mixed - White and Black African	0.16%
Asian/Asian Brit - Bangladeshi	0.15%
Other Ethnic Groups - Chinese	0.14%
White and Black Caribbean	0.13%
Black or Black British - Any other Black background	0.12%
Black/Blk Brit - African	0.10%
Any other ethnic group	0.09%
Asian/Asian Brit - Indian	0.08%

Ethnicity - Outpatient	%
Asian/Asian Brit - Pakistani	0.07%
Any other mixed background	0.06%
Pakistani	0.05%
Chinese	0.04%
Indian	0.04%
White and Asian	0.04%
Black/Blk Brit - Caribbean	0.03%
Any other Asian background	0.03%
White and Black African	0.02%
African	0.02%
Caribbean	0.02%
British	0.02%
Any other Black background	0.00%

Age

Cumbria as a county is described as having a 'super-ageing' population with 2016 estimates of 23.5% of the population aged 65+ (Cumbria Observatory). By 2029 it is estimated that more than half the population in parts of Cumbria will be 50+ (Office for National Statistics). With an aging population patients in Cumbria will have more complex health needs. As shown below 69% of inpatient activity was for patients aged 65+, compared with 54% of outpatient activity.

Age Profiles – Inpatient community and Mental Health

Age	85+	75-84	65-74	55-64	45-54	25-34	35-44	16-24
Total	32%	25%	12%	8%	7%	6%	6%	4%

Age Profiles – Outpatient Community and Mental Health

Age	75-84	85+	65-74	55-64	45-54	35-44	25-34	16-24	5-15	<5
Total	20%	18%	15%	12%	9%	7%	6%	6%	4%	3%

Religion

The highest percentage of religion recorded was Church of England for both inpatient and outpatients. High proportions were classified as unknown, this will be explored over the next 12 months.

Inpatient Community and Mental Health

Religion	Total	Religion	Total
Unknown	76.01%	Anglican	0.07%
Patient Religion Unknown	11.35%	Church of Scotland	0.07%
Church of England	7.48%	Not Religious	0.07%
Religion not supplied	1.51%	Pentecostalist	0.05%
Roman Catholic	0.90%	Religion (Other Not Listed)	0.02%

Christian	0.68%	Zen Buddhist	0.02%
Atheist	0.68%	Baptist	0.02%
Agnostic	0.63%	Reformed Presbyterian	0.02%
Methodist	0.32%	Quaker	0.02%
Jehovah's Witness	0.09%		

Outpatient community and Mental Health

Religion	Total	Religion	Total
Unknown	62.51%	Baptist	0.06%
Church of England	12.09%	Spiritualist	0.06%
Patient Religion Unknown	6.17%	Jewish	0.06%
Roman Catholic	4.58%	Orthodox Christian	0.05%
Atheist	3.70%	Zen Buddhist	0.04%
Christian	3.58%	Salvation Army Member	0.03%
Religion not given - PATIENT refused	1.83%	Presbyterian	0.03%
Methodist	1.69%	Hindu	0.03%
Not Religious	0.67%	Mormon	0.02%
Anglican	0.54%	Humanist	0.02%
Agnostic	0.40%	Christian Humanist	0.02%
Jehovah's Witness	0.39%	Ismaili Muslim	0.02%
Religion (Other Not Listed)	0.17%	Unitarian	0.02%
Church of Scotland	0.17%	Pentecostalist	0.02%
United Reform	0.15%	Reformed Presbyterian	0.02%
Buddhist	0.13%	Plymouth Brethren	0.02%
Protestant	0.13%	Sikh	0.01%
Catholic: Not Roman Catholic	0.12%	Evangelical Christian	0.01%
Muslim	0.12%	Church of Ireland	0.01%
Pagan	0.10%	Greek Orthodox	0.01%
Nonconformist	0.09%	Free Church	0.01%
Quaker	0.08%		

Modern Slavery Act

As of October 2015 all commercial organisations carrying on business in the UK with a turnover of £36m or more have to complete a slavery and human trafficking statement for each financial year. The Modern Slavery Act consolidates offences relating to trafficking and slavery (both in the UK and overseas). As a large business we need to publicly state each year the actions we are taking to ensure our suppliers are slavery free. The Trust is working within the act.

Quality Report 2017/18

Quality Report

This Quality Report is set out in accordance with the Quality Account Regulations and NHS Improvement, the sector regulator for health services in England and includes the following parts:

Part 1: Statement on quality from the Chief Executive of Cumbria Partnership NHS Foundation Trust (the Trust)

Over the last year we have been on quite a journey which has had some real milestones for us in terms of our quality and safety agenda. Not only have we started to work closer with North Cumbria University Hospital Trust but we have been aligning our quality agendas in both organisations to work together on continuously improving services for our patients and communities as well as for our staff.

Our community services in the south of the county transferred to University Hospital Morecambe Bay and we have commenced work on looking at how neighbouring mental health Trusts can help to improve the quality of services in our mental health and learning disability services.

Our Trust values of kindness, fairness, ambition and spirit are becoming even further embedded in our organisation and we were delighted that this was recognised in our CQC inspection report which was published in January 2018. CQC also recognised that we have a positive and open culture and this is exactly how we want to work with our communities, with each other and with our partners. We recognise and appreciate that our staff are putting so much effort into living our values during these challenging times.

We remain committed to the four long term goals we have set:

- To consistently deliver the highest quality of services we can;
- To ensure we are fulfilling the potential of all of our staff, patients, families and carers;
- To improve and transform services with our partners;
- To be relentlessly efficient and effective to ensure we are financially sustainable.

During 2017/18 we have embedded a number of initiatives:

- Further development and refinement of an equality and quality impact assessment to assess quality outcomes when making efficiency decisions;
- Published our Learning from Deaths policy
- Launched our freedom to Speak up Guardian and Ambassadors
- Implemented the Mental Health Safety Thermometer
- Introduced Key Clinical Skills training
- Developed a quality & safety dashboard

The key highlights as detailed in this quality report for 2017/18 include:

- The Care Quality Commission re-inspected some of our services and increased 2 of our ratings in the “caring” domain to “outstanding”
- We participated in the Care Quality Commission Local Area Systems Review
- The NHS Staff Survey is an annual survey that asks staff a number of questions that relate to nine key themes which impact on their experience of work. Of 32 key findings 13 have improved and none have deteriorated.
- The Quality Outcomes Framework is further developing and, of note, without exception, the Trust is performing better than the National average on all aspects of the harm free care agenda.
- There was an increase in our uptake of the flu vaccination this year;
- A large number of local clinical audits were completed in 2017/18.
- Cumbria Partnership NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 94%, and was graded Satisfactory (Green).
- The Trust received and recorded 2432 compliments in 2017/18.
- We have retained our rating of ***Good*** in the *NHS Learning from Mistakes League*;
- We have captured the views of 9953 patients, service users and carers during the year;

Our focus for 2018/19, based on our strategic plans, feedback from our patients, staff and our communities, and from our CQC regulatory inspections will be:

- We will aspire to improve the quality of our services to improve our CQC rating across all services.
- We will continue with the work already started to improve the quality of our mental health and learning disability services

Part 2 – Priorities for improvement and statements of assurance from the Board of Directors

This part describes our priorities for improvement for 2017/18, and how we have performed against these over the past year with statements of assurance from the Board of Directors. Extra information is given to help you gain a better insight into our activities.

Part 3 – Other information relevant to the quality of our services

This part includes specific measures of quality and information that are important to the Trust in maintaining quality.

Annexes

Annex 1 – Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees on our quality report
Annex 2 – Statement of Directors’ responsibilities for the quality report

Annex 3 - Independent Auditor's Report to the Governors Council

Declaration

I confirm that to the best of my knowledge the information contained in this report is accurate and presents a balanced view of the quality of services provided by the Trust.

Signed..... Date: 24 May 2018
Dr Andrew Brittlebank, Medical Director

Signed..... Date: 24 May 2018
Stephen Eames, Chief Executive for CPFT and NCUHT

Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Priorities for improvement

Progress against 2017/18 priorities for improvement set out in last year's Quality Report

Current Leadership & Governance Arrangements

- Executive lead is Executive Director of Nursing for CPFT & NCUHT, on behalf of the Board.
- Each of the Associate Directors of Nursing is accountable for the progress and activity against trust wide key priority areas.
- Progress and development/ improvement are through the care groups supported and monitored by the Head of Clinical Governance and Clinical governance Team.
- Reporting is via the care group and Trust Wide Clinical Governance groups.
- Priority area for quality and nursing as set out in the 2017/18 business plan objectives.

Quality Priority 2017/2018 and ongoing for 2018/19	**Progress**
Preventing people from dying prematurely as a consequence of suicide	Rationale: The overall numbers and rate of suicide for the population of Cumbria is higher than the national average. Suicide has a devastating impact. Not only is it the loss of the individual's life and their potential, but the wider impact on family, friends and health care professionals is significant. **Current Progress:** 1. The suicide prevention plan for the Lancashire and South Lakes Suicide Prevention task and finish group has been further developed. This is in line with the Sustainable Transformation Plan (STP) footprint. The Trust is due to jointly lead on improving sensitive media reporting. The Cumbria wide group are aware of the overall plan along with senior staff in the Trust. (This is currently still draft and being finalised with a view to going to H and W board for sign off). The draft intermediate outcomes of the overall plan are; **Outcome 1 -** A strong integrated Suicide Prevention Action Plan that is owned by all key stakeholders **Outcome 2 -** Elimination of suicides for in-patient and community mental health care settings

Outcome 3 - Clear pathway of care for Children and Young People (CYP) and Adults who self-harm that meets NICE guidance
Outcome 4 - Effective support to those who are affected/bereaved by suicide by April 2018
Outcome 5 - To provide better information and support to those affected by suicide
Outcome 6 - Improved use of evidence, data and intelligence

This will be monitored through the Cumbria Multi-Agency Suicide Prevention Leadership Group.

In the Trust;

2. STORM and risk formulation training for mental health staff continues to be delivered. This training is ongoing and is monitored through the Mental Health Risk Group.
3. STORM training for non- registered mental health staff is due to be delivered. This will be a specific bespoke package developed for the Trust. This training was carried out in September 2017 with positive feedback, however based on attendance lists only approx. 26 staff attended 100 places.
4. Work on protocols on real time surveillance continues to be developed. Real time Alert report on progress completed by the Suicide Prevention Lead at end October 2017.
5. Ongoing progress with outstanding SIRIs in place – use of data is a priority action for 2018.
6. The suicide prevention E-learning packages available are now agreed by the steering group (26/2/18) and are due to go the Professional Council in April for ratification and roll out.

Next steps - 2018/19 focus:

- Continue to complete data collection on suspected suicides for people known to CPFT services and triangulate with other relevant information. Ongoing progress with outstanding SIRIs in place – use of data is a priority action for 2018
- Continue to support development of the Sustainable Transformation Programme (STP) plan for suicide prevention. The final draft has been reviewed and commented on prior to sign off.
- Rollout the suicide prevention e-learning following ratification at the Professional Council.
- Co-ordinate further training for specific staff groups, including non–mental health using a train the trainer approach e.g. STORM. The Trust's suicide prevention training plan for all staff is being discussed/ agreed in December steering group.

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Implement National Confidential Inquiry into Suicide and Homicide findings as per plan. Several actions remain outstanding from previous audits therefore this is being reviewed and updated with achievable, measurable objectives. Any outstanding longer term actions will be picked up in the Trust's suicide prevention action plan.
Showcase film from the Trust's suicide prevention conference. This is currently outstanding and being actively chased.
Phase 1 of the ICC project (Designing a Suicide safety culture in ICC's) is complete and the proposal for phase 2 implementation is being presented at the Mental Health ICC steering Group 28/2/18.

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<tr><td>Treating and caring for people in a safe environment and protecting them from avoidable harm</td><td>
Rationale:
It is well recognised that patients can experience avoidable harm within health care settings. Avoidable harm is best described as that which could have been avoided through the actions of health care staff. Examples of avoidable harm include pressure ulcers, falls, venous thromboembolism (VTE) medication errors and hospital acquired infections. It is important to note that not all of these incidents necessarily cause harm and not all occurrences are avoidable.

Current Progress:

Harm Free Care

The latest Harm Free Care data published on the NHS Safety Thermometer is for January 2018, below is a summary of our performance compared with all organisations:

<table>
<tr><th></th><th>All Organisations Jan 2018 %</th><th>CPFT % Nov 2017</th><th>CPFT % Dec 2017</th><th>CPFT % Jan 2018</th></tr>
<tr><td>Harm Free Care</td><td>94.2</td><td>94.3</td><td>94.5</td><td>95</td></tr>
<tr><td>Harm Free Care (New)</td><td>98</td><td>99.1</td><td>98.1</td><td>98.5</td></tr>
<tr><td>Pressure Ulcers (All)</td><td>4.5</td><td>3.3</td><td>4.6</td><td>4.1</td></tr>
<tr><td>Pressure Ulcers (New)</td><td>0.9</td><td>0.4</td><td>0.9</td><td>0.7</td></tr>
<tr><td>All Falls</td><td>1.6</td><td>0.6</td><td>1</td><td>1.1</td></tr>
<tr><td>Falls with Harm</td><td>0.5</td><td>0.2</td><td>0.4</td><td>0.5</td></tr>
<tr><td>Catheterisation</td><td>13.9</td><td>7.8</td><td>8.1</td><td>7.8</td></tr>
<tr><td>Catheter Acquired UTI</td><td>0.6</td><td>0.3</td><td>0.3</td><td>0.4</td></tr>
<tr><td>VTE</td><td>0.4</td><td>0.1</td><td>0.4</td><td>0.2</td></tr>
</table>

Without exception the Trust is performing better than the National average on all aspects of the harm free care agenda.
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As a Trust we do not utilise the Safety Thermometer as much as we could to celebrate the safety of the care we deliver. Work is ongoing between the care groups and the clinical governance team to look at how we can utilise this data further.

Within mental health, the MH Safety Thermometer has been implemented on all the wards and in quarter one 2018/19 we are undertaking a survey with staff to understand the impacts on patient care and safety of utilising the Safety Thermometer.

- FALLS

Work continues to embed all of the development work around the Prevention and Management of Slips, Trips and Falls as outlined in the Policy POL/001/048. We continue to embed Falls Risk Assessment and Management Plan (FRAMP) within all of our inpatient units and the Community Care Group.

Within mental health the FRAMP tool has had a positive impact on Ruskin ward where we are seeing an increased diligence around recording of all falls related incidents with a significant reduction in moderate and severe harm related incidents. This learning has been shared across Memory and Later Life services and monitored at both network and care group level.

The September 2016 – March 2017 Thematic Review of Falls within Community Hospitals was presented to Trust Wide Clinical Governance in November 2017. This report highlighted that Falls in our inpatient units are multi-factorial, the implementation of the FRAMP across our inpatient areas has enabled staff to use evidence based interventions tailored to the individual needs of our patients. Incident reporting of falls continues to be robust and both Networks involved have seen an improvement in the rating of harm, application of duty of candour and an increased knowledge of appropriate interventions to reduce the risk of falls.

- Pressure Ulcers

Work continues to embed all the recent developments around Pressure Ulcer and the Pressure Ulcer Prevention and Management Policy (July 2017-Aug 2020) POL/001/069 has been updated.

Pressure ulcers in the Community care group, continue to be the largest group of incidents being reported, due to the fact that the policy requires all levels of pressure harm to be incident reported. There majority of

pressure ulcer incidents reported are low harm, with moderate and severe harm incidents resulting in an investigation being carried out by the team to draw out learning and any improvement to practice.

There is a Trust Wide Pressure Prevention group led by the team who participated in the Pressure Ulcer collaborative to continually work at embedding the findings from the Collaborative to avoid pressure harm occurring. Team leads and Tissue Viability Nurses (TVN) continue their training and prevention work with teams however due to the limited staffing resources available to this roll out, progress is slower than we would like.

A thematic review of Pressure Ulcers across the care group for the period March – September 2017 was completed and ratified through Care Group Clinical Governance in January 2018 and was presented at Trustwide governance in March 2018. The report demonstrated that overall there has been a slight reduction each month in the number of reported pressure ulcers that were deemed avoidable, however also identified a number of challenges the Trust faces as it works towards the ambitious aim to have a 0% avoidable pressure ulcers.

One area of celebration to note is that one of the Care Homes who worked and continue to work in partnership with our Copeland District Nursing Team and TVN, implementing the learning from the pressure ulcer collaborative, have recently celebrated 535 days of harm free pressure care.

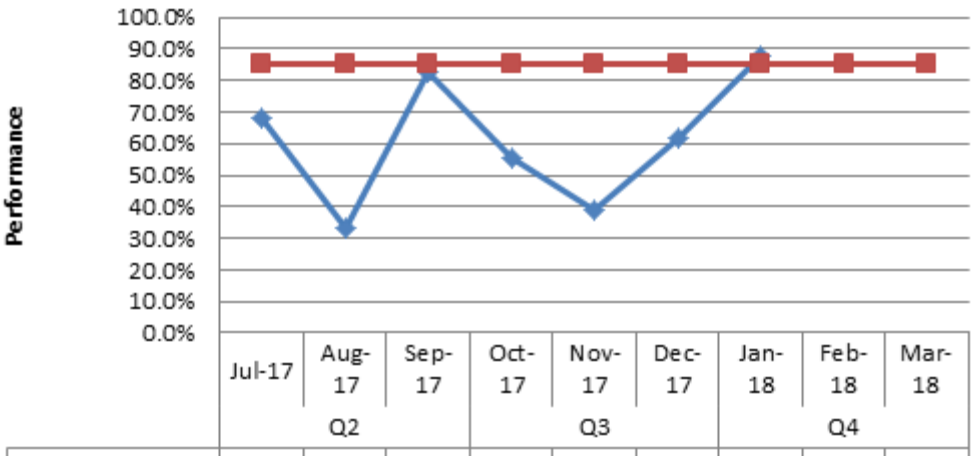
- Infection Prevention

The Infection Prevention Team is continuing to provide Key Clinical Skills Training and dates have been planned until March 2018. This training is not currently mandated and has only been commissioned by the Community care group at this time, however other care groups are keen to have the course rolled out and conversations supporting this are currently in place. The course includes; Basic Life Support, Vaccination and Immunisation, Infection Prevention Level 2 and Hand Hygiene training (which are all mandatory for clinical staff) and in addition Aseptic Non Touch Technique (ANTT), The National Early Warning Score (NEWS) and Sepsis Recognition training. So far over 400 staff have been trained during the last 9 months.

Our Infection Prevention leads presented the implementation of Aseptic Non- Touch Technique (ANTT) within the Trust in November 2017 at the ANTT National Conference. ANTT is key to reducing the number of

	Catheter Acquired Infections and following on from the completion of the baseline assessment on preventing healthcare associated Gram-negative blood stream infections (GNBSI) the Infection Prevention Team have been tasked to lead on the reduction GNBSI through better management of catheters. Meetings to complete this work have started and a clear plan is in place to support the programme with colleagues across the health economy. • Diabetes and Insulin Administration Following on from the task and finish group work to improve insulin administration and reduce related medication errors in the home, the final version of the new insulin booklet and administration record have been received by teams across the county and are starting to be used. Progress and incident data will be monitored and feed into future evaluation of the work. **Next Steps – 2018/19 focus:** • Quality of care boards A proposal around the quality of care boards for community hospitals and inpatient wards was developed. This would be a visual display of key safety and quality information for patients, members of staff and visitor to see. These boards have the potential to be linked to the quality and safety dashboard. Support for the project to be provided through the CG team. Concept to reviewed at the Quality and Safety Systems meeting (previously the Ulysses systems group) in March 2018.
Building health resilience in children and young people	Rationale: The health and resilience of children and young people is important not only for health and wellbeing in childhood but significantly for adulthood too. Nationally we know that the level of emotional resilience in young people has changed with increasing rates of mental ill health evidenced through self-harm. The same picture is seen in Cumbria with increasing demand for Child and Adolescent Mental Health Services (CAMHS) seen year on year. Therefore developing emotional resilience is a key priority for the county and, as the provider of universal child health services through to specialist (tier 3) CAMHS, the Trust has a significant role to play within a multi-agency strategy.

	The health needs of Children Looked After (CLA). This group of children is the most vulnerable in the county and most at risk in relation to physical health and emotional health. This group of children are also at increased risk of childhood sexual exploitation which is an area that we will focus on in the year ahead. **Current Progress:** • A robust quarterly report and data collection is in place for looked after children with a focus on quality performance and patient experience. • A CLA Health and Emotional Well-Being annual report for 2017/18 will now be completed and will be submitted to the Quality and Safety Committee during Q1 2018/19. This will provide fuller and more detailed information than can be presented within this report chapter. • Initial Health Assessments (IHAs) completed for CLA - there have been some challenges getting the IHAs completed in the last quarter and this was due to a number of factors including: availability of paediatrician clinics for IHA's being sporadic depending on capacity; no standardised process for monitoring IHA performance at local team level and management; capacity of CLA Nurses to meet demand of IHA's; escalation of monitoring of IHA's not being visible at senior management level in the Trust and no process for escalation of 'Did Not Attends' (DNA')s. • IHAs for July, August and September 2017 (Q2) were at 61% overall performance. The reasons identified for this downward trend by the CLA team is due to the factors outlined above. Performance remained unstable during Q3 (52% overall performance) as there were some changes to the administrative staff which resulted in the new staff not receiving access to an additional, external system in a timely manner which is used to capture and monitor our performance. This has now been rectified and is being updated with up to date information reflective of our actual performance. Current figures available for the beginning of Q4 (January 2018) show a significant improvement of 87.5%, achieving the baseline target. With the developed processes in place and with continued close monitoring, it is expected that the Initial Health Assessment performance will improve and remain at a satisfactory level.



	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
		Q2			Q3			Q4	
Performance	68.2%	33.3%	82.4%	55.6%	38.7%	61.9%	87.5%		
Baseline	85%	85%	85%	85%	85%	85%	85%	85%	85%

Throughout this financial year steps have been put in place to ensure CLA are 'fast-tracked' for both initial assessments and for therapy within the service. For this quarter there is now in place a full and detailed recovery plan for CLA IHA Performance, with a report submitted to the Quality and Safety Committee in December 2017).

- Standard 'routine' CAMHS CHOICE (initial assessment) appointments have an in service target of 35 days, however CLA are now receiving a service within 15 working days with urgent cases being assessed in 24 hours.
- The implementation of a single point of access for Tier 2 and 3 children's mental health services with a standard operating procedure is now in place for the County.
- As part of the 0 to 19 years consultation and remodelling of the services commissioned by Cumbria County Council and delivered by the Trust a 'Strengthening Families' service has now been in place since March 2017. This provides an integrated safeguarding offer working closely with the safeguarding hub; working specifically with those children, young people and their families that require a statutory intervention, so that they are either on a Child Protection Plan, Child in Need Plan or are a Child Looked After. The CLA team that was, will therefore be further integrated into the Strengthening Families team with one clinical services manager for the County.

Update from the last quarterly report priorities above and actions in place to address the challenges in performance detailed above:

- An audit of IHAs was completed on 23/10/17: The audit looked at all IHAs for Cumbrian CLA and for non-Cumbrian CLA placed in Cumbria referred for an IHA from the 6 month period from 01/01/17 to

30/06/17 and has created an action plan to inform and improve IHA systems (audit available upon request).Availability of paediatrician clinics for IHAs being sporadic depending on capacity: – new model of community paediatric clinic delivery is being piloted currently. This provides additional capacity for potential IHA appointments across all areas of the county, totalling up to 33 available sessions per month.

- No standardised process for monitoring IHA performance at local team level and management and escalation of monitoring of IHAs not being visible at senior management level: To review current performance monitoring systems against proposed process from another Trust and develop standardised approach for North and South CLA teams and process mapping sessions completed with business support. Daily reporting of IHA performance to be made available with a weekly conference call on a Friday to monitor progress with IHAs - weekly call now in place. RiO data cleanse complete and work to create a robust system behind using a Patient Tracker List (PTL) is also underway. Proposed go live date for the PTL is 8 January 2018, from which date the current CLA spreadsheet will no longer be in use.
- Vacancy was filled.
- Capacity of Looked After Children (LAC) Nurses to meet demand of IH's and staff training needs: Caseloads and whole time equivalent (WTE) to be reviewed at capacity and demand session scheduled with new clinical staff in post. The initial tranche of this work is now complete and will be ongoing, monitored via the management and safeguarding supervision processes. Roles and responsibility matrix to be completed. Band 6 Nurse in South team to undertake an advance practice course, Oct 2017-Apr 2018, to enable her to develop a nurse led IHA service to compliment the medical provision, thus giving the service additional capacity and flexibility.
- No process for escalation of DNAs: - The process for DNA has been reviewed by the responsible strategic Paediatrician lead for CLA. The standard operating procedure (SOP) is being written to include the required process but will need support from Cumbria County Council to populate and implement.
- All other actions from the last quarterly report were completed.

Child Sexual Exploitation (CSE)

CSE continues to be a priority for Cumbria Local Safeguarding LSC Childrens Board (LSCB):

- Within the Trust there is now a CSE chapter on the Trust's Safeguarding intranet, information is also available on Cumbria LSCB and CSE is integral in Safeguarding training. Practitioners working

with young people also attend the Cumbria LSCB CSE face to face training.

- Risk assessments for CSE are fundamental in Sexual Health services and the Spotting the Signs assessment is available and used by practitioners.
- Reporting of CSE is via Ulysses this would alert Safeguarding team and Children and Family care group management team. The practitioner can then be supported.
- LCSB CSE sub-groups and focuses are under review currently.
- LSCB oversight group is attended by Specialist Nurse for Safeguarding and Safeguarding Lead for Sexual Health. This highlights children that are deemed high risk from a Police and Children Social Care perspective. Alerts are put on health care systems which allows staff to identify if there is a plan of support around the young person so that practitioners can link with the support team as necessary.
- The strategic LSCB CSE group is attended by designated nurse. The CSE LSCB Working group attendance is attended by the Named Nurse for Safeguarding Children. The safeguarding lead as well as key practitioners will also be attending the multi-agency presentation of the new National CSE Working group assessment tool in the Autumn. Support for management and highlighting complex CSE cases are discussed with the safeguarding team and complex cases that need escalated would either follow the LSCB escalation guidance and/or be discussed with the Designated Nurse.

Children and Families Care Group Patient Experience:
The Trust's Patient Experience team (PET) have been producing monthly reports for care groups which includes the data and information on the compliments and complaints received which is both quantitative and qualitative. A shorter version 'report on a page' has been introduced, which will clearly also show, most importantly the lessons learned/changes to practice from complaints.

