Cumbria Partnership NHS Foundation Trust

Annual Report and Accounts

2018/19

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

Annual Report, Quality Report and Supplementary Material 2018/19

Contents

Chair and Chief Executive Welcome

2018 was a special year for the NHS as it turned 70 years old on 5 July. To mark the occasion, we held a variety of celebrations looking back at how the NHS and its staff has saved and transformed so many lives.

We also looked to the future, which is very much centred on much closer working between health and care partners. During 2018/19, we are pleased to say that our work to integrate our services made great strides. In May 2018, the North Cumbria Health and Care System was confirmed by NHS England as part of the next wave of Integrated Care Systems (ICS), putting our area at the forefront of national policy. This has given us the green light to further integrate health and care services across organisational boundaries, making it easier for teams to work together for the benefit of patients and communities.

One of the ways we are working to join up health and adult social care services in north Cumbria is in the development of eight Integrated Care Communities (ICCs) to enable closer working, help people to stay well and provide more out of hospital care. The first phase of ICCs aimed to increase the capacity of community teams to keep more people at home and support people to leave hospital sooner. This has already had a significant impact with hundreds of people avoiding a hospital stay.

As part of our system working, we have also been progressing the merger with North Cumbria University Hospitals NHS Trust (NCUH) which is set to take place in October 2019. We are already working as a joint Board across the two organisations and our teams are working closely together so this next step feels like a natural progression. As part of the joint Board, Professor Robin Talbot is now joint Chair of both Trusts.

At the same time, there has been a significant amount of work to address the future of mental health, learning disability and Child and Adolescent Mental Health Services (CAMHS). In line with commissioning intentions and in order to improve the quality of services delivered to patients in Cumbria, the Board of Directors agreed in December 2018, that transferring services in north Cumbria to Northumberland, Tyne & Wear NHS Foundation Trust (NTW), who are rated as outstanding by the CQC, would provide the best outcome for patients in the long term.

The process in south Cumbria concluded shortly after the year end in April 2019 when it was agreed that services in south Cumbria would transfer to Lancashire Care NHS Foundation Trust (LCFT). The Trust worked with Morecambe Bay Clinical Commissioning Group and regional and national bodies to put in place an improvement plan with the support of Northumberland, Tyne and Wear NHS Foundation Trust (NTW), to ensure that critical areas such as CAMHS are fully supported, and to provide a clear road map for services to be transformed in south Cumbria and across the whole of the Lancashire and South Cumbria Integrated Care System footprint. All of the organisations are now working

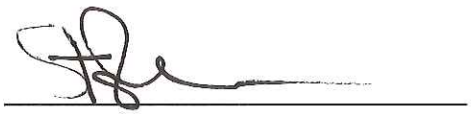
together, in the best interest of patients and staff, to ensure that the transfer can be undertaken safely and effectively for 1st October 2019.

Looking ahead to 2019/20, it will be another busy year with some big landmarks with this work and the merger in October which will result in the beginning of a new organisation, which will be the platform for the North Cumbria Integrated Health & Care System.

It's important to note that although mental health services will be transferred to other regional providers, services and staff will very much be a big part of the respective systems. Additionally, we will still be a provider of services on countywide footprint, with a range of specialist and children's services in south Cumbria - we need to support and champion our services in the south Cumbria system which will remain a priority.

Throughout the course of the year, we have been fortunate to have the input of our staff, governors and staff representatives and have heard their voice clearly on a number of change projects which has helped us conclude the arrangements for the future of mental health services in Cumbria. We look forward to that continuing and working alongside our fantastic staff and we would like to pay tribute to them for their continued hard work and commitment – thank you.

Professor Robin Talbot
Chair
23 May 2019



Professor Stephen Eames
Chief Executive
23 May 2019

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.

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. You can find out more about the Trust, its services and how to contact us on the Trust's website: www.cumbriapartnership.nhs.uk

Over the last year we have continued on our journey to system working across North Cumbria, this year, work has included a significant programme of development in terms of joint ways of working between our Trust and North Cumbria University Hospital NHS Trust (NCUH), whilst also recognising the statutory duties of both Trusts as separate legal entities. This work has included the development of joint meetings, policies and procedures. Further development of joint ways of working across the both Trusts, prior to the merger in October 2019, now feed in to the system governance arrangements.

We continue to work with partner organisations to ensure high quality mental health provision across Cumbria and as such mental health, learning disability and CAMHS services within south Cumbria will be transferring to Lancashire Care NHS Foundation Trust (LCFT) and those services in north Cumbria to transfer to Northumberland, Tyne & Wear NHS Foundation Trust (NTW) on 1 October 2019.

In March 2019 we officially launched our brand new set of values shared across both Trusts and NHS North Cumbria Clinical Commissioning Group which are:

Kindness - Kindness and compassion cost nothing, yet accomplish a great deal

Respect - We are respectful to everyone and are open, honest and fair - respect behaviours

Ambition - We set goals to achieve the best for our patients, teams, organisation and our partners

Collaboration - We are stronger and better working together with and for our patients

We are currently focusing on ways in which these values can become more embedded into practice; activities to support this include the review of appraisal documentation to ensure the values are built into discussions with members of staff.

We want to build a new integrated health and care system together, using our collective capabilities for a healthier and happier population and we are committed to the four long term goals we have agreed jointly with our system partners:

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 Care Groups as follows:

- Integrated Families (intergrated with North Cumbria University Hospitals Trust women's and childrens services)
  - Children's Community Nursing
  - Health Visiting
  - Public Health and Wellbeing Nurses
  - Allied health professions such as physiotherapy and speech and language therapy
  - Children Looked After
  - Community Paediatrics
  - Children's Audiology

- Mental Health
  - Adult Mental Health
  - Childrens Mental Health (CAMHS
  - Adult Learning Disability Nursing
  - Childrens Learning Disability Nursing
  - Autism

- Community and Specialist
  - Community Nursing (e.g. District Nursing)
  - Community Hospitals

- Allied health professions such as physiotherapy and podiatry
- Community Dentistry
- Palliative Care
- Neurology
- Physical Health Psychology
- Sexual Health
- Acquired Brain Injury Team

Over recent years we have undertaken an annual self-assessment against NHS Improvement's (NHSI) Well Led Framework which informs our evaluation of our quality governance arrangements. In Quarter 3 we commissioned a peer-review against NHSI's Well Led framework, led by Northumberland Tyne and Wear Foundation Trust, which was undertaken between October 2018 and February 2019. The next external review of our quality governance arrangements will take place during 2020. Delivery of improvement actions has been monitored through relevant governance forums and with board level oversight. Further details can be found in the Annual Governance Statement and in the Quality Report.

Key risks and associated controls

Key risks to the delivery of our objectives and associated controls are set out in our Board Assurance Framework (BAF). The BAF is reviewed on a quarterly basis, with the framing of top strategic risks being reviewed on at least an annual basis, usually during quarter 3. Details of the key risks can be found in the Annual Governance Statement.

Significant operational and clinical risks

Risks are identified, managed and monitored through our governance frameworks, in accordance with the Risk Management Policy and the aligned performance framework. 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 enables a line of sight to risk management performance at all levels throughout the Trust. Examples of significant operational and clinical risks affecting us can be found in the Annual Governance Statement.

Statement on going concern

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 2019/20 plan includes receipts of Department of Health and Social Care revenue support loans of £4.8m, the