Next Steps – 2018/19 focus:

- The CLA team will continue to monitor performance weekly and any drop in performance identified will be highlighted to the Specialist Nurses for further action.
- Plan to fill the vacancy in the east of the county.
- A training needs analysis will be undertaken to identify the training needs of the team.
- The Specialist Nurses will look at Chapter 6 'Not Seen Not Heard - Transitions and Access' (CQC report 2016) to ensure Care Leavers

	who have a health needs have access to appropriate services when they are no longer looked after. This will include the development of the proforma for young people to check they are beginning to take responsibility for their own health needs. The Specialist Nurses will work with identified Social Workers in the development of guidelines on internet safety.
Ensuring people have appropriate and timely access to services based on need	Rationale: 'Appropriate access' means "are people getting direct access to the right service for their needs?" Across our services we have worked hard to enable timely access to our services. This has been prioritised due to the increasing demand on services and the universal issue of recruitment difficulties in Cumbria – especially for specialist roles. **Current Progress:** • There are a range of access standards across the Trust derived either from the NHS Constitution, our regulators, or developed locally through CQUIN schemes. At present we do not report access standards for all Trust services. • As the Trust was achieving the national standards at the end of 2016/17 for the A&E 4 hr wait, RTT and Referral to Diagnostic (RTD) monitored for the Sustainability and Transformation fund, and there was no underperformance expected in 2018/19. The Trust was not required to set and achieve improvement trajectories, but was expected to maintain the national standard. • There has been further investment into the Mental Health Liaison service to ensure that patients can be assessed quickly within acute hospital sites, specifically from A&E over the winter period to alleviate pressures on the local Acute sites. Performance against the standard has fluctuated throughout 2017/18 but generally increased with high achievement attained in Q4 2017/18. • 2017/18, as a Trust we have achieved the 4 hour wait target 95% for A&E and achieved the EIP 50% standard in 11 of 12 months. • Referral to treatment (RTT) position for consultant-led services has sustained performance over the 92% threshold throughout 2017/18, dipping in March 2018 due to a combination of reduced capacity and the impact of a period of increased demand in Q3 for Neurosciences service. • The Childrens care group engaged in whole system review of the Children Looked After pathway in response to a year of fluctuating performance for both Initial Health Assessments (IHA) and Review Health Assessments (RHA) against the locally defined standards. Care Group and Local Authority staff have worked together to identify and resolve issues. Performance shows improvement in Q4 17/18,

	however the indicators are subject to some factors which are beyond the Trust's control (e.g. timescale for IHA for Cumbrian children placed out of county). • ABI performance has improved from 16/17 and has achieved 100% for the last 7 months of 17/18. • CAMHS Urgent access has maintained performance over target throughout the 2017/18 year. **Next Steps – 2018/19 focus include:** • CAMHS Routine performance has remained a challenge after a period of recovery towards the end of 16/17 and start of 17/18. The Childrens Care Group are working closely around this issue with both CCG partners and the Local Authority via contract meetings and the local Emotional Health and Wellbeing board. • The First Step service is nearing the realisation of the recovery plan to address achievement of the referral to treatment 6 week pathway. Changes to the data capture definitions used by clinicians were put in place in February 18 which is expected to show improvement in the 6 week standard for those completing an episode of care by the end of Q1 18/19.
Ensuring people have a positive experience of care through better use of feedback and patient involvement and engagement	Rationale: We collect a lot of feedback from our patients and carers on their levels of satisfaction with our services. We also use a range of approaches to engage with patients and carers led by our Patient Experience Team. We recognise and endeavour to use patient feedback as a core quality indicator. We need to aim to work with patients as partners both in their own care and in service design and delivery. **Current Progress:** • Patient stories shared to the Board each month. In April there is a focused Board story related to least restrictive interventions to raise the profile of both staff and patient experience to the Board. • The Participation Strategy is currently on hold as this will now be system wide following the IHCS arrangements. • The complaints dashboard is now accessible to care groups giving overview of the responsiveness to complaints and the ability to identify and address any trends and is now embedded across the care group. Bespoke complaints training is being delivered to care groups to support complaint responses being improved and completed within the timescales. **Next Steps – 2018/19 focus:** • Next steps include supporting a positive culture change and moving

	from collecting patient feedback to using feedback as part of service improvement. This work commencing in quarter 1, 2018/19 will be based on the ladder of participation– moving from capturing patient satisfaction to co – production o Quarter 1 - scoping and options paper to capture network priorities area o Quarter 2 - network survey to capture where each care group and network leadership team currently are on the ladder of participation. o Quarter 3 - Share results with TWCGG/ Board and agree top 3 priorities and implementation plan for each care group. o Quarter 4 - review, amend and adapt leaflets available across the organisations. • A programme of Learning Disability access reviews (was audit) continues, led by the Associate Director of Nursing for Specialist Services and the Quality Governance Projects Manager. These reviews have been developed to identify potential opportunities to improve access for people with a learning disability to all services. This work also supports the assurance process associated with Learning Disability Access MHS Improvement indicator. A Public Governor, who has a learning disability, takes part in the audit process, which is currently in its sixth phase. Feedback from these reviews has been really positive and staff have engaged well with them. The term audit was changed to 'review' to ensure that they are seen as a joint process between the reviewing team and staff teams.

Duty of candour

The Trust has in place a policy and process which meet the statutory requirements of Regulation 20 of the Health and Social Care Act (2008) Regulated Activities (2014). Here is a link to the Trust's Being Open and Duty of Candour policy:
www.cumbriapartnership.nhs.uk/assets/uploads/policy-documents/Duty_of_Candour_POL-001-040.pdf

The objective of the Trust's policy is to ensure that following an incident where harm or a near miss to a patient has occurred, there is appropriate communication, investigation and support provided for the patient, their relatives and staff. The type and level of communication and support provided will be dependent on the severity and nature of the incident.

Mortality Review – Learning from Deaths

The Mortality Review Steering Group is well established, and in September 2017 ratified the new Learning from Deaths policy:
https://cdn.cumbriapartnership.nhs.uk/uploads/policy-documents/Learning_from_Deaths_Policy_POL-001-078.pdf

As of Q3 2017/18 the Trust was required to report on information around deaths and reported the statistics from April – September 2017, to the Board in January 2018. This was the first report to be published with Mortality information; with subsequent reports submitted to the Board each quarter.

(i) Mortality Statistics for Q1 – Q4, can be found below:

Ref ***	**Indicator**	17/18	Q1	Q2	Q3	Q4
27.1	**Total Number of Deaths***	622	153	159	139	171
27.2	**Total number of deaths that have been subjected to a case record review or investigation)** *[Structured Judgment Reviews (SJR's) and SIRI investigations)*	54 (18 SIRI's 36 SJR's)	This was captured collectively as part of combined Q1 /Q2 information presented to the Board in Jan 18.	18	16	20
27.3	**Estimation of the number of deaths for which a case record review or investigation has been carried out which has been judged as a result of the review or investigation was more likely than not to have been due to problems in the care provided.****	0% *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0% *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0% *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0% *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0% *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*
27.7	**Total Number of SJR's or investigations completed in the current reporting quarter, but related**	N/A *[Guidance only available Jan 2018 to include*	N/A *[Guidance only available Jan 2018 to include*	N/A *[Guidance only available Jan 2018 to include*	N/A *[Guidance only available Jan 2018 to include*	N/A *[Guidance only available Jan 2018 to include*

	to deaths reported in a previous reporting period.	*this criteria for reporting]*	*this criteria for reporting]*	*this criteria for reporting]*	*this criteria for reporting]*	*this criteria for reporting]*
27.8	**Estimation of the number of deaths *(where the SJR or investigation has been completed in the current reporting quarter but related to deaths in previous reporting period)* for which a case record review or investigation has been carried out which has been judged as a result of the review or investigation was more likely than not to have been due to problems in the care provided.****	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*
27.9	**Revised total estimate of the number of deaths (from 27.3 & 27.8 above) for which a case record review or investigation has been carried out which has been judged as a result of the review or investigation was more likely than not to have been due to problems in the care provided.****	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*	0 (0%) *[Based on completed SJR's only. Guidance only available Jan 2018 to include this criteria for reporting]*

Footnotes to the data tables:
*As of 1 April 2017, it became a Trust requirement to report all inpatient deaths that were classed as expected, on the electronic incident management system, Ulysses. As of 1 April 2018, the Trust now captures all deaths on Ulysses, as per the Learning from Deaths Policy.

** Each care group uses a SJR and SIRI template to be able to identify if there are any contributory factors or root causes for the incident. The avoidability score (table below) is used to determine how avoidable the death was and an explanation around this. SJR avoidability ratings are discussed and agreed by the Care Group Senior Leadership Teams, and reviewed by the Mortality Review Steering Group. As of 1 April 2018, all SIRI investigation panels will decide on this scoring.

a) Please indicate using the scoring system below:
Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50/50)
Score 4 Possibly avoidable but not very likely (less than 50/50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable
(b) Please include a brief explanation below:

*** Indicator reference taken from The National Health Service (Quality Accounts) (Amendment) Regulations 2017. This guidance was made available at the end of January 2018 therefore information for all parts of this will not be available during the 2017/2018 reporting period.

Key Findings from Structured Judgement Reviews completed (Q1 – Q4 2017/2018):
Learning from reported deaths is coordinated through the steering group, which is attended by representatives from all care groups. Specific points of learning following SJR's and investigations are managed and monitored through the care group clinical governance arrangements.

(i) Summary of learning and notable practice include:

- Cases reviewed have all shown good care that meets the medical and nursing needs (Community Care Group)
- Evidence of holistic approach taken (Community Care Group)
- Appropriate care packages recorded involving both the clients and their families for End of Life care (Children and Families Care Group).

- All incidents for reported deaths are now followed up with a 48/72 hour report whether they are expected or unexpected (Children and Families care group).
- Unexpected deaths were presented at LSCB Strategy and/or Rapid Response meetings by relevant clinicians from the care group including the safeguarding nurses team and considered the needs of the family at that time (Children and Families care group).
- Good health care plans in place (Mental Health Care Group)
- Good liaison regarding family support and to physical health care colleagues (Mental Health Care Group).
- Compassion shown to the families ahead of the expected death by Community Psychiatric Nurse (CPN) and after by the families (Mental Health Care Group).

(iii) Actions taken during the reporting period, and those actions proposed going forwards, from what has been learned from SJR's and Investigations undertaken.
No actions identified from completed SJR's. *[Guidance only available late January 2018 to include this as an indicator within Quality Accounts].*

(iv) Assessment of the impact of actions taken. None identified. *[Guidance only available late January 2018 to include this as an indicator within Quality Accounts].*

Next Steps:

- Work is ongoing during April 2018 to finalise the Quality and Safety Dashboard indictors around reporting of deaths, which will show more visually historic or trend data around reported deaths.

2.2 Statements of assurance from the Board of Directors

Statement of coverage
During 2017/18 Cumbria Partnership NHS Foundation Trust provided and/or sub-contracted the following NHS services:
All general community services, including:

- Children's services
- General community nursing and palliative care services
- Inpatient community services on 12 sites
- Rehabilitation services
- Community outpatient services
- Diabetes services
- Various services focused on health promotion and healthy lifestyles
- Mental health services for common and severe problems, including inpatient mental health services on five sites
- Learning disability services, including inpatient services on one site
- Acquired brain injury services
- Dementia services, including inpatient services on two sites.

There are numerous community based teams across the Trust, as per the list above, and these are split across four care groups. The number of community services based on speciality within each care group are:

Community Services - 14
Mental Health Community – 6
Children and Families – 12
Specialist - 13

The Trust has reviewed all the data available to it on the quality of care in all of these NHS services.

The income generated by the NHS services was reviewed in 2017/18 and represents 100% of the total income generated from the provision of NHS services by Cumbria Partnership NHS Foundation Trust for 2017/18.

Participation in clinical audits and national confidential inquiries
During 2017/18, 11 national clinical audits and 6 national confidential enquiries covered relevant health services that the Cumbria Partnership Foundation Trust provides. During that period, the Cumbria Partnership Foundation Trust participated in 82% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table that follows lists the national clinical audits and national confidential enquiries that the Cumbria Partnership Foundation Trust was eligible to participate in during 2017/18.

Eligible to Participate In	Participated
Learning Disabilities Mortality Review (LeDeR) Programme	Yes (NCA)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBBRACE): Maternal morbidity confidential enquiries - Admission with post-partum psychosis in women with a history of bipolar disorder or previous post-partum psychosis	Yes (NCE)
National Audit of Intermediate Care	No (NCA)
National Clinical Audit of Psychosis (NCAP)	Yes (NCA)
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Yes (NCA)
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Chronic Neurodisability, focusing on cerebral palsy study	Yes (NCE)
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Mental Health Conditions in Young People Study	Yes (NCE)

National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness	Yes (NCE)
National Confidential Inquiry into Suicide and Homicide (NCISH): National investigation into suicide in children and young people	Yes (NCE)
National Confidential Inquiry into Suicide and Homicide (NCISH): The assessment of risk and safety in mental health services	Yes (NCE)
National Diabetes Foot Care Audit (Third round) (NDFA)	Yes (NCA)
National Diabetes in Pregnancy Audit (NPID)	Yes (NCA)
National Parkinson's Audit 2017	Yes (NCA)
Physiotherapy Hip Fracture Sprint Audit	Yes (NCA)
POMH Topic 15b: Prescribing valproate for bipolar disorder	Yes (NCA)
POMH-UK 17a: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention	Yes (NCA)
Sentinel Stroke National Audit programme (SSNAP)	No (NCA)

The following table shows the national clinical audits and national confidential enquiries in that the Cumbria Partnership Foundation Trust participated in and for which data collection was completed during 2017/18. The table also shows the number of cases submitted to each audit or enquiry as a percentage of the number of the registered cases required by the terms of that audit or enquiry.

National clinical audits for which the trust was eligible	Registered to participate?	No of cases as a % of required
Learning Disabilities Mortality Review (LeDeR) Programme	Yes	2 of 5 (40%) North CCG Reviews: 1 of 2 (50%) South CCG Reviews: 1 of 3 (33%)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBBRACE): Maternal morbidity confidential enquiries - Admission with post-partum psychosis in women with a history of bipolar disorder or previous post-partum psychosis	Yes	0 of 0 – 100% MBRRACE only contact CPFT if eligible cases arise.

National Audit of Intermediate Care	No	The Community Health Care Group took the decision not to participate due to the ongoing significant transformation and change in structures, preventing determination of clearly defined intermediate care teams in line with the parameters of the audit.
National Clinical Audit of Psychosis (NCAP)	Yes	96 of 100 - 96%
National Chronic Obstructive Pulmonary Disease (COPD) Re-Audit	Yes	112 (100%)
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Chronic Neurodisability, focusing on cerebral palsy study	Yes	1 organisational questionnaire (100%)
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Young People's Mental Health	Yes	4 of 7 clinical questionnaires (57%) and 2 of 2 organisational. questionnaires returned (100%).
National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness	Yes	18 of 18 (100%) suicide questionnaires returned 0 of 0 (100%) homicide questionnaires returned 0 of 0 (100%) Sudden Unexpected Deaths (SUDs) questionnaires returned
National Confidential Inquiry into Suicide and Homicide (NCISH): National investigation into suicide in children and young people	Yes	0 (100%) of eligible cases. 2 SIRIs provided. (100%)
National Confidential Inquiry into Suicide and Homicide (NCISH): The assessment of risk and safety in mental health services	Yes	1 of 1 interviews with clinicians (100%) Risk form documentation also provided.
National Diabetes Footcare Audit (NDFA): Third Round	Yes	54 (100%)

National Diabetes in Pregnancy Audit (NPID)	Yes	The Cumbria Partnership Trust submission is tied into the Morecambe Bay submission number, which was: 6 (100%)
National Parkinson's Audit 2017	Yes	6 of 10 (60%) OT, Physio and Speech and Language Therapy submitted all eligible patients, but still fell below the target of 10.
Physiotherapy Hip Fracture Sprint Audit	Yes	8 (100%)
POMH Topic 15b: Prescribing valproate for bipolar disorder	Yes	16 (100%)
POMH-UK 17a: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention	Yes	28 (100%)
Sentinel Stroke National Audit Programme (SSNAP)	No	The Specialist Services Care Group opted not to take part in this audit due to a lack of administration resource to support the daily input required and the difficulty in separating our submission from that of the North Cumbria University Hospitals submissions. Also, the NICE Stroke baseline tool is reviewed annually along with regular review of internal data.

National Audit Reports

The reports of 10 national clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided:

MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity: Maternal, Newborn and Infant Clinical Outcome Review Programme

The national report was reviewed by a Mental Health Clinical Director / the Chair of the Clinical Effectiveness and Audit Committee. CPFT had not submitted any data to the audit as none of cases met the relevant criteria for inclusion. Therefore we do not have a baseline of our care to compare against the report recommendations. This is mostly a reflection of the fact the audit focused on care that is not directly provided by CPFT. However the Trust's review of the national report concluded that the recommendations are useful for information for a number of our services. The report was distributed to the Associate Medical Directors and Associate Directors of Nursing for each care group for their consideration and onward distribution to relevant services.

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

The national report data, findings and recommendations were closely reviewed and compared against the already positive local Trust position resulting in a number of further quality improvement actions to be completed during 2018. Actions included:

- development and monitoring of a Trust suicide prevention plan for 2018/19
- the creation of Care group service level plans tailored to the specific needs of the service user and carer groups
- development and commencement of self-harm and suicide prevention training and an awareness raising programme across all staff groups
- development of a governance framework around real-time alerts data from police liaison relating to suspected suicides to ensure rapid accessibility to support the bereaved, including staff

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH): National investigation into suicide in children and young people

The national report included young people up to the age of 24 and common themes including age, gender, sexuality, suicide-related internet usage, changing patterns reflecting experienced stresses, bereavement, self-harm and whether known to mental health services. Key national messages from the audit included multiple contributing factors and known vulnerabilities, family factor consideration in prevention management, bereavement support for young people, the shared role of frontline agencies and the need to improve access, collaboration, flexibility and risk-management upskilling, as well as key services responding to self-harm working with alcohol and drug misuse services.

A number of actions were developed in response to the national findings to improve our local services:

- Develop a plan aimed at improving early life experiences through working with families, supporting vulnerable children
- Develop a plan aimed at ensuring availability of CAMHS including services for self-harm and substance misuse
- Develop a plan aimed at ensuring support for young people in crisis
- Develop and deliver tailored self-harm and suicide prevention training and awareness raising programme across all staff groups

National Diabetes Foot Care Audit: Second Round (NDFA)

The national diabetes foot care audit provided useful information to focus on areas to further improve care. The report highlighted nationally that people with new foot ulcers who receive specialist service quickly do best, although overall at the six-month stage after first expert assessment one third still have unhealed ulcers, with referral routes and times affecting the healing rate. In response to the national findings a local action is being taken to introduce a new multidisciplinary diabetic foot team to deliver specialist diabetic foot care in the Trust.

National Diabetes Inpatient Audit (NaDIA)
Although the Cumbria Partnership was not required to participate separately for this national clinical audit, it was agreed to review the published report to ensure cross-boundary learning. In the South of the county a cross-boundary discussion took place involving a number of diabetes teams and agreement was reached on progression of an electronic referral form. A business case was produced by the Trust outlining required funding for inpatient podiatry along with monitoring foot wounds of inpatients to further evidence the need. Additionally, following an all-party working group vascular referrals to Blackburn are being explored.

National Pregnancy in Diabetes (NPID) Audit
Consideration of the national clinical audit data, along with the Trust benchmarked position was undertaken in the Diabetes Network. The Trust achieved 75%, above the national average of 66%, for seeing service users before ten weeks of pregnancy and above the national average uptake of folic acid. One area of improvement identified was to improve the documentation of third trimester haemoglobin tests for service users.

Prescribing Observatory for Mental Health (POMH-UK) - Topics 1g and 3d - Prescribing high dose and combined antipsychotics
The trust submitted data for this audit for 63 patients across 6 clinical teams. In rehabilitation and complex needs services, the trust has reduced the proportion of patients prescribed high-dose antipsychotics from 25% in 2012 to zero (0%) in 2017 (the national average in 2017 was 20%). However the proportion of patients prescribed combination antipsychotic increased from 25% in 2012, to 50% in 2017. The proportion of patients prescribed a total high antipsychotic dose for the acute/PICU subsample in the trust has reduced from 22% in 2012 to 7% in 2017. The number of patients prescribed regular high-dose antipsychotic medication in the trust was 4. None of the 4 had a statement in their care plan that high-dose antipsychotic medication was prescribed. Monitoring of blood pressure, pulse and temperature for these 4 patients were all 100% (national averages were 95-97%). Monitoring of metabolic side effects for our patients were: body weight/BMI 75%, plasma lipids 75%, and plasma glucose 50%, which was below the national average. Assessment of movement disorder was 75% (national average 66%). ECG and a full blood count had been done for 100% of patients. The audit findings have been presented by our Principal Pharmacist for Mental Health to the mental health governance group for physical health, and a policy on high-dose antipsychotics is being developed.

Prescribing Observatory for Mental Health (POMH-UK) Topic 7e - Monitoring of patients prescribed lithium
The trust had 32 cases included in the national report for this audit. Much progress has been made in ensuring that the risks of toxicity are minimised for patients prescribed lithium. However, there is still uncertainty about a robust and clear process for the monitoring of patients prescribed lithium. The highest compliance with the audit standards was seen for ECG tests (80%) and blood tests (75-100%), except for serum calcium in maintenance treatment (52%). Lower compliance was seen for recording that advice was

given about signs and symptoms of lithium toxicity (40%) before lithium treatment was started, and recording of assessment for possible side effects (20%) and of weight/BMI (18%) during maintenance treatment. There were barriers to overcome in order to identify patients prescribed lithium in primary care who were under the care of CMHART. One of the main difficulties was that the CCG were unable to share details of patients prescribed lithium due to information governance requirements. Dialogue between medical directors and pharmacy leads of both CPFT and CCG facilitated this sharing and a list of patients was obtained. Actions taken: the Associate Medical Director for Mental Health Services reminded all prescribers within the trust of the requirements for monitoring of lithium from NICE guidance and NPSA requirements, and the memo he sent was subsequently adapted and communicated to all local primary care prescribers. The senior network manager asked all CMHART practitioners to review their patients who were on lithium and check that blood monitoring was up to date and satisfactory and that patients were in possession of the purple monitoring books. Pharmacy distributed 150 lithium booklets to CMHARTs. It is planned to replicate this work in the Memory and Later Life network, which has already started. There is a lack of clarity and evidence regarding the optimal use of lithium in older adults so there are plans to develop local guidance for the safe use of lithium in older adults. Other recommendations have been made and are under discussion.

Prescribing Observatory for Mental Health (POMH-UK) Topic 15a - Prescribing valproate for bipolar disorder

The national audit report and Trust specific report were reviewed simultaneously. Local practice was shown to be good with accurate and accessible documentation, well documented evidence of medication discussion with service users with follow-up investigation and good team support from Pharmacy and Dane Garth administration. As a result, no actions were undertaken, other than sharing with the ward teams.

Prescribing Observatory for Mental Health (POMH-UK) Topic 16a - Rapid tranquilisation

CPFT was the only trust included in this audit to have no intramuscular rapid tranquillisations carried out during the audit period. Information was submitted on 5 administrations of oral medication. The national report for this audit contains some points of interest from the national data, for example 20% of patients nationally had no post rapid tranquillisation monitoring. The national findings demonstrate that the CPFT policy for rapid tranquilisation is appropriate, for example, Haloperidol is restricted to ‘senior clinician’ use and as part of a documented care plan in order to minimise the risks of it being given without an ECG or BNF maximums being exceeded. The findings, including the points of interest, have been presented to clinicians in a doctors teaching session. The trust plans to carry out the same audit in Edenwood assessment and treatment unit for people with learning disabilities who also have mental health problems. The audit is currently being repeated over a two-month period.

Local clinical audits
The reports of 113 local clinical audits were reviewed by the provider in 2017/18, and the Trust intends to take the following actions to improve the quality of healthcare provided.

Children and Families Care Group

Safeguarding Supervision Audit and Re-audit
Following the introduction of a new safeguarding supervision process within the Children and Families Care Group an electronic staff survey was created to capture staff awareness of the process and policy. 94 staff completed the survey. The results were mixed, with good awareness of the policy and knowing their supervisor and knowing who to contact for support, but lower scores around the regularity of supervisions and recording in the electronic system, RiO. Actions taken in response included working with the clinical systems board to enable supervision data extraction for direct monitoring and promotion to further embed supervision into practice through the development of a '7 minute briefing tool'.

The re-audit saw 121 staff complete the electronic survey and the results saw a rise in awareness and regular participation in safeguarding supervision with scores ranging from 80 to 100%.

Child and Adolescent Mental Health Services (CAMHS) Records Audit
29 records were randomly selected from the Cumbria CAMHS teams to verify that risk assessments and care plans were been completed in the recently updated electronic client clinical records. For quality assurance audit results were double checked against the RIO records by the Clinical Director and Consultant for the Cumbria CAMHS service. The results were quite positive, but requiring improvement with 79% containing risk assessments and 93% containing care plan evidence. There were also discrepancies when the information was checked against the RiO system around the documenting of 'significant others / adults in the child's life', which was explained by the short time to scan into RIO from the time of the audit. The action taken was to work with the RIO system to build uniform care plan and consent forms. The re-audit is currently in progress to determine the level of quality improvement.

Health Visitor Outcomes Against Key Contacts
An electronic survey was created specifically for the audit and completed by health visitors across the county to capture key data from five key contacts, namely; antenatal, primary visit, 6-8 weeks, 1 year and 2 to 2.5 years. The audit criteria included adult smoking status in the household, dentist registration guidance for the parent, maternal mood reviews and child assessment. Findings found that there had been a general improvement compared to a previous review, but that there was a requirement for further training in completing documentation on RiO, which has subsequently taken place. A re-audit is currently in progress to determine the impact.

Community Health Care Group

Diabetic Foot Amputation Rates

Public Health England publishes annual diabetic foot care activity profiles and the data from three consecutive years was used locally to examine trends over a longer period. The information showed the trust is doing well on the episodes of care in hospital and the total number of days spent in hospital per 1000 people. However, the number of amputations per 1000 people is greater in Cumbria than nationally. In response to this the Trust informed senior management of Cumbria Partnership and North Cumbria University Hospitals and submitted the data to commissioners in support of one-off national funding. Additionally, key information was shared back to clinicians.

Improving Oral Hygiene in nil-by-mouth (nbm) patients on stroke unit at Cumberland Infirmary

Poor oral hygiene is known to be a risk factor for pneumonia and a cause of heightened mortality in stroke. The audit measured compliance with four-hourly oral hygiene for the relevant patients. The audit then looked at the use of the SAGE Q4 oral hygiene kit, in collaboration with SAGE, focusing on the importance of good oral hygiene. Staff satisfaction surveys were undertaken before and after using the new product. Weekly data collection was carried out during the trial period and feedback was given to staff around progress and compliance. Staff compliance with four-hourly oral hygiene in nbm pts rose from 18% to 80%. There was also 50% reduction in hospital acquired pneumonia requiring antibiotics when comparing nil by mouth patient pre and post-trial. There were striking improvements in staff satisfaction from the pre-trial findings where 90% of surveyed staff felt they did not have time to do oral hygiene, when compared to the post-trial findings when 100% of staff reporting they had enough time when using the new kit. Stroke mortality figures also improved during the audit period. Actions from the audit included staff training and securing funding to continue the use of the new product.

Audit and two re-audits of North Community hospitals notes audit 2017

A documentation audit and two re-audits were undertaken across the North community hospitals involving every patient on every ward at the time of each audit. The initial audit found generally high compliance, but also found potential gaps around re-assessment, re-evaluation and personalised care planning. There was also a variation in the documentation methods being used across the units. Uniform care plan documentation was introduced, communicated through clinical governance routes and made available on the Trust shared drives. Learning from the audit was shared widely, re-emphasising the importance of clear evaluation of care and ward managers self-audited their own wards.

The re-audit found improved result at numerous hospital sites, but continued differences in compliance relating to variation in documentation methods used. Clarity was sought around a single documentation system, a standardised consent care plan was implemented, a signature sheet was introduced in Penrith and best practice was imparted through the clinical governance structures to ensure continuous best practice.

The second re-audit found positive results with high levels of compliance being maintained or increased, but alongside minor variations in documentation methodology, hampered in part by some units using electronic systems and some written documentation. A further improvement is currently being implemented relating to a single template for all units to use, alongside feedback and communication through clinical governance.

Mental Health Care Group

Audit and re-audit of assessment of capacity to consent to treatment by the Responsible Clinician

An audit was carried out of the assessment and documentation of capacity to consent to treatment before the first administration of medication by the responsible clinician. 43 people detained in mental health wards across Cumbria were included. 51% had an assessment of capacity to consent documented in the first round of the audit. Following the first round of the audit, a capacity column was added to ward information boards as a prompt, and individual action plans were developed by the Clinical Director with responsible clinicians. A re-audit was then carried out in which 94% of the sample of 50 had an assessment of capacity to consent documented. The Clinical Director will discuss and agree actions with the responsible clinicians regarding the 3 missing assessments.

Risk formulation in Community Mental Health Assessment and Recovery Team (CMHART)

The completeness and quality of risk formulation within the Galatean Risk Screening Tool (GRiST) was audited for 60 GRiSTs, completed by CMHART staff across all localities of Cumbria. 98% of the GRiSTs had a recorded risk assessment, and 93% a risk formulation. However, only 62% of the GRiSTs had been updated within the previous 6 months, and in a few instances information was correct but in the wrong place. Actions to be taken as a result of the audit include: offering risk formulation training to CMHART staff; network-wide agreement on the correct completion of the GRiST for people presenting as low risk; and identification of who will provide supervision on the quality of risk formulation for CMHART staff.

Retrospective audit examining the impact virtual clinics have had on referrals to Allerdale CHESS (Care Home Education & Support Service)

This audit looked at referrals from 5 care homes before and after introduction of a trial of virtual clinics aimed at ensuring the growing demands of the service can be met efficiently and responsively. It was found that 2 of the 5 care homes reduced referrals during the trial, 2 continued not to refer, and one slightly increased its referrals. Improvement actions include: moving to virtual clinics for a further 5 care homes and reviewing the CHESS protocol for triaging referrals received by the GP and outside organisations.

Specialist Services Care Group

To what extent is the Community Learning Disabilities Service Eligibility Process adhered to?

The project aimed to assess eligibility assessment procedures being adhered to within the Community Learning Disability Team South. The audit looked at the frequency and results for Learning Disability Screening Questionnaires (LDSQs), the Adaptive Behaviour Assessment System (ABAS) and the Wechsler Adult Intelligence Scale; an assessment of cognitive ability.

The audit found that adherence to the local Eligibility Assessment Process is generally good, with the exclusion of screening with the LDSQ. There is currently no mechanism for assessing the extent that clinical judgement was used to determine further assessment of eligibility. Adherence should be re-audited once a means of recording clinical judgements has been developed. Service user experience of the audit process and communication of results would extend and enrich the audit design. The eligibility pathway is currently under review. Learning from the clinical audit was shared with Learning Disability Psychologists, team meetings, clinical leads and at an eligibility county-wide team day.

Cumbria wide Audit of the Just in case medication and syringe driver documentation

A new set of documentation was developed and launched in September 2015 comprising of six separate forms, two of which are completed by the prescriber and four by community nurses when the need arises to prescribe. The forms cover patient demographics, correct medicine and controlled drug prescribing, daily monitoring, prescription discontinuation and care planning. The audit evaluated how the forms are being completed with the aim to identify areas of improvement.

Areas of improvement identified included older forms being used in some instances, along with areas of lower than required consistency around accurate recording of patient demographics, GMC or NMC number recording, documenting drug compatibility in syringe driver charts, district nurse monitoring, prescribing water for injection and allergy box completion.

As a result further training is being implemented to educate District Nurses and General practitioners in completing the forms, amendments to the current forms to provide additional guidance, along with a presentation of the findings to the Palliative Care Group.

Central

Medicines Optimisation Audit

An audit was carried out of the NICE guideline: “Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes” (NG5). Information on medicines reconciliation was audited for 30 mental health inpatients. The findings showed that improvements were needed to achieve compliance with the NG5 guideline. As a result of the audit a Standard Operating Procedure (SOP) for Medicines Reconciliation was

developed and introduced by the Principal Pharmacist who has commenced training sessions, targeted firstly at Pharmacy staff, and afterwards at wider staff groups.

Clinical Effectiveness (NICE)

The National Institute for Health and Care Excellence (NICE) is the independent organisation responsible for developing national guidance, standards and information on providing high-quality health and social care, and preventing and treating ill health. NICE guidance helps deliver the best possible care based on the best available evidence.

As a Trust we are committed to quality improvement and support and monitor the assessment of NICE guidance across all of our services. Systems are in place to ensure clinicians are informed of new and updated guidance, and are supported to use the NICE produced tools to ensure assessment of our services against the evidence-based national standards NICE guidance outlines.

Following a previous Trust-wide retrospective review, all published NICE guidance is continually reviewed by clinicians appointed as NICE Leads across our services. New and updated guidance is published each month by NICE and the Trust considers each publication for relevancy to the services we provide. Relevant guidance is prioritised, allocated to a clinician for assessment before a committee sign off. If actions are deemed necessary these are monitored and reported on with evidence of completion to show resulting improvements.

In 2017/18 the Trust tailored NICE Guidance baseline assessment training and delivered it to clinicians across the county who had or were going to have responsibility for assessing guidance. 58 guideline assessments have been signed off so far across the Care Groups.

In addition the Medicines Management Committee has systematically reviewed published NICE Technology Appraisals published in 2017/18 to identify new and identified medicine related guidance relevant to our services to ensure provision and compliance.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Cumbria Partnership NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee 837.

There is a well-established relationship between research activity within NHS organisations and a range of outcomes. A recent review reports a positive association between engagement in research by healthcare organisations and improvements in healthcare performance within the specialities engaging in research. A paper submitted for publication by members of the CPFT research team, that has analysed data from UK wide trust quality and R&D data, shows a number of correlations. In summary the paper shows that increased levels of clinical research activity are linked with better care quality commission ratings, increased speciality clinical trial activity is linked with reduced mortality, that these relationships are primarily associated with interventional research

(clinical trials) activity and that, although the associations are more pronounced for teaching hospital trusts, the link between clinical trials activity and mortality and CQC ratings still persists for non-teaching hospital trusts.

The Trust's Research and Innovation Strategy (2015-2018) identifies four core aims towards becoming an increasingly research engaged organisation:

1. To increase the opportunities for people in Cumbria to participate in well governance clinical research (a core 'right' in the NHS constitutions)
2. To maintain the highest standards and governance of research activity in the Trust
3. To increase the research awareness of staff working in the Trust
4. To support research active staff to develop research activity that could lead to innovation and/or funded grant applications

The Research & Development (R&D) team consists of 12 staff, equating to 9.5 WTE. These staff are funded both from the North East and North Cumbria CRN (NENC CRN) and from commercial studies income. Following discussion with the NENC CRN and executive teams of CPFT and NCUH there is an agreement to bring the R&D teams from CPFT and NCUH together as a single department from April 2018. Preparatory work towards this has begun and Professor Dave Dagnan has been the joint R&D Director for both trusts since April 2017.

Strategic Aims:

1. To increase the opportunities for people in Cumbria to participate in well governanced clinical research (a core 'right' in the NHS constitutions)

The R&D Department's core function is to recruit participants into research studies which are included in the National Institute for Health Research's (NIHR) portfolio. To be eligible for inclusion on the portfolio a research project must meet certain standards (commercial and academic studies that are of good scientific quality, peer-reviewed and funded from a competitive funding stream). As of 08/01/2018 the Trust's recruitment figure stands at 837 participants into 33 different portfolio studies. Table 1 summarises recruitment activity since 2010 by financial year. The study identified in 2013-15 (Catfish) was an unusually large study looking at the effects of fluoridisation in Cumbria which distorted underlying trends, and so the data is reported both with and without this study.

Year	Patient Accrual	Number of studies
2010-11	176	12
2011-12	124	19
2012-13	210	23
2013-14	1435 (366 without Catfish)	24
2014-15	1235 (595 without Catfish)	25
2015-16	663	23
2016-17	1051	27
2017-18	837	33

Studies can be classified in a number of different ways. Firstly, they are listed as commercial or non-commercial. A commercial study is a study where a commercial company has developed the study protocol and fully funded the additional costs of hosting the trial within the NHS. The Trust currently has 3 commercial studies open to recruitment, with 41 recruits to date. This activity has particularly contributed to strategic aim 4: To support research active staff to develop research activity that could lead to innovation and/or funded grant applications.

Studies can also be classified as observational, interventional or CTIMPS (Clinical Trial of an Investigational Medicinal Product). The Trust currently has 20 observational portfolio studies and 8 interventional portfolio studies open to recruitment. We have 1 CTIMP currently open which is in follow-up stages and 1 CTIMP in set-up.

The table below summarises recruitment by study and shows the broad range of services within which we run studies which includes mental health, older adults, neurology, diabetes, sexual health, continence services and primary care.

Study title, speciality and number of participants for studies active in CPFT 2017-2018.

Study Title	Managing Speciality	Participants
Lifestyle Health and Wellbeing Survey	Mental Health	103
DARE	Diabetes	72
N-CAT	Children	63
PIPSET	Dementias and neurodegeneration	44
WIDE	Diabetes	88
PrEP Impact	Infectious disease, and microbiology	56
ReQol	Mental Health	50
Safetxt	Infectious disease, and microbiology	40
BrainCool	Neurology	36
Tonic Phase 3	Dementias and neurodegeneration	41
Hospital discharge for Homeless People	Mental Health	20
HAWS	Diabetes	25
FICUS	Primary Care	25
Tonic Phase 2	Dementias and neurodegeneration	27
Tonic Sub study 4	Dementias and neurodegeneration	12
Impart	Mental Health	15
NCISH	Mental Health	15
EMBARC	Respiratory	13
Tonic Phase 4	Dementias and neurodegeneration	35
Adult Autism Spectrum Cohort	Mental Health	7
PREVUE	Cardiovascular	6
ADDRESS 2	Diabetes	6

Psychological adjustment in MS	Dementias and neurodegeneration	5
Modem	Dementias and neurodegeneration	12
AD Genetics	Dementias and neurodegeneration	4
DAWN-SMI	Mental Health	3
SCIP	Children	3
mATCH	Mental Health	3
DPIM bipolar	Mental Health	3
High Energy Protein Peptide Feed	Children	2
eTIPS	Children	1
The Assessment of Risk and Safety in Mental Health Services	Mental Health	1
Improving healthcare for probationers	Health Services Research	1

2. To maintain the highest standards and governance of research activity in the Trust

The R&D department reviews both portfolio and non-portfolio studies (which include both educational and some of our 'home-grown' projects). From April 2017 we have approved 18 studies to run within the trust - an increase on this time last year. These include 4 Investigator Initiated Trials (IITs) which we have developed ourselves within the trust and which contribute to Strategic Aim 4. All four of these studies are included on the national NIHR portfolio.

The Trust is committed to processing and appraising new research projects in line with England-wide processes. Whereas in the past there was a two tier system involving first National Research Ethics Service (NRES) review and then NHS Trust-specific review (Trust approval), the process of obtaining the green light for a new research project now involves NRES and Health Research Approval (HRA) followed by Trust confirmation. The HRA essentially provides the assurances that in the past each NHS Trust in the country would give, and Trusts now adopt the HRA opinion offering an opinion on our capability and capacity to host each study.

In addition to meeting national standards for Research Governance Targets the North East and North Cumbria CRN set an additional continuous improvement objective this year to have 90% of the information recorded in LPMS (the Local Portfolio Management System) complete and accurate. The Trust achieved 100% compliance.

3. To increase the research awareness of staff working in the Trust

The R&D team has a core role in 'horizon scanning' for national studies that would fit into the clinical portfolio of the trust. The R&D team then liaise with clinical teams to discuss to discuss the potential for them to participate in the studies for their clinical area. This process requires established relationships between the R&D team staff and key clinical teams and services. The team continues to develop and maintain these links with the clinical teams.

The R&D team continues to organise an annual R&D conference to showcase activity within the trust and its partners. The 2017-2018 conference is planned for 11th of May 2018. This is slightly later than has previously been the case but the date has been chosen to allow this conference to be a joint conference for the combined CPFT/NCUH R&D department.

We continue to publish the Cumbria Partnership Journal of Research, Practice and Learning. The last issue was the Summer 2016 issue, but was published early in 2017 due to delays caused by changes in the printer/publisher we use for the journal. We plan to continue publication of the journal on an annual basis; the next issue will be a combined CPFT/NCUH publication.

4. To support research active staff to develop research activity that could lead to innovation and/or funded grant applications

We continue to support research interested and research active staff in developing their own projects where appropriate which also supports Strategic Aim 4. We aim to provide support to clinicians in line with the Royal College of Physicians position paper 'Research for All', whereby we will ensure that:

- All new staff with research experience or interest are offered a meeting with R&D to discuss how their research interests can be facilitated.
- Ensure all staff are aware of relevant portfolio studies for which they could be PIs and to ensure maximum support from R&D Department for participation
- We use R&D funding streams to ensure that support is available to staff to develop research and evaluation interests and collaborations
- We ensure that the support from the R&D department and associated teams in developing research and evaluation design, ethical and other approvals and funding applications are advertised.

The impact of research participation

Some research studies have potential for immediate impacts upon service delivery and some studies establish an evidence base that will impact upon clinical practice over longer periods of time. An example of a recent study that has had measureable impact on services is the NIHR HTA funded BEAT-IT trial of guided self-help and behavioural activation for people with learning disabilities and depression. Cumbria was a key site in this large multi-site Randomised Controlled Trial. In Cumbria the study involved training nearly all band 5 and 6 nurses in the community teams to deliver the interventions and subsequent random allocation of people with learning disabilities with depression to each arm. The trail has demonstrated that both interventions have clear and lasting impacts upon depression in this population. The clinical techniques involved have now been embedded into pathways for psychological therapies within the community teams of people with learning disabilities and there is an ongoing program of training and supervision for nursing staff to deliver the interventions.

This year has also seen the opening of our first home-grown multi-centre study – the BrainCool study. This research project is a Randomised Controlled Trial looking at a novel treatment for migraine involving an intra-nasal cooling device. This project is giving migraine sufferers in the North-East of the country the opportunity to try a new therapy for migraine which wouldn't normally be available to them.

Commissioning for Quality and Innovation (CQUIN)
A proportion of Cumbria Partnership NHS Foundation Trusts income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Cumbria Partnership NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with, for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The National guidance and details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf

For 2016/17 the amount of CCG CQUIN income available was £3.28m. The negotiated settlement for 2016/17 was £2.78m which represents 85% of the available total. The value of NHSE CQUIN available was £50k and this was all achieved.

Changes to the national contract by NHS England mean that our latest contract is for two years spanning 2017 – 2019. All CQUIN schemes are therefore; two years in length in addition the detail of the schemes has been nationally mandated.

CQUIN schemes for 2017 – 2019 are:

- Improvement of health and wellbeing of NHS staff
- Healthy food for NHS staff, visitors and patients
- Improving the uptake of flu vaccinations for frontline clinical staff
- Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses
- Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians
- Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco and Alcohol screening
- Improving the assessment of wounds
- Personalised care and support planning
- Supporting proactive and safe discharge
- Improving services for people with mental health needs who present to A&E
- Transitions out of Children and Young People's Mental Health Services (CYPMHS)

Performance for year 1 to be confirmed.

Registration and regulation from the Care Quality Commission (CQC) and Ofsted
The Trust is required to register with the CQC and its current registration status is 'full registration with no conditions'. The Trust is registered with the CQC to provide the following regulated activities.

Assessment or medical treatment for persons detained under the Mental Health Act 1983 – The Trust can only carry out these activities at:

- Carleton Clinic, Carlisle
- Dova Unit, Barrow
- Kentmere Ward, Westmorland General Hospital
- Ramsey Unit, Barrow
- Yewdale Unit, Whitehaven.

Diagnostic and screening procedures – The Trust can only carry out these activities at:

- Abbey View, Barrow
- Alston Hospital
- Brampton Hospital
- Cockermouth Hospital
- Copeland Unit
- Haverigg Prison
- Langdale Unit, Westmorland General Hospital
- Keswick Hospital
- Millom Hospital
- Penrith Hospital
- Wigton Hospital
- Workington Hospital
- Maryport Hospital
- Voreda House

Family planning – The Trust can only carry out these activities via Trust Headquarters, Voreda House.

Surgical procedures – The Trust can only carry out these activities at:

- Voreda House
- Primary Care Assessment Service, Westmorland General Hospital

Treatment of disease or injury – The Trust can only carry out these activities at:

- Alston Hospital
- Abbey View, Barrow
- Brampton Hospital
- Cockermouth Hospital
- Carleton Clinic, Carlisle

- Copeland Unit
- Dova Unit, Barrow
- Haverigg Prison
- Kentmere Ward, Westmorland General Hospital
- Keswick Hospital
- Langdale Unit, Westmorland General Hospital
- Millom Hospital
- Penrith Hospital
- Ramsey Unit, Barrow
- Wigton Hospital
- Workington Hospital
- Yewdale Unit, Whitehaven
- Maryport Hospital
- Voreda House

The Care Quality Commission has not taken enforcement action against Cumbria Partnership NHS Foundation Trust during 2017/2018.

As part of the transfer plans for South Cumbria Community services to University Hospitals of Morecambe Bay Trust (UHMBT), as of 1 April 2018, the following locations were removed from Cumbria Partnership's CQC registration:

- Millom Hospital
- Abbey View
- Langdales Unit
- Kendal PCAS

Care Quality Commission registration

During 2017/18 the Trust had a process in place for undertaking the assessment of Care Quality Commission registration requirements. The work which has taken place during this time period included the following:

- Non-Executive Director/Governor Visits – these visits take place on a regular basis to services across the Trust and are facilitated by our Corporate Governance Team. Any issues raised from these visits are discussed at the care groups Clinical Governance Meetings and the Quality and Safety Committee.
- Annual Care Group Clinical Governance Reports – these provide assurance against the systems, processes and outcomes in relation to:
    - Governance structures
    - Listening and responding to patient experiences
    - Patient Safety Incidents
    - Risk management
    - Staffing and staff management
    - Education, training and continuing professional development
    - Clinical audit

    - Evidence based care and effectiveness
    - Clinical Information
- The central Quality, Safety and Safeguarding Team have conducted an assessment of evidence in relation to the CQC new guidance and inspection process which includes assessment against the CQC's Fundamental Standards and Key Lines of Enquiry (KLOE).
- Support for clinical teams from the Trust's Quality, Safety and Safeguarding Team to embed required improvements following CQC inspections which highlight any issues and concerns.
- Introduction of a Peer Review process, led by Care Groups, based on the CQC KLOE's. The aim of the review process is to share learning through the review of services across care groups, highlighting area's of best practice, and identifying area's for improvement. This is monitored through CQC Steering Group and through clinical governance structures.

Regulatory inspections
Cumbria Partnership NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Under the new CQC inspection framework, introduced in April 2017, the Trust received inspections to six core services (during September and early October 2017) and an overall Trustwide inspection of the Well Led domain, on the 10 – 12 October 2017.

The core services inspected were:

- Memory and Later Life – Community Services
- Memory and Later Life - Inpatient Services
- Community Mental Health Assessment and Recovery Team (CMHART)
- Dental Services
- Child and Adolescent Mental Health Services (CAMHS)
- Community Inpatient Services (including Primary Care Assessment Service (PCAS) and Minor Injury Unit (MIU) and Nurse Led Treatment Centres)

The final report was published on the 25 January 2018.
Copies of any published inspection reports will be available for review on the CQC website www.cqc.org.uk.
It is noted that all core services inspected were rated Good or Outstanding for the Caring domain.

Memory and Later Life – Community Services
The community based services at Carlisle, Whitehaven and Kendal were inspected.

Overall the service was rated Requires Improvement. Previously the service was rated 'Good' overall in the 2015 comprehensive inspection.

There are four requirements or 'must do' actions relating to this service, and four 'should do' actions. Improvement work is underway within the Trust around the areas identified in the report. Formal response to the requirement notices was submitted to the CQC in February 2018.

Memory and Later Life – Inpatient Services
The inpatient services for older people in Carlisle and Barrow were inspected. Overall the service was rated Requires Improvement, which was the same rating as previously rated in 2015. It was however noted that the service were rated 'Outstanding' for the Caring domain.

There are two requirements and nine should do actions related to this service. Improvement work is underway within the Trust around the areas identified in the report. Formal response to the requirement notices was submitted to the CQC in February 2018.

Community Inpatient Services
The inpatient, PCAS, MIU and Nurse Led Treatment Centres visited across the Trust:

- Copeland Unit and Loweswater suite, West Cumberland Hospital at Whitehaven.
- Abbey View at Furness General Hospital
- Victoria Cottage Hospital at Maryport and a nurse-led treatment centre
- Ellerbeck Ward at Workington Community Hospital
- Brampton War Memorial Hospital
- Isel Ward at Cockermouth Hospital
- Eden Unit at Penrith Hospital
- Ruth Lancaster James Community Hospital - nurse-led treatment centre
- Millom Community Hospital
- Langdale South and Langdale North wards at Westmorland Hospital, Kendal.
- Primary Care Assessment at Westmoreland General Hospital, Kendal.

Overall this core service line was rated Requires Improvement, the same rating applied in the 2015 inspection. There were seven requirements and thirteen should do actions associated with this service. Improvement work is underway within the Trust around the areas identified in the report. Formal response to the requirement notices was submitted to the CQC in February 2018.

CAMHS
The teams in Workington and Barrow were inspected. Overall the core service was rated the same as in 2015 – Requires Improvement. There are five requirement and seven should do actions for this service. Improvement work is underway within the Trust around

the areas identified in the report. Formal response to the requirement notices was submitted to the CQC in February 2018.

Dental Services
The services in Carlisle, Ulverston, Penrith and Kendal were inspected. The service was rated Requires Improvement overall – this was the first time this core service had been inspected. The service was also rated 'Outstanding' for the Caring domain.

There is one requirement and five should do actions for this service. Improvement work is underway within the Trust around the areas identified in the report. Formal response to the requirement notices was submitted to the CQC in February 2018.

Trustwide - Well Led
The overarching Well Led inspection took into account how well led the trust was overall, taking into consideration findings of how well led services were during the core service inspections. Overall the Trust ratings remained the same as in 2015 – Requires Improvement.

There are three requirements and four should do actions related to the Well Led inspection. Improvement work is underway within the Trust around the areas identified in the report. Formal response to the requirement notices was submitted to the CQC in February 2018.

Across the core service and Well Led inspection, the CQC did acknowledge that improvements had been made in some areas. There were a large number of areas of notable practice identified by the CQC, along with some examples of outstanding practice.

All actions are being progressed, with two of the 22 requirement or must do actions now complete. All actions are monitored through the fortnightly Trust wide CQC Steering Group, chaired by the Deputy Director of Nursing.

The Trust current CQC ratings

An overview of the current ratings for the Trust and services can be found on our website and in the matrix below:

Overall Trust Ratings:

Services				Overall	Overall
Safe	Effective	Caring	Responsive	Well-led	
Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Community health services for children and young people	Good ↑↑ Apr 2017	Good ↑ Apr 2017	Good ↔ Apr 2017	Good ↑ Apr 2017	Good ↑↑ Apr 2017	Good ↑↑ Apr 2017
Community health inpatient services	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018	Good ↑ Jan 2018	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018
Community end of life care	Good Mar 2016	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Requires improvement Mar 2016	Requires improvement Mar 2016
Community dental services	Good Jan 2018	Good Jan 2018	Outstanding Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↔ Jul 2017	Requires improvement ↔ Jul 2017	Good ↔ Jul 2017	Good ↔ Jul 2017	Requires improvement ↔ Jul 2017	Requires improvement ↔ Jul 2017
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Wards for older people with mental health problems	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Outstanding ↑ Jan 2018	Good ↔ Jan 2018	Good ↑ Jan 2018	Requires improvement ↔ Jan 2018
Wards for people with a learning disability or autism	Requires improvement ↔ Feb 2017	Good ↑↑ Feb 2017	Good ↔ Feb 2017	Good ↑ Feb 2017	Requires improvement ↑ Feb 2017	Requires improvement ↑ Feb 2017
Community-based mental health services for adults of working age	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018
Mental health crisis services and health-based places of safety	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Specialist community mental health services for children and young people	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018	Inadequate ↓ Jan 2018	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018
Community-based mental health services for older people	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018
Community mental health services for people with a learning disability or autism	Good Mar 2016	Good Mar 2016	Good Mar 2016	Not rated Mar 2016	Good Mar 2016	Good Mar 2016

CQC Local Area Systems Review

Commissioned by the Secretaries of State for Health and for Communities and Local Government the CQC were required to undertake a local system review in Cumbria. The local area was one of a number chosen across England that would feed into a wider national report. The main review in Cumbria took from the 12 – 16 February 2018.

The local system reviews are looking at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old, and people with dementia.

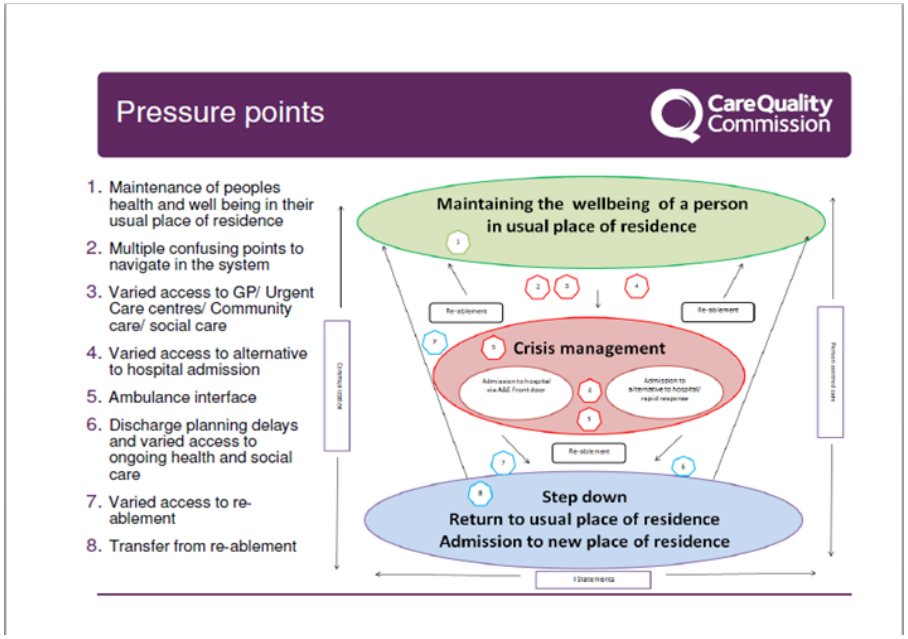
They also include an assessment of commissioning across the interface of health and social care and of the governance systems and processes in place in respect of the management of resources.

The CQC review team visited a number of Trust community inpatient units and rehabilitation teams, and focussed on the following three main areas:

1. Maintaining the wellbeing of a person in their usual place of residence.
2. Crisis management
3. Step down – return to usual place of residence, or admission to new place of residence.

The CQC developed a set of KLOE's to support the review, which involved speaking with staff, patients, families and carer's and reviewing records. The well led part of the review included interviews and focus groups with key senior individuals from providers and the overall system.

Eight pressure points were identified by the CQC through previous reviews undertaken, and these were a focus for the CQC team, and how these entwined with the three key areas, as shown in the image below:



High level feedback was provided at the end of the review on the 16th February 2018. The final report was received in May 2018 and includes the findings and recommendations for the local area. A Quality Summit with the CQC and the Local Area has been arranged for the 21st May 2018, and a completed action plan to address the recommendations to be submitted within 20 days of the summit. Findings and actions are not specific to Cumbria Partnership NHS Foundation Trust.

Upon completion of all local area system reviews commissioned, a national report will be published by the CQC.

Ofsted inspections

The Trust did not receive any external inspections from Ofsted during 2017/18.

Hospital Episodes Statistics data

Cumbria Partnership NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
    - 100% for admitted patient care;
    - 99.3% for outpatient care; and
    - 93.5% for accident and emergency care
- which included the patient's valid General Medical Practice Code was:
    - 100% for admitted patient care;
    - 99.9% for outpatient care; and
    - 88.6% for accident and emergency care

Information Governance (IG)

Cumbria Partnership NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 94%, and was graded Satisfactory (Green). This was independently verified by Audit One auditors.

Information plays a key part in the clinical and corporate governance of the Trust. Quality in the provision of patient services, planning, performance measurement, assurance, and financial management relies upon accurate and available information. Information Governance is how we govern the use of information we use at the Trust Ensuring that personal and sensitive data is kept safe and secure in line with our vision that we "*Enable high quality care by facilitating the ethical, legal, effective & appropriate use of accurate & reliable information that maintains confidentiality, integrity & availability*". There are numerous standards we have to adhere to in order to help us comply with the data laws, such as Data Protection Act 1998 (soon to be replaced by General Data Protection Regulations on 25 May 2018).

The **Information Governance Toolkit** submission is required by 31 March each year and is a measurement of our performance to ensure that personal and sensitive data is dealt with securely and confidentially. Unique for 2017 / 2018, the IG Toolkit has been a "*roll over*" year allowing some time to plan for the significant changes that are occurring in 2018 / 2019 and the latter parts of 2017/ 2018, namely:

- On 12 July 2017, the Government accepted the ten data security standards recommended by Dame Fiona Caldicott, the National Data Guardian for Health and Care. The Trust has been working to demonstrate that they are implementing these ten data security standards prior to a new assurance framework coming into place from April 2018.
- From April 2018, the new Data Security Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit. It will form part of a new framework for assuring that organisations are implementing the ten data security standards and meeting their statutory obligations on data protection and data security. The Trust has been preparing in advance for the new arrangements.
- The General Data Protection Regulation (GDPR) implementation date is 25 May 2018. Alongside this Regulation is the Data Protection Bill (published in September 2017) which introduces a number of changes to the GDPR requirements which are extensive.
- Compliance with the Information Commissioner's 12 step approach to GDPR together with receipt of associated guidance from the Article 29 Working Party) and receipt of specific health IG guidance from NHS England, IG Alliance.
- National Data Opt Out Programme

Due to external pressure in receiving compliance in the changing landscape a strategy of maintaining compliance with IG Toolkit has taken place in 2017 – 2018. The table below represents a comparison year on year.
Note: that these are not a direct like for like comparison because each year additional requirements are included in the IG Toolkit for achievement.

Assessment	Stage	Overall Score	Self-assessed Grade
Version 14.1 (2017 – 2018) (roll over year)	Published	94%	Satisfactory
Version 14 (2016 – 2017)	Published	91%	Satisfactory
Version 13 (2015 – 2016)	Published	91%	Satisfactory
Version 12 (2014-2015)	Published	90%	Satisfactory
Version 11 (2013-2014)	Published	82%	Satisfactory
Version 10 (2012-2013)	Published	75%	Satisfactory

Incident Report - During the reporting period, the Information Governance Team has recorded 413 IG incidents between 1 April 2017 and 31 March 2018. The Trust uses the national Incident Reporting Tool to report level 2 Information Governance 'Serious

Incidents Requiring Investigation' (IG SIRI) to the Department of Health (DH), Information Commissioner's Office (ICO) and other regulators. Level 2 IG SIRIs are those incidents which are sufficiently high profile or serious enough to be reportable; these will mainly involve a breach of Data Protection Act principles or the Common Law Duty of Confidentiality. The severity of the incident will also be determined by the number of data subjects affected and the sensitivity of the information compromised.

Level 2 and level 1 incidents for 2017 - 2018 are summarised below:

IG SIRI level 2

The Trust reported two level 2 SIRI in 2017 - 2018

Date of Incident	IG SIRI reference number	IG SIRI level	Status	Summary of Incident	Outcome
12 May 2017	CSI/11823	2	Closed	Cumbria Partnership NHS Foundation Trust received a report that a PC was infected by the Wannacry Virus. The user was immediately disconnected from the network. The IT Security Team monitored which showed an increase in virus attack in progress and we took down the system to limit the impact.	ICO notified 12 May 2017
10 May 2017	IGI/11822	2	Closed	Theft of IT equipment from the IT Workshop with evidence of being resold. Police involved	ICO notified 10 May 2017

IG SIRI level 1

IG SIRI level 1 incidents are those that involve small numbers of patients and / or information that is unlikely to identify individuals.

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS 2017 - 2018		
Category	**Breach Type**	**Total**
A	Corruption or inability to recover electronic data	24
B	Disclosed in Error	148
C	Lost in Transit	11
D	Lost or stolen hardware	54
E	Lost or stolen paperwork	63
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	8
H	Uploaded to website in error	11
I	Technical security failing (including hacking)	5
J	Unauthorised access / disclosure	12

K	Other	77
	Total	413

IG Performance

The Information Governance Department is committed to the principle that Performance Management is not solely concerned with the monitoring of key performance indicators (KPIs) but is a tool to drive improvement on performance across the organisation. The Information Governance performance model has been implemented to provide a consistent approach to the way IG performance and quality is managed, monitored, reviewed and reported. This has been a crucial component in ensuring that up to date, accurate, evidence based information is available for all areas covered by the department enabling and supporting leads with their business planning and decision making and so contributing to the continual improvement culture. The IG compliance programme and performance against the IG Toolkit is closely monitored by the IG Board that meets on a quarterly basis. The meeting is chaired by the Director of Finance, Strategy and Support Services (our Senior Information Risk Owner). The Medical Director (Caldicott Guardian) and the Director of Quality and Nursing for CPFT and NCUHT are regular attendees at this meeting, and along with representatives from the care groups, provides the much needed clinical input. In addition, the Head of IG chairs a monthly IG Performance Group with operational managers.

Some of our key successes in 2017 – 2018 include:

Overarching Successes

- This year has been about preparing for the future changes in Data Protection legislation with the new Data Protection Act 1998 as a result of the General Data Protection Regulations. The Information Commissioners 12 step approach has been used as a guide. The team held a Rapid Process Improvement Workshop in September results in time out to review all processes which have been written up, pilot tested and implemented in advance of May date.
- The Trust are on an integration agenda with North Cumbria University Hospitals NHS Trust and in year have commenced shared understanding of roles / processes which are being aligned with the driver of change in Data Protection Legislation.
- The strong IG performance framework we have in place means an evidence base of compliance and continual improvement.
- Head of IG chairs the Lancashire and Cumbria Group ensuring we are a key strategic partner in changing arena.
- Compliant IG policies and procedures
- Getting ready for national changes but also changes in internal landscape, i.e. integration with NCUHT, establishment of Integrated Care Communities.

Information Governance Compliance

- Introduced new IAO/IAA training and assessment used by CPFT and NCUH.

- New DPIA (data protection impact assessment) proforma and process used by CPFT and NCUH that is GDPR (general data protection regulation) compliant.
- Updated work package with PMO (programme management office) to incorporate GDPR and privacy by design.
- 98 assets and processes assessed by the team up for the year.
- Development of a data mapping electronic tool to support the requirement for a "record of processing activities" as a result of implementing new Data Protection legislation.
- New contracting toolkit that has been provided to Procurement / Business Managers to ensure compliance with the new legislation.

Improvement figures:

	CPFT		CCG	
	Status	Improvement	Status	Improvement
Asset Validation IAO	100%	3%	100%	22%
Asset Validation IAA	100%	4%	100%	30%
IAO Training	88%	7%	83%	No Change
IAA Training	90%	8%	100%	No Change

Privacy and Information Sharing

- The Information Sharing Gateway has won the ISD Network (North West) Award for innovation. The Information Sharing Gateway was shortlisted for the HSJ (Health Service Journal) award – using technology to improve efficiency. Expansion of the information sharing gateway with Manchester Combined Authorities using this for their primary enabler for information sharing.
- Continued expansion of privacy monitoring in year with Strata and Summary Care Record.
- New data protection impact assessment process applied in preparation for changes in legislation.

Data Quality

- Data Quality team gone from "limited" to "Good" for RTT (referral to treatment). Also has some excellent feedback from Audit one on our training for staff on Referral to Treatment.
- Clinical Coding Mental Health 100% for primary diagnosis Coding IG Level 3 achieved.
- Health visiting open referrals reduced from 16,000 to 300.
- 100% of all planned appointments are accurate for the patient arriving.

Health Records

- By the end of 2017/18 the Trust will be using one tracking system Trac-It which will ensure that records can be managed in one central location. Trac-It also complies with Information Governance and it contains a full audit trail of where records have been.

- Health Records have developed and are in the process of implementing health records keeping training. This training is based on the needs identified through health records keeping audits across Trust Electronic Patient Record Systems.
- Despite staff shortages, health records staff have worked to achieve their key objectives and performance indicators. All requests for records have been answered within 24 hours, large amounts of records continue to be archived through the department and deceased notifications are been placed on the record within the specified time period in order to avoid deceased patient relatives receiving inappropriate clinical correspondence.

Information Rights

- Freedom of Information Act requests – As a public authority we have a duty to be open and transparent about what we do. The Freedom of Information Act 2000 allows anyone to ask for information about the Trust's business and we provide information to support this. We received 448Freedom of Information Act requests from 1 April 2017 to 31 March 2018. This is the same as the previous year. 98% were responded to within the 20 day legislative timescales which maintains the performance from 17-18, with one internal review requested in year.
- Subject Access Requests (SARs) –This process gives individuals the right to find out what personal data we hold about them, why we hold it and who we disclose it to. The team have dealt with 670 requests within 2017/2018. 100% responded with 40 days. In preparation for General Data Protection Regulations which it is anticipated (although not yet confirmed) that the response times will drop from 40 days to 30 days the Trust has been baselining its compliance and responded to 71% responded with 30 days. The average number of days to complete a SAR is 24 (without clock stopped) within the dept.
- A Rapid Process Improvement Workshop was held in September to review our processes for handling SAR (Subject access requests) requests and to prepare for the new extended rights that the public hold with the introduction of the new legislation.
- For seventh year in a row all staff have been trained in information governance (hitting over 95% compliance)

Registration Authority

- Our Registration Authority Service continues to excel and provides a first class service not only to the Trust but the CCG
- We are progressing the move to paperlite service by moving GP's and Pharmacies to CIS
- Supporting project work including EMIS, Strata, Adastra

Payment by Results

Cumbria Partnership NHS Trust was not subject to the Payment by Results clinical coding audit during 1 April 2017 – 31 March 2018.

Data Quality Statement

Cumbria Partnership NHS Foundation Trust (the Trust) will be taking the following actions to improve data quality. The Trust recognises that Data quality is an underpinning issue in most things that we do in the Trust. Following feedback from a number of external audits, the Trust has developed an overarching Data Quality Strategy and 3 year implementation plan. A sustained focus on data quality within our electronic patient record systems is a key enabler of our Strategy. Our clinicians and managers recognise that poor data quality impacts on patient care as well as the credibility of information and has a negative effect on efforts to improve information management.

Reporting against core indicators

Indicator – The percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period (target 95%).

This Trust Q1 score	**Q1 National Score**	Q1 Low Score	Q1 High Score	This Trust Q2 score	**Q2 National Score**	Q2 Low Score	Q2 High Score	This Trust Q3 score	**Q3 National Score**	Q3 Low Score	Q3 High Score	This Trust Q4 score	**Q4 National Score**	Q4 Low Score	Q4 High Score
92.8%	96.7%	85.4%	97.1%	97.3%	96.7%	95.3%	100%	95.1%	95.4%	93.3%	96.6%	96.1%	Not Available	95.9%	96.3%

The Trust considers that this data is as described for the following reasons. We have in place detailed data definitions, standard operating procedures concerning the collection and collation of information from our systems and data validation reports, reviews and audits to provide assurance of the data.

The Trust intends to take the following actions to improve this indicator and so the quality of its services, by reviewing and improving the data capture of patient discharge destinations to ensure that all exemptions from 7 day follow up requirements are identifiable, adding assurance to the reported performance. This has been identified as an issue in the annual audit.

Indicator – The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.
Issues have been identified with the data sets used to provide Seven Day Follow Up and Crisis Gate Keeping indicators.

This Trust Q1 score	**Q1 National Score**	Q1 Low Score	Q1 High Score	This Trust Q2 score	**Q2 National Score**	Q2 Low Score	Q2 High Score	This Trust Q3 score	**Q3 National Score**	Q3 Low Score	Q3 High Score	This Trust Q4 score	**Q4 National Score**	Q4 Low Score	Q4 High Score
95.2%	98.7%	89.2%	98.3%	98.5%	98.6%	95.7%	100%	97.2%	98.5%	95.6%	98.1%	98.2%	Not Available	96.8%	100%

The Trust considers that this data is as described for the following reasons. We have in place detailed data definitions, standard operating procedures concerning the collection and collation of information from our systems and data validation reports, reviews and audits to provide assurance of the data.

The Trust intends to take the following actions to improve this indicator and so the quality of its services, by conducting an audit of the processes used and its paper records to verify that these indicators are accurate. The indicators will be updated in due course.

Indicator - The percentage of patients aged:
(i) 0 to 15 and
(ii) 16 or over
readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

The NHS Digital Quality Accounts resource for this indicator has not been updated since 2013, with the latest available data relating to 2011/12 (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts/domain-3-helping-people-to-recover-from-episodes-of-ill-health-or-following-injury#section-3) A statement on the Quality Accounts resource website states: “Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.”

Local data for 2017/18 reports that there were 0 (zero) 0-15 re-admissions to hospitals provided by the Trust, and 163 16 or over re-admissions to hospitals provided by the Trust.

Indicator – The Trust’s ‘Patient experience of community mental health services’ indicator score with regard to a patient’s experience of contact with a health or social care worker

The NHS Digital Quality Accounts resource for this indicator has not been updated since 2013, however a new resource via NHS England has been used to provide the following data (https://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info/)

Community Mental Health Teams Overall Patient Experience Scores 2017/18

	Trust Scores		Performance	
Domain	**2017/18**	**2016/17**	**80th percentile for 2017/18**	**Performance in top 20% for 2017/18**
Access and waiting	81.5%	82.0%	86.5%	No
Safe, high quality, coordinated care	72.8%	68.9%	73.2%	No
Better information, more choice	72.4%	70.5%	72.6%	No
Building closer relationships	79.6%	76.5%	79.3%	Yes
Clean, comfortable, friendly place to be	Domain not used	Domain not used	Domain not used	Domain not used
Overall	76.6%	74.5%	77.2%	No

The Trust intends to take the following actions to improve this indicator and so the quality of its services, based on the findings of the survey the Trust will continue to monitor and challenge Service access and waiting time performance across the care group with a view to minimising waiting times wherever possible.

Indicator - Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:
a) inpatient wards
b) early intervention in psychosis services
c) community mental health services (people on care programme approach)

The Trust takes part in a national audit annually, the results of the audit has not been published yet, however our local estimation of the results is as follows:

- EIP 58% pass rate
- CMHART 52% pass rate
- Inpatients 54% pass rate

The Trust intends to take the following actions to improve this indicator and so the quality of its services. An Improving Physical Health Care steering group sits monthly and the importance of the assessment completion and necessary data capture is a regular agenda item at network operations meetings in the Mental Health care group.

Indicator – Admissions to adults facilities of patients under 16 years old
Due to small numbers the nationally published figures for this indicator for the Trust are suppressed. Local data reports that there were 0 (zero) bed days for patients under 16 years old at adult facilities provided by the Trust.

The Trust intends to take the following actions to improve this indicator and so the quality of its services, by continuing to locally monitor the use of beds in adult settings for under 16 admissions.

Indicator - Inappropriate out-of-area placements for adult mental health services

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
8	1	5	2	3	3	0	4	1	1	3	2

The monthly average for the year was 3.

The Trust intends to take the following actions to improve this indicator and so the quality of its services, through an agreed trajectory with NHS England for the reduction of Inappropriate OAP bed days over the next 3 years.

Indicator - The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period that resulted in severe harm and death.
Relative performance of Cumbria Partnership NHS Foundation Trust:

		Severity of Harm									
		None		Low		Moderate		Severe		Death	
Time Frame	No. of Incidents Reported to NRLS	N	%	N	%	N	%	N	%	N	%
CPFT Q3-Q4 2016-2017	1674	678	40.5%	900	53.8%	80	4.8%	2	0.1%	14	0.8%
MH Av. Q3-Q4 2016-2017*			64.8%		28.9%		5.2%		0.3%		0.8%
CPFT Q1-Q2 2017-2018	1577	544	34.5%	953	60.4%	65	4.1%	4	0.3%	11	0.7%
MH Av. Q1-Q2 2017-2018*			65.7%		28.7%		4.6%		0.3%		0.7%

*Mental Health national average based upon figures provided on the NPSA website (based on 55 reporting Trusts).

The calculation of the rate per 1000 bed days is performed by the national agency. The denominator used for the Trust excludes non Mental Health bed days.

The data that is included for this national performance measure uses a comparator against Mental Health organisations and therefore the figures included do not provide a clear picture in regards to incident reporting and levels of harm from patient safety incidents in our Trust services. The figures shown above also include patient safety incidents which relate to community hospitals, community services, children and young people services and specialist services.

The "Organisation patient safety incident reports" are published every 6 months with the most recent figures on incidents that occurred from 1 April 2017 to 30 September 2017 being published on 21 March 2018. 2017/18 Q3 and Q4 information will be published in September 2018.
https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-data/

The Trust considers that this data is as described for the following reasons. We have in place detailed data definitions, standard operating procedures concerning the collection and collation of information from our systems and data validation reports, reviews and audits to provide assurance of the data.

The Trust has taken the following actions to improve this indicator and so the quality of its services by:
Improving the processes around the reporting of incidents and completion of investigations

- The Trust is committed to supporting and embedding a positive reporting culture within the organisation to enable the organisation to learn when things have gone wrong.
- Over the last year that has continued to be a clear focus on the investigation, learning and improvement from incidents which have occurred in our services and to support other healthcare organisations across the system, through collaborative and joint learning events. In the NHS 'Learning From Mistakes League' (published in March 2016) the Trust was rated as 'good' for the levels of openness and transparency in regards to patient safety incidents. We are also an active partner in the North East and Cumbria 'Alliance' for learning from deaths.
- An established Mortality Review Group is in place, which links with the already well established processes in place within our care groups and meets the recommendations set out in the Mazars' Review of Mental Health and Learning Disabilities Deaths at Southern Health NHSFT.
- At a support service level there has been continued work completed by the Incident and Risk Management Team to support staff across the Trust to report incidents, register risks and encourage their review at team meetings, supervisions and appraisal.

- Development of a patient safety forum where trends and emerging themes from incidents and risks are reviewed by the Head of Clinical Governance, Clinical Risk and Patient Safety Manager and Deputy Director of Quality and Nursing.
- Collectively key people within the organisation attend the Quality and Safety Systems Group (was Ulysses Systems Group) to discuss current project management arrangements of module changes and updates to support the ongoing use of the system and ensuring we meet our statutory obligations with accuracy.
- Further embedding within the care groups of the Quality and Safety Dashboards that incorporate the Incident and Risk dashboards.
- Continued development of the dashboards to allow staff with more user friendly and visual way of reviewing their quality and safety information.

Our patient experience

We have in place a range of options to capture patient experience from people using our services to pass on their concerns, feedback, compliments and comments.

Working with our Patient Experience Involvement Group (PEIG), our Patient Experience Team has captured the views of over 9953 patients, service users and carers during 2017/18. All survey findings and recommendations are reported monthly to the relevant care groups, Executive Team and Board of Directors; and quarterly to the Quality and Safety Committee. Feedback is received from/via the following sources:

- Complaints, Compliments and Comments cards
- Face to face/telephone/post/email and SMS texts
- Surveys of all our 23 inpatient wards at the bimonthly 'Here for You' visits and on discharge
- Surveys of people who use our community services via the following questionnaires: Adult Community; Minor Injury; Community Mental Health; Friends and Family question; Child and Parent
- Patient Story to the Board
- National Community Mental Health Survey
- National patient feedback sites
- Trust web page
- Trust and the Patient Experience Team social networking sites
- Corporate website contacts
- Communications helpdesk contacts
- Patient Advice and Liaison services
- Partnership working with other agencies, industry and events in the workplace.

Examples of services gathering patient feedback during 2017/18

Team	Care Group	Quantity
Inpatient Wards	Mental Health	208
Inpatient Wards	Community	973

Team	Care Group	Quantity
Community Services	Community	1556
Here for you visits	Community & Mental Health	935
Parent	Children & Families	384
Children	Children & Families	1140
Community Services	Specialist Services	876
Friends and Family SAE Card	Trust	8509

Examples of findings from surveys and patient feedback for 2017/18:

- 99.4% of people who used the Physiotherapy Service said they were treated with dignity and respect by the staff
- 97.4% of people using the Stroke Rehabilitation Service said that they were treated with dignity and respect by the staff
- 92.5% of people using the Diabetes Services said that their treatment or care was explained in a way that they could understand.
- 95.3% of children using the Immunisation Nurses Service said that they felt safe
- 99.8% of people using the Specialist Palliative Care Service said that they were treated with kindness and compassion by the staff looking after them
- 98.8% of parents who's child was using the Physiotherapy Service said that the location was suitable for their child's needs
- 95.8% of people using a Minor Injury Unit said that they were involved as much as they wanted to be in decisions about their care and treatment
- 97.8% of people using the Specialist and Special Care Dental Services said that their treatment completed in an efficient, timely and pain free manner
- 93.6% of people using the Memory and Later Life Service said that their diagnosis was disclosed in a sensitive and compassionate way
- 96.9% of people who had an inpatient stay in a Community Hospital said that the staff they came into contact with have demonstrated competency when communicating with them

The majority of responses received scored above 90%, even where some concerns may have been raised. One of the priority areas for the patient experience team and care groups is to ensure that the highest possible number of patients and families are able to provide feedback on the services that we provide as for some of the above services, the percentages above only relate to a small number of returns.

Friends and Family Test Question (FFT)

The National Friends and Family Test question has been added to all our questionnaires as per National Guidance. Members of the Patient Experience Team are alerted immediately by email if there is a negative response to the FFT question. This is then shared with the service / team lead for them to respond to and the alert on Meridian (system used to capture patient experience) is updated.

The Trust has received 8509 completed FFT questions, of which 6844 contained free text comments to support their answer.

Examples of findings from the FFT question are as follows:

- 83.7% of people are extremely likely or likely to recommend the Mental Health inpatient ward to friends and family
- 96.3% of patients are extremely likely or likely to recommend the Community inpatient ward to friends and family
- 96.4% of people are extremely likely or likely to recommend the First Step Service to friends and family
- 98.2% of people are extremely likely or likely to recommend the Health Visiting Service to friends and family
- 100% of people are extremely likely or likely to recommend the Children's Speech and Language Therapy Service to friends and family
- 95.4% of people are extremely likely or likely to recommend the Minor Injury Unit to friends and family
- 96.2% of people are extremely likely or likely to recommend the Community Pulmonary Rehabilitation Service to friends and family
- 97.2% of people are extremely likely or likely to recommend the Neurology Service to friends and family
- 99.3% of people are extremely likely or likely to recommend the Dental Service to friends and family.

Mandated National Mental Health Survey 2017

The Mental Health Community Survey 2017 is part of a series of annual surveys required by the CQC for all NHS Mental Health Trusts in England. Quality Health was commissioned by 7 UK trusts, including us, to undertake the Mental Health Community Survey 2016. The survey is based on a sample of all service users who were seen between 1 September 2016 and 30 November 2016.

A total of 850 patients from our Trust were sent a questionnaire. 813 were eligible for the survey, of which 211 returned a completed questionnaire, giving a response rate of 26%. This survey has highlighted many positive aspects of the service user experience.

Key facts about the 211 service users who responded to the survey:

- 80.3% of respondents have been told who is in charge of organising their care and services
- 21.8% of respondents had been in contact with NHS mental health services for less than 1 year,
- 74.8% of respondents in the last 12 months had a formal meeting with someone from NHS mental health services to discuss how their care was working
- 63.9% of respondents knew who to contact out of office hours if they had a crisis
- 48.8% of respondents were male and 51.2% were female.

- 12.3% were under 35, 17.5% were aged 36-50, 25.6% were aged 51-65 and 44.5% were aged 65 and over.

Any other public and patient involvement activities

The Trust has in place arrangements for service user and carer involvement through the trust-wide Patient Experience Involvement Group (PEIG) which is made up of both mental health service users and carers and community service users and carers.

In 2017/18 our service users and carers (PEIG) have been involved in the following:

- Sitting on Trust interview panels: following our policy for a service user or carer representative, trained in interviewing, to sit on all Band 6 and above interviews as part of the panel
- Supporting the Diabetes User Group
- Corporate meetings: service users and carers attend Trust meetings to contribute and share their thoughts and ideas e.g. Infection Prevention, Clinical Effectiveness and Audit Committee Here for You ward visits: service users and carers are involved in the bimonthly ward visits facilitated by the Patient Experience Team. The visits take place to gather patients' feedback on a set of questions to support the NICE Quality Standards for Patient Experience in Adult Community and Mental Health Services
- Gathering and monitoring patient feedback via the bimonthly Here for You visits
- Sharing their own experiences to all new staff at corporate induction
- Development of leaflets: service users and carers provide constructive feedback on new or updated Trust leaflets to ensure that the information is accessible
- Patient Led Assessments of the Care Environment (PLACE) assessments: service users and carers take part in annual assessments to give the Trust a clear picture of how their environment is seen by those using it, and how we can improve it
- Being an integral part of learning disability (LD) audits in terms of access to services. This supports the Monitor LD Access Indicator.

Volunteers

The Patient Experience Team currently co-ordinate all new volunteers requests for the Trust. Volunteers are managed and supervised by team leaders or ward managers. Although the role of the Volunteer will vary from team to team, examples of their activities are as follows:

- Assisting with the discharge questionnaire on inpatient wards
- Befriending on our wards and visiting those patients who don't receive any visitors
- Delivering speech after stroke support groups in the Speech and Language Service in Carlisle and Allerdale
- Supporting patients at meal times on Community inpatient wards
- Supporting staff with administration tasks on Mental Health inpatient wards
- As Assistant psychology volunteer within the Memory and Later Life service
- Support the Medical Education Department to recruit volunteers to support them in delivering the training outcomes to the student medical doctors

Work is continuing to raise the profile and promote volunteering at various events including local job fairs, members meetings.

Collaborative/Interagency working

Throughout the Trust there are numerous examples of work that is taking place with third sector organisations and statutory organisations, some examples although not exhaustive are as follows:

- Local Healthwatch
- People First Advocacy
- Age Concern
- Cortland's Trust
- Mind
- Governors of the Trust
- Multi-organisational Learning Event Acute Trusts
- Cumbria Council for Voluntary Service
- Alzheimer's Society
- Bi-polar UK
- British Lung Association
- CCG and the other NHS providers in Cumbria
- Carer Support Groups.

Patient stories to the Board of Directors

Patient stories to the Board have continued to be presented at the quarterly open Board meetings during 2017/18. A patient, service user or carer has been invited to attend the quarterly public Board meetings to share their experience of the services they have been accessing.

The people invited can be identified in a number of ways:

- From promotion within a service area e.g. poster displays, information leaflets or staff asking people if they want to take part
- Incident forms
- Serious Untoward Incidents/Deaths
- Complaints
- Suggestions from clinical or operational management staff
- Experience of care feedback e.g. compliments, comments, questionnaire feedback

People have attended the Board meetings who have accessed the following services:

- First Step Service, a patient shared their experience regarding their experience of the service relating to accessing the service a second time to be provided with therapy by the same Practitioner, which was denied and then being informed following her initial assessment not being suitable for the service which led to the patient raising a formal complaint. The patient wanted the Board members to know the impact this experience had on her wellbeing.

- Adult Autism Diagnostic Service, a patient who has assessed by the Adult Autism Diagnostic Service attended to share their experience of using the service from first assessment to diagnosis.
- Child & Adolescent Mental Health Services (CAMHS), a parent shared theirs and their child's experience of CAMHS, the parent's experience resulted in a complaints being raised via their MP. The parent also shared with the Board their experience of the complaints process.

Our staff experience

We would like our staff to have the best experience of working within the Trust because we know that when staff are happy and fully engaged they provide the best possible care for our patients and they are more likely to stay in the organisation.

The NHS Staff Survey is an annual survey that asks staff a number of questions that relate to nine key themes which impact on their experience of work. Of 32 key findings 13 have improved and none have deteriorated.

The results from the 2017 National NHS Staff Survey show that our staff engagement score (3.84) and staff recommending the Trust as a place to work or receive treatment (3.78) is better than average when compared to Trusts of a similar type.

The Trust continues to implement the People and Organisational Development strategic plan to support improvements in the culture within the organisation. Last year a focus on appraisal meant that all staff were encouraged to have a meaningful appraisal conversation with their manager and managers were offered training in coaching conversations and objective setting. The 2017 NHS staff survey results indicate an improvement in both appraisal compliance and quality of appraisal.

Staff health and wellbeing is also a priority. The Trust is working towards a bronze health and wellbeing at work award and has trained 23 health champions, from a range of professions, to promote healthy workplaces. The Trusts first health needs assessment identified mental health as being the top concern for staff and a series of campaigns have been undertaken to promote staff wellbeing and all staff have access to personal resilience and mindfulness based intervention programmes.

Some results in the survey show no statistical change yet are below average when compared to similar Trusts.

Results from the 2017 National NHS Staff Survey are included here for the key findings of:

- KF24. (% reporting most recent experience of violence)
- KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- KF15. % satisfied with the opportunities for flexible working patterns

KF24. % staff / colleagues reporting most recent experience of violence

		Trust improvement /deterioration
2017	78%	Statistically no change
2016	83%	

Whilst the percentage of staff reporting incidents of harassment, bullying or abuse from staff through the survey has improved overall reporting of violence has remained unchanged. The Trust has an active Freedom to Speak up Guardian and staff are encouraged to raise concerns and report any incidents they see.

KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

		Trust improvement /deterioration
2017	3.72	Statistically no change
2016	3.65	

The Trust continues to implement its values of kindness, fairness, spirit and ambition but there is room for improvement in staff perceived fairness and effectiveness of incident reporting.

KF15. % satisfied with the opportunities for flexible working patterns

		Trust improvement /deterioration
2017	56	Statistically no change
2016	53	

This key finding remains low and is reflected in other forms of staff feedback including the quarterly staff pulse check and exit interviews. In 2018-19 work will be done to understand the issues behind flexible working.

In 2018/19 we will continue to deliver on our programme of activity to support the People and OD plan, working more closely with our partners in North Cumbria Acute Hospital. Key pieces of work planned are:

- Continue to implement our staff the health and wellbeing programme
- 'This is us' face to face staff engagement programme linked to staff appraisal

You can find further details about the staff survey results, and other ways we engage with our staff, in the Staff Report.

Complaints Handling

There have been a total of 566 of the above recorded by the Patient Experience Team of which:

- 228 PALS
- 218 Service Complaints
- 120 Formal Complaints

Of those:

- 8 were closed due to the terms of reference not being agreed with the complainant
- 31 were closed due to consent from the patient not being received
- 2 were superseded by the Serious Incident Requiring Investigation (SIRI) process

Formal Complaints

The total number of formal complaints received, including joint complaints with other organisations, in the year 2017/18, is 120, an increase of 2.6% from 117 complaints in 2016/17. Of the 120 processed, 17 of those did not meet criteria to progress to entirety:

- Terms of reference for investigation not agreed – 4
- Consent not received - 11
- Identified as a SIRI - 1

The number of complaints recorded as 5 day service complaints received in 2017/18 is 218 compared to 300 in 2016/17, a decrease of 27.3%.

The total number of all complaints received in 2017/18 is 338, compared to 417 in 2016/17, a decrease of 23.4%.

The number of Patient Advice & Liaison enquiries received in 2017/18 is 228 compared to 289 in 2016/17, a decrease of 21%.

The number of formal complaints has increased during 2017/18; this is due to the Patient Experience Team risk assessing complaints when they are received in line with the Handling of Complaints Policy, with an increasing number being managed at service level. Our Care Groups now learn lessons at a local level which encourages timely resolution of issues.

- During 2017/18, there have been a number of improvements within the Patient Experience Team which has improved the complaint process, these are as follows: better, leaner systems and processes for the management of complaints, which ensures that all complaints are dealt with in a timely way.
- The Patient Experience Team risk assess all enquiries / concerns to encourage them to be resolved as a PALs for a more timely outcome to the complainants satisfaction to ensure that they do not result in a service or formal complaint being made.
- Staff are encouraged to meet with patients to discuss any concerns prior to a complaint being made.

Time Taken to Respond to Formal Complaints

We currently have a target of 35 working days for response time for resolved formal complaints. For 2017/18 we achieved 34% compared to 49% in 2016/17.

Number of Days taken to respond to Complaints	Formal complaints	% of complaints responded to in 2017/2018
≤35	30	43 %
≤45	19	27%
≤55	8	1%
>55	13	19%
Total	70	68%
complaints remaining open on 01/04/2018	33	32 %
Total	103	

There was a combination of reasons for the extended time to complete complaints investigations including:

- Investigation of complex complaints
- Staff on annual leave or off work sick
- The complaint was in relation to a number of different organisations
- Delay in draft complaint responses be quality assured and signed in the care groups and then at Chief Executive level.

Specific issues from complaints received during the year have been as follows:

Mental Health care group

- Complaints relating to the Community Mental Health Assessment & Recovery Teams and these are regarding access to the service, access to a Care Coordinator and discharge from the service.

Children and Families care group

- Accessing the service for treatment especially within CAMHS.

Community Health care group

- Patients complained about the diagnosis of a fracture being missed.
- Complaints received from relatives relating to the poor communication between the ward staff and themselves.

Specialist Services care group

- Patients complained about the delay in receiving scan results from the Neurology Service.

Examples of improvements following a complaint:

- Health Visiting Service: If a child's red book is in the possession of the Health Visitor these will be collected by the parent/carer, where possible but in circumstances when

this is not possible they will be sent to the parent/carer by registered delivery via Royal Mail to ensure safe return.

- Community inpatient ward: a complaint investigation identified that the entries in the patient notes by the Healthcare Assistants must be countersigned by the Nurse in Charge for that shift - the Ward Manager implemented this with all ward staff via ward staff meetings and supervision and they are monitoring this via auditing the patient clinical records. Community Mental Health Assessment & Recovery Team: have carried a review process to see if any changes could speed up the process of offering face to face assessment appointments.
- Neurology Service: A review of internal processes for Neurology in relation to reviewing non urgent results in a timely manner and currently a draft protocol is in the early stages of development.

Parliamentary and Health Service Ombudsman (PHSO)

For the period of 2017/18 – 4 cases were under review by the PHSO, these are from years 2014/15, 2016/17 and 2017/18. The number and details of these cases are as follows:

- 3 Cases- remain ongoing.
- 1 Case - has been fully investigated and is now closed.

Future priorities

From the feedback received in 2017/18 the following priorities have been identified for 2018/19 to further improve the Trust's complaints process:

- To review and unify the processes regarding serious incidents and complaints ensuring that recommendations and findings are compared and analysed to ensure lessons are learned and services are improved.
- Reduce the time it takes to complete the complaints process to enable the complainant to have a satisfactory resolution to their issues as soon as possible.
- Continue to increase the amount of complainants who are offered a face to face meeting with the appropriate member of staff to discuss their complaint.

Compliments

The Trust received and recorded 2432 compliments in 2017/18. This is decrease from 2016/17 when 3246 were received. During 2017/18 the Trust has received 6844 free text comments through the Friends and Family Test.

Health, safety and security

The Trust recognises and accepts its duty towards ensuring the health, safety and welfare of all our employees and people who use our services and premises. As far as is practicable, we ensure that all work is carried out in the safest possible manner without undue risk to staff, patients and others.

The Trust places a high value on both the physical and psychological wellbeing of our staff and service users. We will ensure health and safety legislative compliance as a minimum

standard, and will endeavour to achieve recognised good practice standards wherever practicable.

Responsibilities for the principal health, safety and security functions across the Trust are shared between the Quality and Nursing and Corporate Governance directorates with the core health and safety and security functions in Corporate Governance. In practice, the teams work closely together and operate as a 'virtual team'. The Workforce and Organisational Development directorate cover the staff wellbeing element of health and safety including stress.

The Trust's Corporate Fire, Health and Safety and Security Committee meets on a quarterly basis and includes union health and safety representation.

The number of incidents reported, along with the harm levels recorded for incidents relating to Health and Safety/ Security (inclusive of Violence and Aggression) are shown in the table below.

Incident Type	0 No Harm / Injury	1 Low Harm / Injury	2 Moderate Harm / Injury	3 Severe Harm / Injury	Death	Unknown / Not stated	Total Number of Incidents*
Health and Safety	14	85	18	0	0	125	185
Manual Handling	5	23	11	0	0	54	59
Security	15	2	1	0	0	231	174
Violence/ Aggression	180	227	53	3	0	1823	1170

* As there may be more than one person involved in an incident, harm statistics can exceed the total number of incidents.

All incidents for health and safety, manual handling, security and violence and aggression are reviewed. Incidents are followed up dependent on a range of factors including actual harm, the potential for harm, identification of a trend, identification of a potential Trust wide issue, RIDDOR reportable incident, or at the request of managers.

In addition the following work was carried out relating to Health and Safety and Security in 2017/18.

- Specialist reviews/ environmental assessments/ specialist advice – 42
- New estates projects (specialist health, safety and security advice) - 6
- Policy/Strategy reviews – 1

Examples where specialist reviews, environmental assessments or providing specialist advice have led to tangible improvements to safety and security include:

- The identification and resolution of issues at an early stage in building refurbishment/design projects to ensure the design offers a safe and secure workplace
- Collaborative working with managers to develop and implement workable and sustainable solutions to address issues or concerns raised by staff.

During 2018/19 we will be working in partnership with the health and safety and security team from North Cumbria University Hospitals Trust as part of the integration of support services for the two Trusts. There will be a wider pool of expertise and experience and this will provide an opportunity to standardise policies, procedures and documentation, review training and implement new ways of working.

Part 3: Other information relevant to the quality of our services

The following tables provide information against a range of performance indicators.

Domain	Indicator	Target 2017/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Patient safety	Number of reportable infections identified	3 or less	1	0	0	0	1	0	0	1	0	0	3	5
	Proportion of returned hand hygiene audits scoring 95%+	95%	76%	81%	99%	96%	87%	83%	86%	100%	95%	94%	94%	88%
	MRSA – meeting the MRSA objective (Number of confirmed cases of Trust acquired MRSA bacteraemia)	n/a	0	0	0	0	0	0	0	0	0	0	0	0
	Clostridium difficile year on year reduction (Number of confirmed cases of Trust acquired Clostridium Difficile infection)	n/a	0	1	0	0	0	0	1	0	0	0	0	1
Clinical quality	Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge	95%	85.4%	96.0%	97.1%	96.6%	100.0%	95.3%	96.6%	93.3%	95.4%	96.3%	96.0%	95.9%
	Care Programme Approach (CPA) patients having formal review within 12 months	95%	83.0%	81.3%	83.4%	81.4%	79.2%	78.6%	87.8%	83.4%	91.2%	92.9%	95.7%	96.3%
	Admissions to inpatient services had access to crisis resolution home treatment teams	95%	89.3%	98.3%	98.1%	95.7%	100.0%	100.0%	98.1%	98.0%	95.6%	97.9%	96.8%	100.0%
	Trust Performance against Financial Ceiling for agency spend	0.0%	-13.1%	19.3%	18.0%	-1.3%	6.5%	19.6%	31.1%	17.5%	-1.0%	48.3%	38.6%	60.1%
Patient Experience	Minimising delayed transfers of care (% of Individuals who have had a delayed transfer)	7.5%	20.9%	22.8%	21.1%	20.3%	22.8%	22.5%	21.5%	18.2%	13.6%	19.2%	21.9%	23.3%
	Complaints received by the Trust	n/a	6	7	9	12	11	2	10	14	11	11	13	11
	Number of occasions when the Trust Delivering Same Sex Accommodation policy was not adhered to	0	0	0	0	0	0	0	0	0	0	0	0	0

Indicator	Comments
Cost of all bank/agency staff as a percentage of gross salary bill	Indicator has been replaced by "Trust Performance against Financial Ceiling for agency spend"
Minimising delayed transfers of care (% of Individuals who have had a delayed transfer)	Indicator includes Community Health inpatients as well as Mental Health

Domain	Indicator	Target 2017/18	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	National Standard	Indicator description and source
Patient safety	Number of reportable infections identified	3 or less per month	85	12	8	7	2	3	11	Not Available	The number of reportable Health Care Acquired Infections patients have contracted whilst staying on our wards. *Data Source: Infection Prevention Audit*
	Proportion of returned hand hygiene audits scoring 95%+	95%	99%	74%	96%	95%	98%	82%	90%	Not Available	The purpose of this audit is to support inpatient areas in assessing the quality of hand hygiene technique performed by staff and in working with staff to improve their hand hygiene technique. *Data Source:Hand Hygiene Audit.*
	Number of confirmed cases of Trust acquired MRSA bacteraemia	n/a	3	2	0	0	0	0	0	Not Available	The MRSA objective applies to all NHS organisations to ensure patients receive clean safe care across the whole NHS. It requires the Trust to make the sustain their existing rate of reporting and strive for further reductions where possible. *Data Source: Weekly Surveillance Data Mechanisms.*
	Number of confirmed cases of Trust acquired Clostridium Difficile infection	n/a	9	13	8	11	11	14	3	Not Available	Tackling healthcare-associated infections, such as Clostridium difficile (C. difficile) is a key patient safety issue and is a priority for the Trust. This indicator measures the reduction in reported incidents. *Data Source: Weekly Surveillance Data Mechanisms.*
Clinical quality	Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge	95%	96.5%	97.6%	97.7%	97.4%	98.2%	94.9%	95.3%	Not Available	The proportion of enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital. It is Trust practice to follow up all individuals face-to-face unless the patients circumstances deem this to be inappropriate. The practice of 7 day follow up supports reductions in the rate of death by suicide. *Data Source: IPM/RiO National Definition: Monitor/NHSI*
	Care Programme Approach (CPA) patients having formal review within 12 months	95%	96.4%	96.7%	96.7%	96.4%	96.6%	94.0%	86.2%	Not Available	Annual reviews ensure that patients receive effective and appropriate care and treatment. This enables the Trust to monitor effective case management and reduce clinical risks. *Data Source: IPM/RiO National Definition: Monitor/NHSI*
	Admissions to inpatient services had access to crisis resolution home treatment teams	95%	97.2%	98.1%	99.1%	98.5%	97.0%	96.5%	97.3%	Not Available	A crisis resolution team provides intensive support for people in mental health crises in their own home: they stay involved until the problem is resolved. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. *Data Source: IPM/RiO National Definition: Monitor/NHSI*
	Trust Performance against Financial Ceiling for agency spend	0.0%						42.6%	20.3%	Not Available	The financial cost of agency staff against the financial ceiling. *Data Source: Integra*

Patient Experience	% of Individuals who have had a delayed transfer*	7.5%	3.0%	4.6%	1.1%	1.9%	3.0%	7.6%	20.7%	Not Available	Delayed discharge' refers to inpatients remaining in hospital care after they have been clinically assessed as fit for discharge/transfer home or to another care setting. Delayed discharges are a significant factor with negative consequences for the effectiveness and quality of care received by service users in psychiatric in-patient wards. They also contribute to significant additional direct and indirect costs of inpatient care. *Data Source: IPM/RiO National Definition: Monitor/NHSI*
	Complaints received by the Trust	n/a	88	144	160	117	56	115	117	Not Available	Complaints help the Trust understand patient experience and where patients feel they have not received appropriate or adequate care or treatment. This indicator monitors the number of complaints received by the Trust during the month. *Data Source: Ulysses*
	Number of occasions when the Trust Delivering Same Sex Accommodation policy was not adhered to	0	0	0	0	0	0	0	0	Not Available	The number of occasions when the Trust Delivering Same Sex Accommodation policy was not adhered to. *Data Source: NHS England*

Indicator	Comments
Cost of all bank/agency staff as a percentage of gross salary bill	Indicator has been replaced by "Trust Performance against Financial Ceiling for agency spend"
Minimising delayed transfers of care (% of Individuals who have had a delayed transfer)	Indicator includes Community Health inpatients as well as Mental Health

Single Oversight Framework	Regulator	Target performance	Actual performance 2015/16	Actual performance 2016/17	Actual performance 2017/18
A&E: Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge		>=95%	97.9%	97.9%	96.9%
6 Weeks referral to diagnostics		>=99%	94.8%	97.6%	99.9%
Referral to treatment (RTT): Incomplete Pathways		>=92%	90.2%	94.8%	95.4%
IAPT Recovery Rate		>=50%	n/a	n/a	55.0%
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral		>=75%	54.5%	70.8%	72.3%
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral		>=95%	98.3%	99.4%	99.9%
Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.		>=50%	52.7%	63.9%	61.3%
Total number of bed days patients have spent out of area in last quarter		TBC	n/a	n/a	n/av*
MHSDS quarterly score in DQMI		>=95%	n/a	n/a	98.6%

*Nationally published OAP bed days are inaccurate and work is on-going with Commissioners and NHS England to establish true current OAP performance and set a trajectory to reduce inappropriate OAP bed days across the county.

Indicator	Comments
Single Oversight Framework	In October 2017 NHSI released an updated version of the single oversight framework which made significant changes to the reporting requirments. The above table has been adjusted to show the operational metrics that we are required to report on.

Performance during 2017/18

Key Highlights

As a Trust we have achieved the 4 hour wait target 95% for A&E, the 6 week referral to diagnostic standard in paediatric audiology and achieved the EIP 50% standard in 11 of 12 months. The Referral to treatment (RTT) position for consultant-led services has sustained performance over the 92% threshold throughout 2017/18, dipping in March 2018 due to a combination of reduced capacity and the impact of a period of increased demand in Q3 for Neurosciences service.

Areas for improvement

1. Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral

Performance against this target is closely related to recruitment difficulties. Our IAPT Service has developed and implemented a robust recovery plan which has delivered improvements towards the end of the year with full recovery forecasted by the end of quarter 1 of 18/19.

2. Percentage of Individuals who had a delayed transfer of care

Reducing the number of patients who experience a delayed transfer of care has been a key priority for the Trust in 2017/18. The Trust has worked jointly with its key partners in Health and Social Care with the objective to support the reduction of patient delays through improving our control and visibility of delays and the underlying causes, while also developing a plan to address the longer term solutions required to prepare us for next winter. Joint projects to reduce delayed transfers, include the creation of a Discharge Lounge at Cumberland Infirmary, the introduction of interim ASC beds for patients who required longer period of rehabilitation and the Hospital to Home scheme which supports patients to return to their place of residents whilst awaiting the finalisation of longer term care packages. This work is continuing into 2018/19.

3. Care Programme Approach (CPA) patients having a formal review within 12 months

The Trust recovered this standard in the latter half of the year following an extensive process review. Weekly management scrutiny remains in place to monitor achievement of this standard.

The Governors Advisory Committee reviewed the 30 key indicators in December 2017 to identify the Top 3 for the Governors Council to choose one local indictor to be audited. On 1 February 2018, the Governors Council agreed on the indicator “People followed up within 7 days of discharge”.

Further consultation was required with governors during March 2018, in consultation with the external auditors, to identify an alternative mandated indicator to be audited. The Governors Council agreed on the indicator 'Mental Health Services - 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'.

The Governors had sight of the draft Quality Report from 15 March 2018 and were given till the end of March to provide feedback. Governors offered no comments.

LD access indicator

The indicator shown above relates to access to healthcare services for people with a diagnosis of learning disability. The Learning Disability Protocol and Awareness packs continue to be updated on an annual basis, which provide staff with key information and guidance to help them to support people who access their services, who have, or they suspect to have, a learning disability. The updated self-assessment and protocol packs were well received by care groups, and the new documentation makes a more effective way of being able to identify improvements and areas of best practice, for sharing.

To provide further depth and assurance around the information captured within the self-assessment, the bi-annual audit programme continues across the care groups, within clinical services. The audit programme is supported by a service user representative who takes an active role in the completion of these audits.

Findings of the audits are fed and monitored through the care group and trust wide governance arrangements. Some of the benefits and improvements from this work include:

- Greater awareness of the LD access self-assessment by teams.
- Involvement of a service user representative in the process, who can help develop services by giving feedback on accessibility.
- Promotion of the LD Protocol and Awareness packs to support staff in supporting people who access their services who have a learning disability.
- Services having greater awareness of the support that is available across the Trust, such as through the LD teams.
- Raising the profile of learning disability – reports that go through care group and trust wide level governance structures.
- Provides the Trust with a greater level of assurance around access and support for people with a learning disability.

Next Steps:

Following a recent review of the process, in January 2018, it was agreed that the name will be amended to 'Learning Disability Review'. Following the fifth round of audits it was decided that the name would be modified to reflect the flexible, supportive and

improvement based nature of the process. It is a well-received process within the care groups, and the aims are to build upon this with more visibility across services.

As of April 2018, the process will also move from bi-annual to quarterly. Therefore there will be greater coverage of services.

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Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Corroborative Statement from NHS North Cumbria CCG & Morecambe Bay CCG for Cumbria Partnership Trust's (CPFT) Quality Account 2017/18

NHS North Cumbria CCG (NCCCG) and Morecambe Bay CCG (MBCCG) welcome the opportunity to review and comment on the Quality Account for CPFT.

As commissioners, both NCCCG and MBCCG are committed to commissioning high quality services from CPFT and take seriously their responsibility to ensure that patients' needs are met by the provision of safe high quality services and that the views and expectations of patients and the public are listened to and acted upon.

The CCGs would like to thank the Trust for sharing the 2017/18 Quality Report and for the opportunity to comment upon it. We would like to acknowledge the openness and transparency in the work the Trust has achieved to date, in the delivery of the 2017/18 priorities and in the on-going delivery of the quality measures.

Through the Quality Review Group (QRG) the CCG's have remained sighted on the Trust's priorities throughout the year for improving the quality of its services for its patients, and have continued to provide robust challenge and scrutiny at the QRG meetings with the Trust.

We would like to commend the hard work, commitment and resilience of CPFT staff, and the annual NHS Staff Survey has 32 improved findings, with none deteriorating, and the 'staff engagement', and the Trust as a 'place to work or receive treatment', being better than comparators, emphasises that.

It is the efforts of staff that has contributed to the Care Quality Commission's findings in January 2018 that all core services inspected were rated as Good for the caring domain. The CQC acknowledged improvements and areas of notable practice, and the overall rating remained the same; 'Requires Improvement'.

The CCGs note the Trust plans to improve services and that this is key to services reaching a rating of good. The Trust have stated they support the integration of health and care services across north and south Cumbria and the rapid development of Integrated Care Communities (ICCs), which they acknowledge is the next step to enable the Trust to

align mental health services locally with the ICCs and for the more specialist services such as Child and Adolescent Mental Health Service (CAMHS) and forensic medicine, forming strong partnerships with large providers in the North East and Lancashire.

The Quality Account provides an open account of the achievements made in the past year and describes the priorities for 2018/19 and is an important contribution to public accountability in relation to quality. The CCG appreciates the amount of work involved in producing this report.

We note the Trust's lead role as part of the Lancashire & South Lakes Suicide Prevention Group, and the work going forward; continuing the STORM Training, e- learning and the work in real-time surveillance; given the higher than average suicide rate in Cumbria.

The CCG acknowledges the progress & recent performance being above the national average illustrated in the Harm-Free Care Safety Thermometer, and note the Mental Health Safety Thermometer has been implemented on all the wards, and look forward to data starting to flow from this and the Medication Safety Thermometer in the coming year.

The report details the work implementing the FRAMP falls risk assessment and reduction in harms, and in reducing harm from pressure ulcers, and applaud the joint work in the care home sector in the achievements of harm free pressure area care.

The CCGs recognise the challenges that the Trust have had in the year pertaining to the children and young people's services, and the CCGs acknowledge the significant role the Trust has within the multi-agency Strategy. We note the ambition to improve performance in Initial Health Assessments for 'children looked after', and note the recent Q4 improvement, and the good performance in CAMHS CHOICE appointments, and the single point of access now being in place for the county. The involvement of the Trust in developments on respect of the Child Sexual Exploitation with the Local Safeguarding Children's Board is also noted and commended.

We note the access to services, the maintenance of performance in the year, and the further investment in mental health liaison services which helped alleviate winter pressures in Acute Services, and the ABI performance reaching 100% for the past 7 months. We note the improvements in the recovery plan for First Step RTT pathway, and the expectation that this will improve early in 2018/19.

In the section on 'positive experience of care' the report identifies that 'patient stories are presented each month to the Board, and the plan to use patient feedback as part of service improvement work, based on the 'ladder of participation, and look forward to hearing about improvements in this development. There is a process of access reviews, to improve the service responsiveness for people with a learning disability.

The report records the implementation of the Mortality Review process, and the development of the Structured Judgment Review process, and we note the positive findings recorded from the initial stages of this process, and look forward to further updates in the coming year. The CCGs acknowledge the actions to improve services, taken from the learning from 10 National Clinical audits.

The CCGs thanks the Trust for the honesty in reporting the deteriorating picture relating to the response of formal complaints and notes the position.

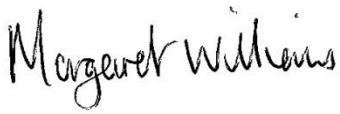
North Cumbria CCG supports the Research and Development progress, and notes the integration between the two NHS Trusts in North Cumbria which started in April 2017, and has led to a single department from April 2018.

Morecambe Bay CCG acknowledges the collaboration undertaken between University Hospitals of Morecambe Bay NHS Foundation Trust and Cumbria Partnership NHS Foundation Trust and the Board approval to integrate hospital and community services across south Cumbria from April 1 2018. This integration aims to bring the health and care system together in line with the Better Care Together Strategy. Working in a much more integrated and 'joined up' way to improve patient care and experience. It will also support to reduce duplication and allowing the services to offer more consistent care across the whole of Morecambe Bay.

North Cumbria CCG and Morecambe Bay CCG can confirm to the best of their ability that the information provided in Cumbria Partnership NHSFT's Quality Account is a fair reflection of the Trust's performance in relation to Quality for the year 2017/18. The Quality Account is clearly presented and provides the required information in the required format. North Cumbria CCG and Morecambe Bay CCG looks forward to continuing to work with CPFT to support and assure the improvement of the quality of services commissioned in 2017/18.

David Rodgers
Medical Director / Interim ACO North Cumbria CCG

Anna Stabler
Director of Nursing & Quality North Cumbria CCG



Margaret Williams Chief Executive Nurse
Integrated Governance & Quality Improvement Morecambe Bay Clinical Commissioning Group
26 April 2018

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Healthwatch Cumbria

Response to Cumbria Partnership NHS Foundation Trust

Quality Accounts Report for

2017-18

27th April 2018

Introduction:

Healthwatch Cumbria is pleased to be able to submit the following considered response to Cumbria Partnership NHS Foundation Trust's Quality Accounts Report for 2017-18.

Part 1: Statement on quality from the Chief Executive

Not included in the report.

Part 2: Priorities for improvement and statements of assurance from the Board of Directors

Progress against 2017/18 priorities for improvement

The Quality Priorities for 2017/18 remain ongoing for 2018/19 and show the progress made against each and the next steps to be taken. The narrative is very detailed but clear and easily readable.

Given the numbers and rate of suicide for the population of Cumbria it is reassuring to note the progress thus far and continued and the Trust's continued aspiration to improve prevention.

The prevention of harm theme continues in the following priorities and reflects some notable improvements, for example; the Trust is performing better than the National average on all aspects of the harm-free care criteria and in the case of pressure ulcers celebrates, quite rightly, the achievement of the Copeland District Nursing Team and Tissue Viability Nurses work in partnership with Care Homes following learning from the pressure ulcer collaborative.

The National emphasis on the mental health of young people remains a priority for the Trust, particularly looked-after children who are arguably the most vulnerable as does the prevention of child sexual exploitation. This increased demand for timely and appropriate support for children and young people chimes with the intelligence received by Healthwatch Cumbria.

The audit and re-audit methodology as described in the narrative has brought about tangible improvements and echoes the cycle of learning and improvement theme throughout the document.

The value and impact of engagement in research is well described and again demonstrates emphasis of improvement from learning approach that the Trust has adopted.

The CQC regulatory inspections continue to identify areas requiring improvement but do acknowledge areas of good and outstanding practice.

Overall, we would say that this is a well-balanced document, open about areas needing improvement and identifying remedial measures necessary to address them. We are aware that the Trust is actively collaborating with other organisations and listening to public opinion, actions we fully support.

Last year we commented on the level of rigour being applied and we welcome this once again. We acknowledge that challenges still exist, however we are recognising significant improvements across the Trust and are supportive of the actions it is taking.

Sue Stevenson
Chief Operating Officer
Healthwatch Cumbria

Cumbria Health Scrutiny Committee

Cumbria Partnership Foundation Trust

Quality Accounts Feedback 2018

The Cumbria Health Scrutiny Committee welcomes the opportunity to comment on the Cumbria Partnership Trust's Draft Quality Accounts for 2017/18.

Members understand the format and layout of the document is set for the Trust and found it reasonably straightforward to understand and enables Members to explore the Trust's performance over the year.

Members felt that the report accurately reflects the evidence submitted to the Cumbria Health Scrutiny Committee and Lead Health Scrutiny Members over the past twelve months.

The mechanisms the Trust has in place to capture patient experience were welcomed and Members felt it would be valuable if the report could show clearly how the information gathered from such a wide range of sources has influenced and changed how the Trust delivers it's services. The Committee would always encourage the Trust to focus on patient and staff feedback as drivers for timely and continuous service improvement throughout.

The Committee hope to see improvements in the delivery of the Trusts Mental Health Services. Particularly the improvements identified as necessary in the CAMHS by the Care Quality Commission. The Committee will work closely with the Trust on it's forthcoming review of Mental Health Services.

Overall, we appreciate the co-operation received and look forward to continuing to work with the Trust during the coming year.

Cllr Claire Driver
Chair
Cumbria Health Scrutiny Committee, 30 April 2018

Annex 2: Statement of Directors' responsibilities for the quality report

The quality report must include a statement of directors' responsibilities, in the following form of words:

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to 24 May 2018
  - papers relating to quality reported to the board over the period April 2017 to 24 May 2018
  - feedback from commissioners dated 26/04/2018
  - feedback from governors (none received)
  - feedback from local Healthwatch organisations dated 27/04/2018
  - feedback from Overview and Scrutiny Committee dated 30/04/2018
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 09/04/2018
  - the national patient survey dated 04/07/2017
  - the national staff survey, published March 2018
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 16/05/2018
- CQC inspection report 26/01/2018
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

24 May 2018 .....Prof. Robin Talbot, Chair

24 May 2018 ..... Stephen Eames
Chief Executive for CPFT and NCUHT

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ANNEX 3: INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Cumbria Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of Cumbria Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients at the end of the reporting period; and
- 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

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 NHS Improvement's Detailed Guidance for External Assurance on Quality Reports 2017/18; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting

guidance, and consider the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to April 2018;
- Papers relating to quality reported to the Board over the period April 2017 to April 2018;
- Feedback from Commissioners, dated May 2018;
- Feedback from governors, dated March 2018;
- Feedback from local Healthwatch organisations, dated 27 April 2018;
- Feedback from Overview and Scrutiny Committee, 30 April 2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated May 2018;
- The latest national patient survey;
- The latest national NHS staff survey;
- Care Quality Commission inspection report, dated 26 January 2018;
- The Head of Internal Audit's annual opinion over the trust's control environment for the period April 2017 to March 2018; and
- Any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

This report, including the conclusion, has been prepared solely for the Council of Governors of Cumbria Partnership NHS Foundation Trust as a body, to assist the Council of Governors in reporting Cumbria Partnership NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate that it has discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Cumbria Partnership NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the 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 impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Cumbria Partnership NHS Foundation Trust.

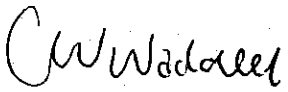
Basis for adverse conclusion

We identified errors in our detailed testing of the Quality report for the year ended 31 March 2018. As a result of these issues, the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and six dimensions of data quality set out in the Guidance.

Conclusion

Based on the results of our procedures, expect for the effects of the matters described in the 'Basis for adverse conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvements' Detailed Guidance for External Assurance on Quality Reports 2017/18; and
- The Early intervention in psychosis (EIP) indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Signed: 

Cameron Waddell
Partner, for and on behalf of Mazars LLP

Date: 24 May 2018

Chartered Accountants and Statutory Auditor
Salvus House
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Durham
DH1 5TS

Annex 1

CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST

Annual accounts for the year ended 31 March 2018

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Cumbria Partnership 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 Cumbria Partnership 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; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for 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..... Date 24 May 2018.
Stephen Eames
Chief Executive

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 ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Cumbria Partnership 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 Cumbria Partnership NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive has overall accountability for risk management within the organisation and discharges that duty through the Executive Team and their respective portfolios. Senior clinical leaders are in place throughout each of our four care groups. They are responsible for driving improvements to quality and safety, and actively support our staff in the identification and management of identified risks. Care groups are supported by staff within Corporate and Support Service teams who are specialists in various aspects of risk management, and who are a central resource for training, advice and guidance.

Risk management is part of the Trust's training programme. In addition to subject-specific training and core skills training, which make up the overall training programme, we deliver risk management training for team leaders, which covers the essentials of risk management. This includes learning from incidents and complaints through appropriate level investigations, and duties as a manager under health and safety law. Policies and procedures to support and enable risk management are available to all staff via the Trust's intranet site.

The Trust benefits from good practice through a range of learning and improvement mechanisms, including:

- Robust investigation processes
- Peer review
- Clinical audits
- Professional and personal development
- The application of evidence-based practice
- Quality improvement tools, such as the Cumbria Production System

Investigation of complaints, incidents and near misses is overseen by our Director of Quality and Nursing, who, during 2017/18, saw their role widen to include Director level responsibility for Operations, Quality,

safety and performance matters are cascaded and escalated through governance frameworks. Improving the quality of care and safety are the driving principles of our quality governance arrangements.

Our quality governance, clinical risk management and leadership frameworks, developed during 2014/15, have become embedded into routine practice and enable us to identify, manage, escalate and report risks, as appropriate to the scale and nature of the risk.

The Board of Directors has line of sight to the management of significant operational and strategic risks through the Board Assurance Framework and through the functioning of its committee and governance frameworks.

The Risk and Control Framework

Board Membership

There were a number of changes to Board membership during the year. Since September 2017 the Trust shares a Chief Executive, and since October 2017, three Executive Directors with North Cumbria University Hospitals NHS Trust (NCUHT). These changes reflect and demonstrate the Trust's commitment in moving toward an integrated health and care system, but do not diminish the Trust's responsibilities and accountabilities as a NHS Foundation Trust.

As at 4 May 2018 the Trust has:

- Five Non-Executive Directors (the Chair plus four other Non-Executive Directors, one of whom is a joint appointment with NCUHT)
- Two Non-Executive Director vacancies
- Seven Executive Directors, five of whom have voting rights (including all of the designated Executive Director posts listed above)
- One Executive Director vacancy (Director of Workforce & OD (non-voting)

The balance between Executive and Non-Executive Directors on the Board of Directors remains in line with the Code of Governance for NHS Foundation Trusts and with the Trust's Standing Orders. For a short period of time between 22 December 2017 and 5 March 2018, the balance between Executive and Non-Executive Directors was in favour of the Executive Directors in terms of voting rights. Whilst during this time the Board of Directors did not have a requirement to undertake a vote, it continued to make any necessary decisions and operated in line with its Standing Orders.
Further details about Board members and changes to Board membership during the year can be found in the Directors Report and the Remuneration Report.
During Quarter 4 of 2016/17 a review was undertaken of the corporate governance structures that support Board subcommittee effectiveness. The review identified some changes were necessary to strengthen quality governance around transformation, financial recovery and strategic planning. Those structures, which disestablished the Strategy Group, took effect in Quarter 1 of 2017/18. During quarters 3 and 4 of 2017/18, some further adjustments were made to Board-level meeting arrangements. Meetings that have been in place during the year, and any changes or adjustments to their arrangements, are set out below.

Board and Board level committee

The Board of Directors is supported by a governance structure as follows, which deals with various components of corporate governance and risk management:

- Quality and Safety Committee (Q&S) – the designated Board subcommittee which oversees quality and safety issues. It is chaired by a Non-Executive Director (NED) and has Executive and NED membership.

The Q&S Committee monitored clinical risk management performance throughout the year and made recommendations to the Board as appropriate.

- Finance Investment and Performance Committee (FIP) - the designated Board subcommittee which oversees financial, corporate performance and investment issues. It is chaired by a NED and has Executive and NED membership. The FIP Committee monitored risks to operational and financial performance throughout the year and made recommendations to the Board as appropriate.
- Charitable Funds Committee – this designated Board subcommittee which oversees the management of Charitable Funds held by the Trust.
- Audit & Risk Committee (A&R) – an independent committee and senior Board subcommittee, with all members NEDs. The A&R Committee has responsibility for overseeing risk management and internal control. The A&R Committee agreed audit plans with our internal and external auditors and received progress updates and audit opinions throughout the year. In January 2018 the Board of Directors agreed to amend the name of this Committee from Audit Committee to Audit & Risk Committee.
- Remuneration Committee – wholly NED membership.
- Executive Leadership Group – membership is Executive Directors, led by the Chief Executive. In practice, due to the joint roles held by the Chief Executive and a number of other Executive Directors across both the Trust and NCUHT, this meeting takes place as a joint Executive Team meeting. The Joint Company Secretary also attends these meetings.

High level governance meetings that support Board subcommittee effectiveness

- Trust Management Board (TMB) - the senior operational management group led by the Chief Executive and attended by Executive Directors, senior officers within care groups and Heads of Support Services. TMB monitors risks to operational and financial performance and provides updates to the FIP Committee.
- Trust Wide Clinical Governance Group (TWCGG) – the senior forum for clinical governance, led by the Director of Quality and Nursing (April 2017 – June 2017) and Deputy Director of Nursing & Quality (July 2017 – March 2018). This monitors risks to quality and safety and provides updates to our Q&S Committee. Representation at the meeting includes the Medical Director, senior clinicians within care groups and senior managers within support services. The change in leadership of this group part way through the year arose in recognition of increasing capacity impacts on the Director of Quality & Nursing associated with their widened role following the departure of the Director of Operations in June 2017 to take up post as Director of Operations at Leeds and York Partnership NHS Foundation Trust.
- Joint Leadership Development Group (April 2017 – August 2017) – led by the Chief Executive and including Executive Directors and senior managerial and clinical leaders, with a specific focus on the development and implementation of Trust strategy. This Group morphed into the Leadership Community Forum (September 2017 – March 2018) and, whilst it has the same target audience and serves the same purpose, it has membership from both Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals Trust.

During 2017/18 the effectiveness of our Board and committee was evaluated through a survey involving Board members and members of each Board sub-committee, and also through consideration of the Committees performance against their work plans. This evaluation indicated each Committee had met and fulfilled their functions in accordance with their Terms of Reference.

During 2018/19 the Trust will be increasingly integrating governance arrangements with North Cumbria University Hospitals Trust. This includes the establishment of shared support services and wherever practical and appropriate, holding joint meetings, including Board-level meetings. It is anticipated these arrangements will lead to more efficient working and enable both Trusts to make best use of their resources, whilst also recognising the statutory duties both Trusts as separate legal entities.

Risk Management Strategy

Our Board of Directors agreed the Trust's Risk Management Strategy in January 2017 and will be reviewing it again during Quarter 1 of 2018/19 as part of the alignment of governance and risk management processes with North Cumbria University Hospitals Trust. In setting out our appetite for risk, the Trust uses a risk appetite framework based upon that promoted by the Good Governance Institute but which it has expanded to include wider range of risk domains that reflect complex sustainability challenges currently facing the NHS. The strategy also sets out our integrated approach to risk governance, which incorporates:

- Strategic planning activities
- Business planning activities
- Quality Governance Framework
- Assurance Framework
- Governance Assurance and Accountability Framework

The Director of Quality and Nursing is accountable for ensuring appropriate systems and processes are in place to enable the implementation of the Trust's Risk Management Strategy.

Our Risk Management Strategy is implemented through the Risk Management Policy which sets out the framework for how risks are identified, evaluated and controlled. Operational risks are managed on a day-to-day basis by staff throughout the organisation through the Trust's governance structures.

The Risk Management strategy is also delivered through other policies and procedures that support the activities mentioned above, including:

- Policies on specific risk areas, including policies and procedures with respect to countering fraud and corruption
- Policies for the reporting and investigation of incidents, complaints, concerns, and claims
- A risk-based training programme based on an annual analysis of skills and competencies required to support the delivery of safe and effective services
- Induction programmes for our staff and governors
- Training delivered by a combination of in-house experts and external partners, that gives the flexibility to provide tailored training to meet the needs of individuals with additional risk management responsibilities
- Reporting to the Board and its committee on quality governance matters, including patient safety, patient experience, performance against key performance indicators and other regulatory and compliance requirements.

Risk Management Policy

The Risk Management Policy, last reviewed during 2016/17, sets out our approach to the identification, evaluation, assessment, management, reporting and monitoring of risks. In addition, it also sets out how risks are to be escalated through the Trust's governance frameworks. Training on the Risk Management

Policy was delivered to team leads during 2017/18 as part of the Trust's risk management training programme.

We are continually seeking ways in which to enhance the quality of information available to frontline services to support their decision making around risk management. Quality and safety dashboards, which have been developed in liaison with our clinical leads, enable our leaders to actively identify and respond to quality and safety risks within their services. Further enhancements to the content, accessibility and functionality of dashboards were made during the year. Embedding the use of dashboards within governance forums is an ambition for 2018/19.

A continual improvement approach is taken to enhance the capabilities of our risk management information system (Ulysses). Our Quality and Safety Systems Group (formerly Ulysses systems group) meets regularly throughout the year to discuss improvement opportunities and to ensure the system enables us to meet our statutory obligations with accuracy.

Our Governance Accountability and Assurance Framework (GAAF) is the Trust's performance measurement and reporting framework. The GAAF sets out responsibilities and accountabilities of staff at all levels and complements the Trust's Risk Management Policy. It is framed around the four domains of our approach to quality improvement Quality, People, Service and Efficiency (QPSE) and is underpinned by performance indicators and metrics that inform our understanding of risks to performance and quality through our integrated performance reporting processes. During the year, the Trust's Governance Manual was updated and expanded to incorporate the GAAF, and also describes the Board Assurance Framework and business planning processes. It is now referred to as the Integrated Governance Manual.

Quality governance

Quality governance is a key activity of the Board of Directors to ensure essential levels of quality and safety are met.

External sources of assurance include:

- Internal and external auditors
- Care Quality Commission
- NHS Litigation Authority
- Other visits and inspections from regulatory agencies.

Internal sources of assurance include:

- Activities undertaken by Quality and Safety Leads within care groups, Clinical Governance Team within the Quality & Nursing Directorate, and the Corporate Governance Department
- Performance metrics
- Non-executive and governor joint visiting programme
- Incident reporting
- Patient and carer feedback, including patient stories at the Board

Over recent years the Trust has undertaken an annual self-assessment against NHS Improvement's (formerly Monitor's) Well Led Framework which informs our evaluation of our quality governance arrangements. The self-assessment undertaken during quarter 4 of 2016/17 was agreed by the Board of Directors in July 2017.

Areas identified for improvement included strengthening arrangements for workforce planning, reviewing our arrangements for corporate risk management, evaluating the effectiveness of the integrated assessment tool at informing risk-based decisions on matters of financial and clinical sustainability and hold

a Board development session on Equality & Diversity to include board responsibilities for setting and delivering E&D objectives. Delivery of improvement actions has been monitored through relevant governance forums and with board level oversight.

Our 2016/17 self-assessment was undertaken against the 2015 version of the Well Led framework, which at the time of the self-assessment was being reviewed jointly by NHSI and CQC who subsequently published a combined Well Led framework in June 2017. The Trust's internal process to support CQC inspection-readiness were updated and all clinical services were requested to update their Key Lines of Enquiry (KLOE) documents to recognise changes within the updated new framework.

In November 2017 the Trust underwent a formal inspection by the CQC and was one of first tranche of Trusts to be inspected under this new framework. The CQC issued their inspection report in January 2018 and assessed the Trust as Requires Improvement overall and stated 22 'must do' actions required immediate attention. Details of the outcome of the CQC's inspection and how we are responding to their recommendations can be found in the Quality Report. The Trust's 2017/18 self-assessment against the Well Led framework, which was conducted during Quarter 4 of 2017/18, takes into consideration the findings and recommendations from the CQC's inspection and our progress with improvement actions identified in our 2016/17 self assessment.

One of those 'must do' actions in the CQC's January 2018 inspection report related to improving the relationship between our operational and strategic risk management processes and strengthening our arrangements for how we gain assurances that risks are being effectively managed. These were areas that the Trust had identified that required attention as part of reviewing the effectiveness of corporate risk management arrangements and were making ready to implement improvement actions at the time of the inspection.

Actions taken during Quarter 4 of 2017/18 to strengthen our risk management arrangements include providing greater visibility of the Board Assurance Framework (the Trust's strategic risk register) to senior managers below Board level, improved scrutiny of the corporate risk register (which contains the most significant operational risks) at Trust Management Board. Other notable improvements achieved during Quarter 4 include a dramatic reduction in the number of risk assessments in our risk registers that are overdue for review (from (19.72% of the total number of open risks on the risk register on 12 January 2018 to 4.31% on 31 March 2018). This aspect of risk register management is now incorporated into our performance management (GAAF) reports and is a regular aspect of quality governance within Care Group and Support Services'. Our risk management policy has also been reviewed to take into account findings of the CQC inspection.

Longer term actions which collectively will strengthen the quality of our risk management arrangements during 2018/19 include refreshing risk management training programmes and guidance documents, reinvigorating governance processes within our care groups and support services, further developing our performance and safety dashboards, and updating the Ulysses risk management system. The Q&S Committee oversees progress and effectiveness of initiatives to address the CQC's must do actions.

The care group model, which was introduced in 2014/15 to realign and refocus our clinical governance arrangements, is now embedded and quality continues to be the driving principle of our governance frameworks. Continual improvement and organisational development also continue to underpin our quality governance arrangements. In 2017/18, a full year's baseline data of our staff engagement activities became available through our Great Teams Great Care approach. This gives us rich information that we are now using to inform our development programmes such as leadership and staff recognition.

The Board receives performance reports on agreed safety and quality key performance indicators in accordance with the Governance Accountability and Assurance Framework (GAAF). The GAAF is framed around four domains: Quality, People, Services, Efficiency which represent the Trust's strategic objectives.

To comply with the governance conditions of the Provider Licence, the Trust is required to provide a Corporate Governance Statement to NHS Improvement (NHSI). The Corporate Governance Statement relating to 2017/18 was presented to the Board of Directors for formal acceptance in May 2018. The Corporate Governance Statement sets out any risks to our compliance with the governance conditions, along with the actions taken or being taken to maintain future compliance. The statement sets out a number of key questions essential for quality governance, with evidence gathered through self-assessment or review. The Chief Executive has overall responsibility for ensuring compliance with the Trust's Provider Licence conditions, which he discharges through the Executive Team. The FIP Committee seeks assurance on compliance with the licence conditions on behalf of the Board of Directors. Risks to performance are managed and monitored through the TMB.

Throughout the year we have maintained good working relations with NHSI and have ensured they have been notified of any significant risks to compliance or service continuity, such as an issue identified with the scheduling function one of our patient information systems (EMIS) during Quarter 4 of 2017/18 which required temporary work-arounds to be introduced whilst the supplier resolved the issues.

The Trust expects to comply with all of the Provider Licence conditions in 2018/19. Should there be any indications to the contrary we will ensure NHSI are notified as soon as they become apparent. NHSI is regularly appraised of the Trust's financial position. Further information on our quality governance arrangements can be found in the Quality Report.

Incident reporting

A positive approach to incident reporting is communicated through Trust policies and procedures. The Trust continues to be consistently within the top third of benchmark trusts in NHS Organisation Patient Safety Incident Reports, in respect of reports of patient safety incidents, with most of our incidents reported falling within the no/low harm categories.

Within the Trust the reporting of incidents or concerns is encouraged and is used as a tool to learn and improve. The Trust has a clear focus on open and honest reporting of incidents, with investigation into an incident proportional to the level of harm or potential harm, as detailed in the Trust's Being Open/Duty of Candour and Serious Incident policies.

A review of the Trust's Raising Concerns (Whistleblowing) Policy and supporting processes was undertaken by the Trust during the year which took into consideration recent national best practice guidance. The approved policy is published on the Trust's website. A designated Freedom to Speak Up Guardian was appointed during the year who provides regular updates to the Board of Directors. The trust's policy and arrangements for conflicts of interest were also updated during the year to reflect best practice.

Risk reporting

Risk management is fundamental to how the Trust operates. The Trust's risk appetite is articulated in our Risk Management Strategy. Risks are identified and evaluated using a 5 x 5 risk grading matrix, and recorded and reported in accordance with the Risk Management Policy.

Top strategic risks are managed through the Board Assurance Framework (BAF). Work activities of the Board and Board level committee are aligned to the BAF in order to enable line of sight to the management of strategic risks.

All operational risks are recorded in the Trust's risk management information system (Ulysses). Those risks recorded within Ulysses collectively form the Trust's risk register. The risks recorded on the Trust's risk register which scored 15-25 i.e. high risks, are also identified on the corporate risk register. An Executive Director or other senior manager is formally accountable for each recorded risk on the Trust's risk register. Individual responsibilities include ensuring appropriate arrangements are in place for effective risk management and mitigation.

The BAF is subject to formal review by the A&R Committee every six months and quarterly by the Board of Directors, Q&S Committee and FIP Committee. The TMB has responsibilities for risk management performance and receives monthly updates on the management of risks on the corporate risk register. The BAF review process, which takes place on a quarterly basis, incorporates a review of the risks on the corporate risk register. The management of risks is a routine item for discussion at each of the care groups' clinical governance forums.

In February and March 2018 the Boards of Directors of CPFT and NCUHT agreed an aligned approach for the Board Assurance Framework and reporting of strategic risks as part of the collaborative working arrangements between both trusts.

The Q&S Committee receive annual reports from each care group about their clinical governance arrangements and Care Quality Commission (CQC) compliance. Any significant risks identified from these reviews are managed as per the agreed accountabilities and responsibilities framework. The Clinical Governance team within the Quality and Nursing Directorate coordinate arrangements for monitoring and overseeing CQC registration and compliance requirements.

Public stakeholders are involved in identifying and managing risks through membership of the Governors Council and by attending specific service users' and carers' groups throughout the Trust. The Governors Council is provided with performance information and is involved in the annual planning process. All service users, carers and visitors are encouraged to provide feedback on the service received and offer suggestions for improvement.

Data quality

Risks to our data quality have been recognised by the Trust for some time and have been highlighted by both our Internal and External Auditors over recent years. In July 2016, the Audit Committee endorsed a Data Quality Strategy for implementation over a three year period (2016/17 to 2018/19) through initiatives to systematically improve data quality across all of our information systems. The A&R Committee received updates on progress against the strategy throughout 2017/18 and the internal audit programme included audits on data quality which demonstrated positive improvements. Details of the steps we have taken to address data quality are provided in the Quality Report.

Top Strategic risks

We take assurance that our quality governance arrangements are effective from a range of sources including audits by our Internal Auditors, and reviews by external bodies such as the CQC. We recognise that balancing high quality care with long term financial sustainability and delivering integrated care are significant and challenging strategic risks. These are integral to our BAF. We are working with our STP partners on major transformation programmes which span the Cumbria footprint to find workable

solutions to these very challenging strategic risks. Examples of transformational schemes include the development of Integrated Care Communities (ICCs) based around GP practice populations across the County, and as part of the integration of community services, the transfer of community staff from the Trust to University Hospitals Morecambe Bay NHS Trust on 1 April 2018 to simplify local health services.

During Quarter 3 of 2017/18 the Board of Directors reviewed its top strategic risks and major operational and clinical risks. Our top strategic risks are as follows:

- Patients or service users do not receive high quality care because either safety, outcomes or experience are compromised
- Unable to sustain the cultural change needed to improve the quality of care for all patients and service users
- High quality and sustainable care is compromised by inability to implement improvement strategies for hard and soft infrastructure (facilities, estate, applications, IT)
- Unable to deliver and sustain senior leadership workforce capability and capacity improvements to deliver modernised and transformed services
- Inability to balance financial sustainability with maintaining high quality, safe services whilst balancing workforce, quality and financial challenges across multiple STP footprints
- Inability to maximise partnership working to achieve safe and sustainable system and service transformation, particularly of services delivered countywide, within the community, and across multiple care models due to the complexities and constraints of current regulatory frameworks
- Failure to influence the shape and delivery of future care models Accountable Care Organisations (ACOs)

A further review of strategic risks will be undertaken during Quarter 1 of 2018/19 as part of the work to integrate the Board Assurance Framework arrangements across CPFT and NCUHT.

Significant operational and clinical risks

Risks are identified, managed and monitored through our governance frameworks, in accordance with the Risk Management Policy and the GAAF. Risk reporting and measurement are actioned through our Outcomes Framework, quality and safety dashboards, and via the risk management information system (Ulysses) - all of which enable line of sight to risk management performance at all levels throughout the Trust.

Examples of significant operational and clinical risks affecting the Trust include the following:

- ability to ensure service continuity in services that are fragile due to challenges in recruitment to specialist roles, such as in some of our district nursing services
- delays in patients accessing specialist dental services due to lack of availability in specialists to support the delivery of care during treatments
- ability to transfer patients out of community hospitals into alternative care settings
- suitability of some of our patient and staff environments, such as our Kentmere ward in Kendal. Oakwood ward on our Carleton Clinic site and Valley View in Whitehaven all of which have their own particular issues which are complex to resolve.

Policy Management

During 2017/18 we continued to see improvements in the number of policies which were due for review. Policies become due for review throughout the year and arrangements are in place to initiate timely review. The number due for review as at 31 March 2018 was 36. This is slightly increased from the position at 31 March 2017 when 30 policies were due for review.

Performance and Delivery Group monitors policy review performance throughout the year, with oversight provided by A&R Committee. Information on how we have responded to the CQC inspection relating to the management and implementation of some policies is provided within the Quality Report.

As part of our increasingly integrated working with North Cumbria University Hospitals Trust, both trusts are working together to implement aligned processes for policy management. Initial work commenced on this during Quarter 4 of 2017/18 and will continue throughout 2018/19. We are also identifying policies appropriate for alignment across both trusts during 2018/19, which may result in adjustments and extension to review timeframes for some policies.

Quality Impact Assessments

Our The Integrated Assessment (IA) approach to undertaking quality impact assessments, which takes a holistic approach to assessing the impacts of major change schemes, including those proposed within our efficiency programme, was applied throughout 2017/18. The IA approach enables decisions to be made based upon a balance of risks to quality, equality and the clinical and financial sustainability of services. The IA process is led by the Medical Director and overseen by the Q&S Committee. It is also integrated into the Trust's business planning process, which evolved during the yearto integrate and incorporate the trust's approach to workforce planning.

Board level assurance on the timely undertaking of impact assessments improved during the year through evidence provided to the Q&S Committee. As part of our collaborative working with NCUHT, an aligned approach to undertaking quality impact assessments was agreed by the Q&S Committee in April 2018 for immediate implementation across both trusts.

Cumbria Partnership NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

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.

Environmental Issues

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

Emergency preparedness

The Trust's emergency planning and business continuity consider organisational resilience and the Trust's ability to respond/recover from incidents and disruption. Very high and high risks in the current version of the Cumbria Community Risk Register are covered by either the Trust's contingency planning, or wider health or multi-agency planning to which the Trust contributes. The Trust works collaboratively and shares information appropriately with responder organisations in furtherance of multi-agency co-operation and co-ordination.
The Trust seeks to comply with the Civil Contingencies Act 2004 regime and align with the international standard for business continuity, BS ISO 22301:2012 and its guidance, BS ISO 22313:2012.

Under NHS England's Emergency Preparedness Resilience and Response (EPRR) guidance, the Trust must:

- have a suitable and up-to-date incident response plan which sets out how it would respond to and recover from a major incident/emergency affecting local communities or the delivery of its services; and
- adopt business continuity plans to enable it to maintain or recover the delivery of its critical services in the event of significant disruption.

The Trust complies with NHS England's requirements by providing an EPRR structure and implementing a business continuity management system through which the Trust will endeavour to respond to critical incidents (which may include so-called 'unusual' incidents) and emergencies as well as maintaining its critical functions, ordinary functions and contractual obligations as far as reasonably practicable.

Review of economy, efficiency and effectiveness of the use of resources

The Trust closely monitors budgetary control and expenditure through the Financial Delivery Group (formerly Financial Recovery and Transformation (FRAT) Group) and TMB. The FRAT group was established in April 2017 to strengthen the governance around financial recovery and to give focus to where small changes could make big differences to the Trust's overall financial efficiency efforts.

The Director of Finance and Joint Director of Strategy and Support Services presents finance reports to both the FIP Committee and the Board of Directors. Through the Trust's Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation the Board of Directors has created clarity regarding delegated authority levels across the Trust. Executive Directors and managers have responsibility for the effective management and deployment of their staff and other resources to optimise the efficiency of each area of the Trust's operations.

The Board receives both performance and financial reports at each of its public meetings in addition to reports from the chairs of its committee, to which it has delegated powers and responsibilities. When required, the Board receives further assurance provided by its internal and external auditors.

The 2-year financial plan for 2017/18 and 2018/19 was developed based on a number of assumptions about the degree of financial recovery that could be delivered over the two year period. We recognised there were risks to the delivery of the 2-year plan which we alerted NHSI of through caveats within the 2-year operational plan and through separate correspondence and routine contacts.
Through concerted efforts driving efficiencies during the year and through our collaborative working with system partners, the Trust exceeded its financial control total for 2017/18 and qualified for bonus and incentive STF of £1.34m. The financial plan for 2018/19 (year 2 of the 2-year plan) has been developed in conjunction with NCUHT and was agreed by both Boards of Directors in April 2018. There are significant risks to the delivery of the financial plan and many of the caveats notified to NHSI for the 2017/18 financial plan remain relevant into 2018/19.

The Trust was rated as being placed in Segment 2 under NHSI's Single Oversight Framework at 31 March 2018. You can find further details about ratings in the NHS Improvements Single Oversight Framework Report.

During 2017/18 the Trust has continued to reduce reliance on agency staff where possible and controls are in place to control expenditure on agency workers. Board-level oversight of expenditure on agency workers is undertaken by the FIP Committee as part of the Board level performance reports. Information is also readily available to front line managers through quality and safety dashboards.

Information governance (IG) and data security

The Trust reported two IG level 2 Serious Incidents Requiring Investigation (SIRIs) relating to IG during the year. Each of these incidents have been reported to the Information Commissioners Office. We are committed to learning from all incidents with a view to preventing recurrence in the future.

The Trust was affected by the international cyber security incident in May 2017 which affected a number of NHS Trusts in the UK. The Trust took swift action to secure its IT systems in response to the cyber-attack and experienced no breaches of its patient records or data loss. You can find further details about our Information Governance and data security arrangements in the Quality Report.

Annual Quality Report

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

The Trust has arrangements in place to assure the Board that the Quality Report presents a balanced view and that there are controls in place to ensure the accuracy of data. Overseeing the Quality Report preparation and content was the responsibility of the Director of Quality and Nursing during 2017/18.

The Trust recognises that good quality data is essential for the delivery of safe and effective care to our patients as well as enabling us to manage services and performance. To support this, the Trust has in place a strategy with supporting policies and procedures which govern the accuracy, completeness and timeliness of data at the point of capture and when reporting either for internal or external purposes.

A governance framework is in place which oversees data quality performance from operational services through to Board level. Data quality performance is overseen by the Information Governance department. Key performance indicators (KPI) are subject to data quality and data validation processes. Performance is routinely reported and regularly reviewed at all levels within local and corporate governance structures in accordance with the Trust's Governance Assurance and Accountability Framework. This includes monthly review by the Board of Directors and review at each meeting of the Governors Council.

A balanced view of our data quality is obtained through comparing and analysing data accuracy from checks undertaken by front line staff and service managers, and through independent audits undertaken by our internal and external auditors.
The Trust currently uses a number of separate electronic and paper patient record systems to record clinical information and produce reports. This includes EMIS and RiO electronic patient record systems which are used in our Care Groups. Checks are in place to provide assurance that the data from these

systems is accurate. Assurances have been provided during the year through the internal audit programme and our data validation checks and monitoring processes that our data quality has improved through implementation of our Data Quality strategy.

Our suite of policies and procedural documents are reviewed as part of an ongoing review programme to reflect changes to legislation and best practice and, more recently, to reflect aligned governance arrangements with NCUHT. The Clinical Policies sub group which was established during 2016/17 continues to meet regularly to ensure clinical policies are reviewed in a timely manner. The work to review policies is ongoing and is overseen by the A&R Committee. Our Governance Assurance and Accountability Framework sets out responsibilities and accountabilities for performance and governance at all levels within the Trust. This is underpinned by the Outcomes and Performance Framework, which comprises performance indicators and metrics by which the Trust measures and monitors its performance with local, regional and national standards and targets.

The Outcomes and Performance Framework populates a set of dashboards which enable our staff and managers to identify, monitor and improve the quality of data derived from patient information systems. The dashboards also provide the basis for assuring the Board of Directors of the quality, accuracy and completeness of data. Our quality and safety dashboards have been expanded during the year to enable triangulation of safety data. Developments will continue during 2018/19.

In Quarter 1 of 2017/18, as part of a refresh of our governance arrangements, the Performance & Delivery Group was formed to identify, monitor and manage risks to performance. Particular focus is given to those areas subject to key performance indicators, such as targets set by NHSI. The Performance & Delivery Group is a sub group of TMB. Our organisational development and service improvement functions, which are now embedded, support our leadership teams with implementing quality improvements. A suite of tools and training on quality improvement methodologies is also available to all staff throughout the Trust.

The Trust achieved a number of quality improvements during the year, including developing the approach to equality & quality impact assessments, building our capabilities around learning lessons from incidents, and use of quality & safety dashboards at network and team level to improve quality governance. Further details about these and other quality highlights, and also details about our performance and achievement of key performance indicators can be found in the Quality Report.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the 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 Report 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 & Risk Committee (A&R), Quality and Safety Committee(Q&S), and Finance Investment and Performance Committee (FIP) and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Director of Quality and Nursing is responsible for developing and delivering the clinical audit programme and for ensuring the audit programme supports a process of continual improvement. The Trust Wide Clinical Governance Group (TWCGG), which reports into the Q&S Committee, oversees the clinical audit programme. The Q&S Committee receives monthly updates from the TWCGG on the management of risks to quality and safety.

The Q&S Committee, FIP Committee, Charitable Funds Committee and A&R Committee each have activity schedules framed around enabling the Board of Directors to have line of sight to any significant risks to internal control. An annual evaluation of committee effectiveness is undertaken for each of these Board committee. This is a self-assessment by committee members and regular attendees, the outcome of which is considered by the A&R Committee.

The Trust also has an active programme of internal and external audit. The audit programme, including recommendations from audits, is overseen by the A&R Committee which is a subcommittee of the Board of Directors. The focus of the internal and external audit programme is set to both support and complement the organisation's objectives and provide an assessment for the Board of Directors on areas of specific risk. The internal audit programme is developed having due regard to the risks and risk controls set out in the Board Assurance Framework and corporate risk register. Audit recommendations are framed around improving internal control and also identifying opportunities for creating added value from our current systems and processes. Any significant risks to internal control identified through the internal audit programme are assigned to a nominated Executive Director to resolve, and are monitored through the Trust Management Group.

During the year the Trust's external auditors changed from KPMG to Mazars. 2017/18 will be the first year Mazars will give their opinion on the Trust's governance arrangements

Our internal auditors awarded substantial, good or reasonable assurance on all audits they undertook during the year, with the exception of our arrangements for duty of candour and procurement which were both awarded limited assurance during quarter 4 of 2017/18. We are actively working to improve and embed our arrangements for duty of candour and an improvement plan has been developed in conjunction with our system partners (NCUHT and UHMB) to strengthen our collective arrangements for procurement and get best value from the contracts we hold and manage. Progress is being managed and monitored through our governance frameworks, with oversight by the A&R Committee. Progress on implementing recommendations from audits is overseen by the A&R Committee.

The Head of Internal Audit has given an overall opinion of good assurance that the system of internal control has been effectively designed to meet the organisation's objectives, and that controls are being consistently applied.

Conclusion

As Accounting Officer and based on the review process outlined above, I conclude that no significant internal control issues have been identified during the year with the exception of our procurement arrangements which have been responded to through the implementation of remedial actions and an improvement plan that will be delivered in conjunction with our system partners during 2018/19.

Signed ..... Date: 24 May 2018
Stephen Eames, Chief Executive for CPFT and NCUHT

Independent auditor's report to the Council of Governors of Cumbria Partnership NHS Foundation Trust

Opinion

We have audited the financial statements of Cumbria Partnership NHS Foundation Trust ('the Trust') for the year ended 31 March 2018. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Government Financial Reporting Manual 2017/18 as contained in the Department of Health and Social Care Group Accounting Manual 2017/18, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of the audit report

This report is made solely to the Council of Governors of Cumbria Partnership NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, 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.

Key audit matter	Our response and key observations
Revenue Recognition Auditing standards include a rebuttable presumption that there is a significant risk in relation to the timing of income recognition, and in relation to judgements made by management as to when income has been earned. The pressure to manage income to deliver forecast performance in a challenging economic environment increases the risk of fraudulent financial reporting leading to material misstatement and means that we are unable to rebut the presumption.	Our approach involved a range of substantive procedures including: • testing of income around the year-end to ensure transactions were recognised in the correct financial year; • testing material year-end receivables to ensure revenue is recognised in the correct financial year; • reviewing intra-NHS reconciliations and data matches; • reviewing management oversight of material accounting estimates and changes to accounting policies; • Substantively testing material accounting estimates; and • testing of adjustment journals selected using specific risk characteristics. **Observations and conclusions** There were no significant findings arising from our work on revenue recognition.
Property valuations	Our approach involved a range of substantive procedures including:

Land and buildings are the Trust's highest value assets. Management engage Cushman & Wakefield, as an expert, to assist in determining the fair value of property to be included in the financial statements. There is considered to be high estimation uncertainty associated with land and building valuations. Changes in the value of property may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Group Accounting Manual.	• updating our understanding of the approach taken by the Trust in its valuation of land and buildings; • reviewing the scope and terms of the engagement with the Cushman & Wakefield; • substantively testing how management used the Cushman & Wakefield's report to value land and buildings in the financial statements; • obtaining from the Cushman & Wakefield, information on the methodology and their procedures to ensure objectivity and quality and consider the reasonableness of their approach; • substantively testing valuation movements to gain assurance that the accounting treatment was appropriate, and • considered evidence of regional valuation trends to challenge the valuation movement. We also considered the Trust's decision to value assets net of VAT and whether this was in line with Group Accounting Manual. We also obtained representation from management on this treatment. **Observations and conclusions** There were no significant findings arising from our work on revenue recognition

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements on the financial statements and our audit. Materiality is used so we can plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. The level of materiality we set is based on our assessment of the magnitude of misstatements that individually or in aggregate, could reasonably be expected to have influence on the economic decisions the users of the financial statements may take based on the information included in the financial statements.

Based on our professional judgement, we determined materiality for Cumbria Partnership NHS Foundation Trust for the financial statements as a whole as follows:

Overall materiality	£2.695m
Basis for determining materiality	1.5% of operating expenses
Rationale for benchmark applied	Operating expenses of continuing operations was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £0.081m, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

An overview of the scope of our audit

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the Accounting Officer and the overall presentation of the financial statements. The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed in the "Key audit matters" section of this report. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Other information

The directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2017/18; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement	
We are required to report to you if, in our opinion: • the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2017/18 ; or • the Annual Governance Statement 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 respect of these matters.
Reports to the regulator and in the public interest	
We are required to report to you if: • we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or • we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.	We have nothing to report in respect of these matters.
Use of resources	
We are required to report to you if the Trust has not put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.	We have nothing to report in respect of this matter.
Other information	
We are required to read the other information and report to you if the other information is:	We have not identified any such material

• materially inconsistent with the audited financial statements or our knowledge obtained in the course of performing our audit; or • otherwise appears to be materially misstated. We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.	inconsistencies or misstatements.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's Responsibilities as the Accounting Officer, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

The Chief Executive as Accounting Officer is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are also required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its 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 its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General (C&AG), having regard to the guidance on the specified criterion issued by the 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. The C&AG determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Certificate

We certify that we have completed the audit of the financial statements of Cumbria Partnership NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Cameron Waddell

For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham
DH1 5TS

24 May 2018

Foreword to the Accounts

Cumbria Partnership NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Cumbria Partnership NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed..... Date 24 May 2018
Michael Smillie
Director of Finance

Signed..... Date 24 May 2018
Stephen Eames
Chief Executive

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	Year ended 31 March 2018 £000	Year ended 31 March 2018 £000	Restated Year ended 31 March 2017 £000	Restated Year ended 31 March 2017 £000
Operating income from patient care activities	3		**165,568**		167,214*
Other operating income	4		**14,589**		13,083
Total operating income			**180,157**		180,297
Operating expenses	5		**(179,635)**		(183,971)
Operating deficit			**522**		(3,674)
Finance costs:					
Finance income		**26**		26	
Finance expense – financial liabilities		**(582)**		(580)	
Finance expense - unwinding of discount on provisions		**(2)**		(3)	
PDC Dividends payable		**(1,582)**		(1,516)	
Net finance costs			**(2,140)**		(2,073)
Gain/ (losses) on disposal of assets	10.3		**(12)**		218
DEFICIT FOR THE YEAR			**(1,630)**		(5,529)
Other comprehensive income					
Impairments on property plant and equipment	10.1		**1,552**		(2,387)
Revaluation gains on property, plant and equipment	10.1		**2,300**		84
TOTAL COMPREHENSIVE INCOME/ (EXPENSE) FOR THE YEAR			**2,222**		(7,832)

* Following reanalysis, £3m of Operating income from patient care activities has been classified as other operating income based on income from recharged services.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Property, plant and equipment	10.1	**66,771**	65,265
Intangible assets	11	**3,178**	3,222
Investment in associates and joint ventures		**35**	35
Total non-current assets		**69,984**	68,522
Current assets			
Trade and other receivables	15.1	**6,998**	9,346
Non-current assets for sale	10.2	**-**	-
Cash and cash equivalents	16.1	**8,119**	5,649
Total current assets		**15,117**	14,995
Current liabilities			
Trade and other payables	17.1	**(17,910)**	(19,326)
Borrowings	17.2	**(352)**	(326)
Provisions	18	**(786)**	(1,165)
Other liabilities	17.6	**(661)**	(481)
Total current liabilities		**(19,709)**	(21,298)
Total assets less current liabilities		**65,392**	62,219
Non-current liabilities			
Borrowings	17.2	**(7,218)**	(7,122)
Provisions	18	**(1,525)**	(1,514)
Total non-current liabilities		**(8,743)**	(8,636)
Total assets employed		**56,649**	53,583
Financed by taxpayers' equity:			
Public dividend capital		**34,758**	33,914
Income and expenditure reserve		**12,596**	10,761
Revaluation reserve		**9,295**	8,908
Total taxpayers' equity		**56,649**	53,583

Signed: ..... Michael Smillie (Director of Finance) Date: 24 May 2018

Signed: ..... Stephen Eames (Chief Executive) Date: 24 May 2018

STATEMENT OF CHANGES IN EQUITY

Changes in Taxpayers' Equity for the year ended 31 March 2018

	Taxpayers' Equity			
	Public Dividend Capital	**Income and Expenditure Reserve**	**Revaluation Reserve**	**Total**
	£000	**£000**	**£000**	**£000**
Balance at 1 April 2017	**33,914**	**10,761**	**8,908**	**53,583**
Other transfers between reserves	-	3,000	(3,000)	**-**
Total Comprehensive Income for the year:				
Retained deficit for the year	-	(1,630)	-	**(1,630)**
Revaluation gains on property, plant and equipment	-	-	3,852	**3,852**
Transfer to retained earnings on disposal of assets		465	(465)	**-**
Public Dividend Capital Received	844	-	-	**844**
Balance at 31 March 2018	**34,758**	**12,596**	**9,295**	**56,649**

Changes in Taxpayers' Equity for the year ended 31 March 2017

	Taxpayers' Equity			
	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Total
	£000	£000	£000	£000
Balance at 1 April 2016	33,414	13,932	13,569	60,915
Other transfers between reserves	-	2,358	(2,358)	-
Total Comprehensive Income for the year:				
Retained deficit for the year	-	(5,529)	-	(5,529)
Revaluation gains on property, plant and equipment	-	-	(2,303)	(2,303)
Public Dividend Capital Received	500	-	-	500
Balance at 31 March 2017	33,914	10,761	8,908	53,583

STATEMENT OF CHANGES IN EQUITY – RESERVES

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 Trust. Additional PDC may also be issued to NHS Foundation Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health and Social Care 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.

Income and Expenditure Reserve

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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**522**	(3,674)
Non-cash income and expense		
Depreciation and amortisation	**3,551**	3,913
Impairments and (reversal of) impairments	**(178)**	3,228
Decrease/ (increase) in receivables and other assets	**2,171**	(2,249)
(Decrease)/ increase in payables and other liabilities	**(899)**	(2,573)
(Decrease)/ increase in provisions	**(370)**	309
Net cash generated/ (absorbed) by operations	**4,797**	(1,046)
Cash flows from investing activities		
Interest received	**26**	26
Purchase of intangible assets	**(693)**	(1,169)
Purchase of property, plant and equipment	**(3,955)**	(3,698)
Sale of Property, plant, equipment	**3,316**	3,133
Cash from Joint Venture	**-**	(35)
Net cash outflow from investing activities	**(1,306)**	(1,743)
Cash flows from financing activities		
PDC received	**844**	500
Movement in loans from Department of Health and Social Care	**448**	1,309
Capital element of PFI payments	**(249)**	(228)
Capital element of finance lease	**(77)**	(79)
Interest paid on finance lease liabilities	**(14)**	(14)
Interest on PFI borrowings	**(544)**	(566)
Interest on Department of Health and Social Care Loan	**(24)**	-
PDC dividends paid	**(1,405)**	(1,724)
Net cash outflow from financing	**(1,021)**	(802)
Increase/ (decrease) in cash and cash equivalents	**2,470**	(3,591)
Cash and cash equivalents at 1 April 2017	**5,649**	9,240
Cash and cash equivalents at 31 March 2018	**8,119**	5,649

NOTES TO THE ACCOUNTS

1 ACCOUNTING POLICIES

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

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 and certain financial assets and financial liabilities.

1.2 Going concern basis

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the coming year. The Trust delivered its full £5.5m Cost Improvement Program (CIP) for 2017/18 and achieved a deficit of £1.63m against a control total of £3.2m which includes £1.34m of performance incentive from the Sustainability and Transformation Fund. Control totals are set by NHS Improvement to measure financial performance and exclude items such as revaluations, impairments, gains/losses on disposal and donations. The Trust is planning a £2.1m deficit for 2018/19, which agrees to the 2018/19 control total, and a closing cash balance of £6.1m at 31 March 2019. The 31 March 2019 forecast cash balance is based on the assumption that the proceeds from the sale of land at Carleton Clinic in March 2018 are held as cash reserves rather than invested in increasing the 2018/19 capital program. However, the 2018/19 plan submitted to and accepted by NHS Improvement was based on a scenario where the proceeds of sale are invested in the 2018/19 capital program and an additional £2.1m of revenue loan support. The Trust received £0.5m of revenue support loan from the Secretary of State during 2017/18 and the Directors consider it reasonable to expect cash support to be available, if required, and for the Trust to continue to be able to meet its liabilities as they fall due.

The Directors recognise that should the operating deficit continue, this poses a significant risk to future years' financial standing. As well as delivering the internal CIP's needed to achieve the control total, the Trust is working to integrate with key local partners and liaising with wider stakeholders and NHS Improvement as it looks to generate the service and financial efficiencies needed to transform the Cumbrian Health Economy.

After making enquiries, the Directors have adopted a going concern basis in preparing these accounts as they do not intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of services to another entity, nor do they believe there is no realistic alternative but to do so.

1.3 Consolidation

The Trust in prior years has consolidated its Charitable Fund within the main accounts however for the 2017/18 accounts, the Trust has exercised judgement based on guidance within the Annual Reporting Manual not to consolidate based on grounds of materiality.

Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. The Trust entered into a joint venture with the partners of Waterloo House Surgery and University Hospital of Morecambe Bay NHS Foundation Trust with each organisation having one third control over the GP Practice. Joint ventures are accounted for using the equity method.

Limited Company

The Trust on the 26 January 2018 established a dormant company called North Cumbria Primary Care Ltd. This company may be used in the future as a vehicle to support primary care.

1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. Where income is received for a specific activity that is to be delivered in a subsequent financial year, that income is deferred until that activity is undertaken.

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.

1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as security costs and apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement relating to employees on sick and maternity leave which has not been taken by employees at the end of the period is recognised in the financial statements.

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.

1.7 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 Trust. 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 NHS Foundation 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 NHS Foundation 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 of the audit of the annual accounts.

1.8 Pension costs

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

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as at 31 March 2017, updated to 31 March 2018 with a summary of global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

The next actuarial valuation was due to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the Scheme Actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

1.9 Property, Plant and Equipment

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;
- individually has a cost of at least £5,000; or
- forms a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment is 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 fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Fair values are determined as follows:

- land and non-specialised buildings - market value for existing use;
- specialised buildings - depreciated replacement cost;
- non-operational properties - market value.

The Trust has adopted the HM Treasury standard approach to depreciated replacement cost valuations based on modern equivalent assets.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately. Assets are revalued and depreciation commences when they are brought into 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 economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Depreciation is charged on property with respect to the remaining useful life as recommended by a professional valuer.

Depreciation on other categories of fixed assets is charged on cost evenly over the estimated useful economic life as follows:

	Years	
Plant and Machinery	10	
Transport Equipment	7	
Information Technology	5	(Equipment)
Information Technology	7	(Infrastructure)
Furniture and fittings	3	(Ward environment)
Furniture and fittings	5	(Office environment)

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 i.e.:
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the fair value less costs to sell falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

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 been previously recognised in operating expenditure, in which case they are recognised in operating expenses.

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 DHSC 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 are 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.

Donated, government grant and other grant funded fixed 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.

Private finance initiative (PFI)

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17. An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income. The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term. An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance

lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value. The element of the annual unitary payment allocated to lifecycle replacement is predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively. Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

1.10 Intangible assets

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.

Software

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

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

Amortisation

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

	Years
Intangible assets	
Software	7

1.11 Inventories

The cost of all consumable goods is charged to operating expenses at the date of purchase. Any stock items purchased are not material in value either individually or in aggregate.

1.12 Taxation

Cumbria Partnership NHS Foundation Trust is a Health Service body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits therefrom exceed £50,000 per annum. There is no tax liability arising in respect of the current financial year.

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.

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

1.14 Financial assets and financial liabilities

Recognition

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

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

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

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

(i) Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

(ii) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets or non current assets as appropriate. The Trust's loans and receivables comprise cash at bank, trade debtors, accrued income, revenue support loan and other debtors.

Loans and receivables are recognised initially at fair value, net of transaction 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 income and expenditure account.

(iii) Other financial liabilities

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

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. The Trust's financial liabilities comprise trade creditors, accruals and other creditors.

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

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined at quoted market prices in the case of investments, and in accordance with independent evaluations or contractual terms in the case of provisions and other liabilities.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.15 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.

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 implicit interest rate is that which produces a constant periodic rate of interest in the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment. The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

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

Leases of land

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.

1.16 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 note 22 in accordance with the requirements of HM Treasury's FReM.

1.17 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 the 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 the clinical negligence provisions carried by the NHS Resolution on behalf of the Trust is disclosed in note 18 but is not recognised in the Trust's accounts.

1.18 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.

1.19 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 HM Treasury's discount rate of 1.56% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 0.1% (2016/17: 0.24%) in real terms.

1.20 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 20 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 19, 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.

1.21 Segment Reporting

An operating segment is a component of the Trust that engages in activities from which it may earn revenues and incur expenses, including revenues and expenses that relate to transactions with any other

inter-government components. All operating segments' operating results are reviewed regularly by the Board to make decisions about resources to be allocated to the segment and to assess its performance, and for which discrete financial information is available.

Segment results that are reported to the Board include items directly attributable to a segment as well as those that can be allocated on a reasonable basis. Unallocated items mainly comprise income and costs for non-clinical service provision and activities to support operating segments.

1.22 Early adoption of standards, amendments and interpretations

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

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

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC which have not been applied by the Trust in these financial statements. The adoption of IFRS 9 and IFRS 14 is not expected to have a significant impact on the Trust's results. The Trust is in the process of assessing the impact on the financial statements from the adoption of IFRS 15 and IFRS 16.

- IFRS 9 – 'Financial Instruments' (Application required for accounting periods beginning on or after 1st January 2018, but not yet adopted by the FReM)
- IFRS 14 'Regulatory Deferral Accounts' (Not yet EU endorsed)
- IFRS 15 – 'Revenue from contracts with customers' Application required for accounting periods beginning on or after 1st January 2018, but not yet adopted by the FReM
- IFRS 16 – 'Leases' (Application required for accounting periods beginning on or after 1 January 2019)

1.24 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 NHS Foundation Trusts 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.

1.25 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Workington Community Hospital was constructed under the Private Finance Initiative (PFI) and meets the criteria for inclusion in the accounts as a finance lease as the Trust bears the risks and rewards of ownership see note 17.4.

1.26 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- The Trust has conducted a review of land, buildings, dwellings and assets held for sale using independent qualified valuers, and revaluations and impairments have been made where required. The valuer also reviewed asset lives which were amended where required;
- Provisions have been made in line with management's best estimates and in line with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.
- The Trust's dispute with its Private Finance Initiative provider is still ongoing and is therefore recognised as a contingent asset in line with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

2. Segmental Analysis

Operating Segments

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Non-segment operating Income	**166,480**	**166,797**
Net segment expenditure:		
Children's Services Care Group	**(16,663)**	**(17,588)**
Community Care Group	**(50,818)**	**(50,907)**
Mental Health Care Group	**(37,969)**	**(38,461)**
Specialist Services Care Group	**(21,745)**	**(22,109)**
Operations and Clinical Management	**(1,044)**	**(1,034)**
Director of Quality and Nursing	**(3,131)**	**(2,778)**
Other non-segmental expenditure	**(31,215)**	**(30,451)**
(Surplus)/deficit before finance costs, depreciation, impairments and movements in fair value of investments	**3,895**	**3,469**
Finance income	**26**	**26**
Finance expense – financial liabilities	**(582)**	**(580)**
Finance expense – unwinding of discount on provisions	**(2)**	**(3)**
PDC Dividends payable	**(1,582)**	**(1,516)**
Movement in fair value of investments	**-**	**-**
Net impairments on revaluation of property, plant and equipment	**178**	**(3,228)**
Gain / (Loss) on disposal of asset	**(12)**	**218**
Depreciation and amortisation	**(3,551)**	**(3,913)**
NET DEFICIT FOR THE YEAR	**(1,630)**	**(5,527)**

The comparative figures have been restated so as to be shown on a comparable basis to the operating segments.

The Board of Directors is considered to be the 'Chief Operating Decision Maker' of the Trust in the context of IFRS 8 'Operating Segments' definition. The net expenditure of each operating segment refers to the operating expenditure, less directly attributable income.

The Trust has six reportable segments, as identified in the table above, which represent the categories of healthcare services provided by the Trust and the operations and nursing management structures. The performance of these segments is reviewed monthly by the Trust's Board of Directors. Segmental assets and liabilities are not reported internally to the Board, and are therefore not disclosed in this note.

Categories of segments:

Income that cannot be allocated to individual activities and segments have been determined by reference to the operating expenses of the Care Group or Directorate. Operating expenditure of these activities is reported where this expenditure exceeds the quantitative thresholds for determining reportable segments. Where two or more operating segments meet the aggregation criteria their operating expenditure has been reported under one segment. Other non-segmental expenditure includes the costs of providing non-clinical services as well as costs to support the activities of healthcare segments.

3. Income from Activities

	Year ended 31 March 2018 £000	Restated Year ended 31 March 2017 £000
NHS Contract Income for Clinical Services	**156,501**	156,124
Non NHS Contract Income for Clinical Services	**8,199**	9,154
Other clinical income from commissioner requested services	**739**	1,785
Income from activities (before non-mandatory income)	**165,439**	167,063
Other non-commissioner requested services clinical income	**129**	151*
Income from activities	**165,568**	167,214
Analysis by type of organisation		
NHS Trusts	**337**	331
NHS Foundation Trusts	**178**	175
NHS England and Clinical Commissioning Groups	**156,972**	157,373
NHS Other	**7**	72
Local Authorities	**7,290**	8,991
Other Non NHS	**784**	272
Income from activities	**165,568**	167,214

* Following reanalysis, £3m of other non-commissioner requested services clinical income have been classified to other operating income

The NHS Provider Licence sets out the goods and services that the Trust is required to provide (commissioner requested services). All of the income from activities before non-commissioner requested services clinical income shown above is derived from the provision of commissioner requested services.

4. Other Operating Income

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Education and training	**2,551**	2,581
Research and development	**375**	384
Non-patient care services to other bodies	**6,651**	4,271
Rental revenue from operating leases	**1,189**	1,096
Sustainability and Transformation Funding	**2,997**	3,571
Other income	**826**	1,180
Total	**14,589**	13,083

The NHS Provider Licence sets out the education and training that the Trust is required to provide.

5.1 Operating Expenses

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Purchase of healthcare from non NHS bodies	**589**	580
Executive Directors' costs	**1,003**	1,162
Non-executive Directors' costs	**113**	122
Staff costs	**136,268**	135,502
Drug	**4,914**	5,223
Supplies and services - clinical (excluding drug costs)	**6,536**	7,001
Supplies and services - general	**5,119**	5,799
Establishment	**1,568**	2,156
Transport	**2,822**	3,222
Transport including Patient Travel	**78**	87
Premises	**12,660**	10,923
Increase in provision for impairment of receivables	**83**	97
Depreciation and amortisation	**3,551**	3,913
Net Impairments of property, plant and equipment*	**(178)**	3,228
Audit fees - statutory audit	**40**	54
Other non audit services provided by external auditors	**8**	10
Internal audit	**128**	154
Clinical negligence	**447**	403
Legal fees	**373**	530
Consultancy	**332**	41
Training courses and conferences	**655**	790
Restructuring	**239**	740
Early Retirements	**-**	266
Change in Discount Rate	**2**	295
Car Parking and security	**6**	8
Insurance	**29**	29
Losses, ex- gratia and special payments	**6**	2
Other**	**2,244**	1,634
	179,635	183,971

*2017/18 Net Impairment of property, plant and equipment includes reversal of impairment relating to land sale at Carleton Clinic site.

** Other expenditure includes costs relating to management fees for agency, pharmacy and data centres.

5.2 Limitation on auditor's liability

There are no specified limitations stated on the engagement letter of the Trust's auditors.

5.3 Other audit remuneration.

Included in the Trust accounts at the 31 March 2018 was an additional £8k remuneration for work on the Quality accounts (£10k 2016/17).

6. Operating Leases

6.1 Operating lease revenue:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Minimum lease receipts	**1,189**	1,096

6.2 Operating lease expense:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Minimum lease payments	**4,178**	4,335

6.3 Future minimum lease payments due:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Not later than one year	**2,904**	3,337
Between one and five years	**2,092**	2,219
Later than five years	**6,914**	7,224
Total	**11,910**	12,780

7. The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts included within interest payable arising from claims made under this legislation. There was no compensation paid to cover debt recovery costs under this legislation.

8. Retirements due to ill-health

During the year ended 31 March 2018 there were nil early retirements from the Trust agreed on the grounds of ill-health (in the year ended 31 March 2017 there were six early retirements). The estimated additional pension liabilities of these ill-health retirements will be £nil, (in the year ended 31 March 2017 the estimated additional liability was £183k). The cost of these ill-health retirements prior to 2017/18 will be borne by the NHS Business Services Authority - Pensions Division.

9 Employee costs and numbers

9.1 Employee costs

	Year ended 31 March 2018	Year ended 31 March 2017
	Total £000	Total £000
Salaries and wages	**108,071**	107,206
Social security costs	**9,999**	10,106
Apprenticeship Levy	**519**	-
Employer's contributions to NHS pensions schemes	**14,064**	13,989
Agency/contract staff	**5,482**	6,216
Termination benefits	**239**	839
Total gross staff costs	**138,374**	138,356
Recoveries in respect of seconded staff	**(728)**	(686)
Total staff costs	**137,646**	137,670
Of which:		
Costs capitalised as part of assets	136	-

10 Tangible Fixed Assets

10.1 Property, plant and equipment as at 31 March 2018 comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction *	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	5,965	50,733	239	-	6,426	228	10,524	1,703	75,818
Additions	-	1,643	-	821	300	26	886	191	3,867
Disposals/ derecognition (Note a)	-	-	-	-	(327)	-	-	-	(327)
Revaluations (Note b)	2,319	(700)	(5)	-	-	-	-	-	1,614
Impairments (Note c)		(726)	-	-	-	-	-	-	(726)
Reversal of impairments (Note c)	725	1,534	19	-	-	-	-	-	2,278
Transfers to assets held for sale(Note d)	(3,000)	-	-	-	-	-	-	-	(3,000)
Reclassifications									
Cost or valuation at 31 March 2018	**6,009**	**52,484**	**253**	**821**	**6,399**	**254**	**11,410**	**1,894**	**79,524**
Accumulated depreciation at 1 April 2017	-	1,115	-	-	2,490	150	5,346	1,452	10,553
Charged during the year	-	980	5	-	613	14	1,303	149	3,064
Disposals (Note a)	-	-	-	-	-	-	-	-	-
Revaluations (Note b)	19	(700)	(5)	-	-	-	-	-	(686)
Impairments (Note c)		1,225	-	-	-	-	-	-	1,225
Reversal of Impairments (Note c)	(19)	(1,384)	-	-	-	-	-	-	(1,403)
Accumulated depreciation at 31 March 2018	**0**	**1,236**	**0**	**0**	**3,103**	**164**	**6,649**	**1,601**	**12,753**
Net book value									
Owned	6,009	35,098	253	821	3,296	90	4,526	293	50,386
Finance leased	-	6,837	-	-	-	-	235	-	7,072
PFI	-	8,998	-	-	-	-	-	-	8,998
Donated	-	315	-	-	-	-	-	-	315
Total at 31 March 2018	**6,009**	**51,248**	**253**	**821**	**3,296**	**90**	**4,761**	**293**	**66,771**

10.1 Property, plant and equipment as at 31 March 2017 comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	6,088	54,929	377	-	6,144	184	10,423	3,750	81,895
Additions	-	2,778	-	-	509	44	215	65	3,611
Disposals (Note a)	(99)	-	(182)	-	(227)	-	(114)	(2,112)	(2,734)
Revaluations (Note b)	12	(4,143)	8	-	-	-	-	-	(4,123)
Impairments (Note c)	(19)	(2,864)	-	-	-	-	-	-	(2,883)
Reversal of impairments (Note c)	58	402	36	-	-	-	-	-	496
Transfers to assets held for sale	(75)	(369)	-	-	-	-	-	-	(444)
Reclassifications	-	-	-	-	-	-	-	-	-
Cost or valuation at 31 March 2017	**5,965**	**50,733**	**239**	**-**	**6,426**	**228**	**10,524**	**1,703**	**75,818**
Accumulated depreciation at 1 April 2016	-	1,042	-	-	2,092	138	3,889	3,204	10,365
Charged during the year	-	1,048	4	-	619	12	1,539	360	3,582
Disposals (Note a)	-	-	-	-	(221)	-	(82)	(2,112)	(2,415)
Revaluations (Note b)	12	(4,227)	8	-	-	-	-	-	(4,207)
Impairments (Note c)	-	3,383	-	-	-	-	-	-	3,383
Reversal of Impairments (Note c)	(12)	(131)	(12)	-	-	-	-	-	(155)
Accumulated depreciation at 31 March 2017	**-**	**1,115**	**-**	**-**	**2,490**	**150**	**5,346**	**1,452**	**10,553**
Net book value									
Owned	5,965	34,522	239	-	3,936	78	4,865	251	49,856
Finance leased	-	6,179	-	-	-	-	313	-	6,492
PFI	-	8,471	-	-	-	-	-	-	8,471
Donated	-	446	-	-	-	-	-	-	446
Total at 31 March 2017	**5,965**	**49,618**	**239**	**-**	**3,936**	**78**	**5,178**	**251**	**65,265**

10.1 Tangible Fixed Assets (cont'd)

*Assets under construction relates to the redevelopment of Millom Hospital.

a) Disposals: During 2017/18 the Trust wrote off assets with a cost of £327k (2016/17: £2,734k) and accumulated depreciation of £nil (2016/17 £2,415k) that were no longer in use.

b) Revaluations: Before the sale of land at the Carleton Clinic site was transferred to assets held for sale it was revalued to its market value less cost of sale £2,300k in 2017/18

c) Impairments: The Trust revalued its Land, Buildings and Dwellings at 31 March 2018 and 31 March 2017. The valuations were carried out by the Trust's external valuers Cushman & Wakefield, who are members of the Royal Institute of Chartered Surveyors. As the Trust has specialist assets for which there is no active market, the valuers have used Modern Equivalent Asset (MEA) valuations as a substitute for market value. The Trust joined the Cumbria E-lift programme as of the 31 March 2017 and has valued its estate on a net of VAT basis from 2016/17. The 2017/18 valuation resulted in an overall net increase in value of £2,011k (2016/17: £5,615k). This was made up of a net increase of £1,552k (2016/17: decrease of £2,387k) in value which was credited to other comprehensive income and a net decrease of £459k (2016/17: increase £3,228k) impairment charged to operating expenses.

d) The Trust sold land at its Carleton Clinic site which had a £nil net book value which resulted in a net gain on disposal of £300k (2016/17 gain of £218k on plant and machinery). There was a small gain on sale of £15k for medical equipment with £nil net book value.

10.2 Non-current assets held for sale and assets in disposal groups

	31 March 2018 PPE - Land £000	31 March 2017 PPE Land £000
NBV at 1 April	**0**	2,151
Assets classified as available for sale in the year	**3,000**	444
Assets sold in year **	**(3,000)**	(2,595)
NBV at 31 March	**0**	**-**

10.3 Asset disposal in year

	Total £000	Land £000	Building exc. Dwellings £000	Plant and Machinery £000
Net book value of asset disposed	**(3,327)**	(3,000)	(327)	-
Sale proceeds**	**3,377**	3,362	-	15
Expenditure associated with sale	**(62)**	(62)	-	-
Gain/ (loss) on sale	**(12)**	300	(327)	15

** The sale of these assets does not impact on the Trust's ability to meet its obligation to provide commissioner requested services as no sales are authorised without full consideration of the impact on service provision. Services previously provided in these buildings are now delivered within existing Trust estate, or the service has transferred to another provider.

The Trust held £6,837k of assets under finance leases at the balance sheet date (£6,179k at 31 March 2017). Depreciation in respect of finance lease assets for the year ended 31 March 2017 was £93k (2016/17: £106k).

11. Intangible Fixed Assets

	31 March 2018 Software Licences £000	31 March 2017 Software Licences £000
Cost at 1 April	**3,797**	2,378
Additions	**443**	1,419
Reclassifications from PPE	**-**	-
Cost at 31 March	**4,240**	3,797
Amortisation at 1 April	**575**	244
Charged during the period	**487**	331
Amortisation at 31 March	**1,062**	575
Net book value		
Purchased at 1 April	**3,222**	2,134
Total at 1 April	**3,222**	2,134
Purchased at 31 March	**3,178**	3,222
Total at 31 March	**3,178**	3,222

12. Capital Commitments

During the year ended 31 March 2015 the Trust signed a £10.6m contract for IT equipment and support, to equip two new data centre buildings. The capital costs included in the Trust accounts to 31 March 2018 were £6.0m. The Trust has a capital commitment of £0.5m at 31 March 2018 and had a capital commitment of £1m under capital expenditure contracts at 31 March 2017. The Trust also has capital commitments relating to the redevelopment of Millom Hospital of £2.3m of which £0.8m is included in the Trust accounts to the 31 March 2018.

13. Other Financial Commitments

The Trust has revenue commitments for IT equipment and software support for its two data centre buildings, Electronic patient record system and Community of Interest Network connections.

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	**1,287**	1,278
after 1 year not later than 5 years	**2,191**	3,521
Total	**3,478**	4,799

14. Inventories

The Trust had no material inventories at 31 March 2018 or at 31 March 2017.

15. Trade and other receivables

15.1 Trade and other receivables – current

	31 March 2018 £000	31 March 2017 £000
NHS receivables	**3,882**	4,899
Other receivables	**1,078**	1,907
Prepayments and accrued income	**2,724**	3,143
Provision for the impairment of receivables	**(686)**	(603)
Total	**6,998**	9,346

There were no prepaid pension contributions at 31 March 2018 or 31 March 2017.

15.2 Receivables past their due date but not impaired

	31 March 2018 £000	31 March 2017 £000
By up to three months	**1,090**	84
By three to six months	**23**	125
By more than six months	**1,255**	68
Total	**2,368**	277

15.3 Provision for impairment of receivables

	31 March 2018 £000	31 March 2017 £000
Balance at 1 April	**603**	506
Arising during year	**241**	330
Utilised	**-**	-
Reversal of amounts unused	**(158)**	(233)
Balance at 31 March	**686**	603

15.4 Ageing of impaired receivables

	31 March 2018 £000	31 March 2017 £000
Up to 3 Months	**193**	-
In three to six months	**-**	22
Over six months	**493**	581
Total	**686**	603

The credit quality of receivables neither past due and not impaired are continuously reviewed. The basis for not impairing is due mainly to custom and practice and ongoing discussions with the payable organisation.

16. Analysis of cash movements

16.1 Reconciliation of net cash flow to movement in net funds

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Net funds at 1 April	**5,649**	9,240
Net change in year	**2,470**	(3,591)
Net funds at 31 March	**8,119**	5,649
Broken down into:		
Cash with Government Banking Service	**8,105**	5,635
Cash with commercial banks and in hand	**14**	14
Net funds at 31 March	**8,119**	5,649

17. Liabilities

17.1 Trade and other payables at the balance sheet date are made up of:

	31 March 2018 £000	31 March 2017 £000
Amounts falling due within one year:		
Tax payable	**2,863**	2,409
NHS payables	**4,413**	4,762
Capital payables	**169**	507
Other payables	**6,026**	6,678
Accruals	**4,439**	4,970
Total	**17,910**	19,326

Other payables include £1,956k outstanding pension contributions at 31 March 2018 (£1,894k at 31 March 2017).

17.2 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Obligations under finance leases (note 18.3)	**78**	77
Obligations under PFI contracts (note 18.4)	**274**	249
Total	**352**	326
Non-current		
Obligations under finance leases (note 18.3)	**137**	215
Obligations under PFI contracts (note 18.4)	**5,324**	5,598
DHSC (note 18.5)	**1,757**	1,309
	7,218	7,122

17.3 Finance lease commitments

	31 March 2018	31 March 2017
	£000	£000
Gross finance lease liabilities which are due:		
Within 1 year	**92**	92
Between one and five years	**201**	277
Finance charges	**(78)**	(77)
Total	**215**	292

	31 March 2018	31 March 2017
	£000	£000
Net finance lease liabilities which are due:		
Within 1 year	**78**	77
Between one and five years	**137**	215
Total	**215**	292

17.4 On SoFP PFI liabilities and service concession arrangements

On 1 April 2013, the PFI agreement relating to Workington Hospital transferred to the Trust as part of the transfer of Cumbria PCT assets. The agreement is for a 25 year term ending 31 March 2030. The site includes a 14 bed inpatient unit, two GP surgeries, a pharmacy, community dental services, community midwifery and a range of other services. At the expiry of the PFI agreement, the property will transfer to the ownership of the Trust.

17.4(a) Imputed finance lease obligations

The Trust has the following obligations in respect of the finance lease element of the on-Statement of Financial Position PFI scheme:

	31 March 2018	**31 March 2017**
	£000	**£000**
Gross PFI liabilities	**9,525**	**10,319**
Of which liabilities are due:		
Within 1 year	**794**	**794**
Between one and five years	**3,175**	**3,175**
More than five years	**5,556**	**6,350**
	9,525	**10,319**
Finance charges allocated to future periods	**(3,927)**	**(4,472)**
Net PFI liabilities	**5,598**	**5,847**
Of which liabilities are due:		
Within 1 year	**274**	**249**
Between one and five years	**1,370**	**1,254**
More than five years	**3,954**	**4,344**
Total	**5,598**	**5,847**

17.4(b) Total on-SoFP PFI service concession arrangement commitments

	31 March 2018	31 March 2017
	£000	£000
Total future payments committed in respect of the PFI service concession arrangements, including the operating cost, the contingent rent and life cycle cost	**15,687**	17,455
Of which liabilities are due:		
Within 1 year	**1,259**	1,244
Between one and five years	**5,112**	5,140
More than five years	**9,316**	11,071
Total	**15,687**	17,455

17.4(c) Analysis of amounts payable to service concession operator

	31 March 2018	31 March 2017
	£000	£000
Unitary payment payable to service concession operator	**928**	1,230
Consisting of:		
Interest charge	**544**	566
Repayment of finance lease liability	**250**	228
Service element	**451**	436
Other	**(317)**	-
Total amount paid to service concession operator	**928**	1,230

17.5 Department of Health and Social Care Loan

The revenue support loans of £1.8m have a term of three years with an interest charge of 1.5% per annum.

17.6 Other liabilities

Other liabilities as disclosed in the Statement of Financial Position comprise deferred income.

	31 March 2018	31 March 2017
	£000	£000
Current	**661**	481
Non-current	**-**	-
Total	**661**	481

18. Provisions

	Current		Non-current	
	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
	£000	£000	**£000**	£000
Pensions relating to other staff	**86**	85	**1,525**	1,514
Restructuring	**162**	280	**-**	-
Other	**538**	800	**-**	-
Total	**786**	1,165	**1,525**	1,514

	Total	**Pensions relating to other staff**	**Restructuring**	**Other**
	£000	**£000**	**£000**	**£000**
At 1 April 2017	2,679	1,599	280	800
Change in the discount rate	2	2	-	-
Arising during the year	608	106	298	204
Used during the year	(643)	(98)	(229)	(316)
Reversed unused	(337)	-	(187)	(150)
Unwinding of discount	2	2	-	-
At 31 March 2018	**2,311**	**1,611**	**162**	**538**

	Total	**Pensions relating to other staff**	**Restructuring**	**Other**
	£000	**£000**	**£000**	**£000**
Expected timing of cash flows:				
Within 1 year	**786**	86	162	538
Between one and five years	**349**	349	-	-
After 5 years	**1,176**	1,176	-	-
	2,311	**1,611**	**162**	**538**

The pension provision is in respect of staff who have taken early retirement or retirement prior to 2017/18 on health grounds for which the Trust still has an obligation to the Pensions Agency to meet some of the cost.

Provisions classified as 'Other' relate to:

- costs relating to the restoration of three (two at 31 March 2015) leased properties to the condition the buildings were in on the date the leases were signed;
- a claim for retrospective reimbursement of premises costs.

£716,969 is included in the provisions of NHS Resolution as at 31 March 2018 (£928,283 at 31 March 2017) in respect of clinical negligence liabilities of the Trust.

19. Contingencies

The Trust has a contingent asset in respect of a dispute with its Private Finance Initiative (PFI) provider relating to fire defects discovered at Workington Hospital. The Trust has made a claim against them for the related penalties and deductions. The outcome of this dispute is uncertain including the quantum of any potential receipt by the Trust. Both parties have agreed to an adjudication process which commenced during 2017/18 and is still ongoing.

There is a contingent liability of £53,900 at 31 March 2018 (£54,050 at March 2017) relating to employer's liability claims made against the Trust as advised by NHS Resolution, which handles claims on the Trust's behalf. These claims are expected to be resolved within 1 year.

20. Financial Instruments

20.1 Credit risk

Credit risk is the risk of financial loss to the Trust if a customer or counterparty to a financial instrument fails to meet its contractual obligations, and arises principally from the Trust's debtors and cash balances. The carrying amount of financial assets represents the maximum credit exposure. Therefore the maximum exposure to credit risk at the balance sheet date, as disclosed in note 20.3, was £13,491k (£13,850k at 31 March 2017) being the total of the carrying amount of financial assets.

The movement in the allowance for impairment of trade debtors is disclosed in note 15.3, and the charge to income and expenditure in note 5. The ageing of non-impaired trade debtors past their due date is disclosed in note 15.2.

20.2 Market risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Trust's income or the value of its holdings of financial instruments. The main potential market risk to the Trust is interest rate risk; the Trust has fixed 1.5% interest rate loans with the Department of Health and Social Care.

20.3 Financial assets by category

	31 March 2018 £000	31 March 2017 £000
NHS and DH Bodies receivables	**3,882**	4,893
Other receivables and accrued income	**1,490**	3,308
Cash at bank and in hand	**8,119**	5,649
Total	**13,491**	13,850

20.4 Financial liabilities by category

	31 March 2018 £000	31 March 2017 £000
NHS payables	**4,413**	4,762
Capital and other payables	**6,197**	7,183
Accruals	**4,439**	4,970
Provisions	**2,311**	2,679
PFI borrowings	**5,598**	5,847
Finance lease borrowings	**215**	292
DH Loan	**1,757**	1,309
Total	**24,930**	27,042

20.5 Fair values of financial instruments

Trade and other receivables
The fair value of trade and other receivables is estimated as the present value of future cash flows, discounted at the market rate of interest at the balance sheet date if the effect is material. The book value of current and non-current trade and other receivables is equal to the fair value of current and non-current trade and other receivables at 31 March 2018.

Trade and other payables
The fair value of trade and other payables is estimated as the present value of future cash flows, discounted at the market rate of interest at the balance sheet date if the effect is material. The book value of current and non-current of trade and other payables is equal to the fair value of current and non-current trade and other payables at 31 March 2018.

Cash and cash equivalents
The fair value of cash and cash equivalents is estimated as its carrying amount where the cash is repayable on demand. The book value of cash and cash equivalents is equal to the fair value of cash and cash equivalents at 31 March 2018.

20.6 Liquidity risk

Liquidity risk is the risk that the Trust will not be able to meet its financial obligations as they fall due. This is also considered in note 1.2.

92% of the Trust's income is derived under block contracts with its Commissioners, which run until at least 31 March 2019, and are financed from resources voted for annually by Parliament. Capital expenditure is financed from internally generated resources, Public Dividend Capital and Charitable Trust Fund.

Of the total provisions at 31 March 2018, £786k is payable within one year, £349k between one and five years. Trade and other payables are due within 1 year.

21. Third Party Assets

The Trust held £1,945k cash at bank and in hand at 31 March 2018 (£1,588k at 31 March 2017) which comprises £73k monies held by the Trust on behalf of patients (£73k at 31 March 2017), and £1,872k held on behalf of The West, North and East Cumbria Sustainability and Transformation Partnership (£1,515k at 31 March 2017). These amounts have been excluded from the cash at bank and in hand figure reported in the accounts.

22. Related party transactions

Cumbria Partnership NHS Foundation Trust is a public benefit corporation authorised by the Independent Regulator for Foundation Trusts. During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Cumbria Partnership NHS Foundation Trust. The Trust as a part of developing an integrated health and care system has moved to working more closely with North Cumbria University Hospitals by forming a Joint Transitional Executive Management Team.

The Department of Health and Social Care is regarded as a related party. During the year Cumbria Partnership NHS Foundation Trust has had a significant number of material transactions with entities for which the Department of Health and Social Care is regarded as the parent department. These entities are:

	2017/18 Income £000	2017/18 Expenditure £000
NHS England	14,071	11
North Cumbria Clinical Commissioning Group	96,064	-
Morecambe Bay Clinical Commissioning Group	49,894	18
North Cumbria University Hospitals NHS Trust	2,961	2,978
University Hospitals of Morecambe Bay NHS Foundation Trust	697	5,698
Health Education England	2,916	41
Cumbria Partnership NHS Trust Charitable Fund	16	-

All income and expenditure with related parties occurs from the normal course of trading.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with the Pensions Agency, HM Revenue and Customs, and Cumbria County Council.

23. Losses and Special Payments

	31 March 2018		31 March 2017	
	Number of cases	**Value of cases £000**	Number of cases	Value of cases £000
Stores losses and damage to property	**1**	**4**	-	-
Bad debts losses	**-**	**-**	28	2
Ex gratia payments	**7**	**2**	6	1
Compensation payments	**-**	**-**	3	1
Total	**8**	**6**	37	4

The above are reported on an accruals basis and there were no cases of loss in excess of £300k in 2017/18 or 2016/17.

24. Events After the Reporting Period

On the 1 April 2018 some Community Services in the south of the county transferred to University Hospitals of Morecambe Bay. This transfer represents a reduction in the Trust income for 2018/19 of £22.7m.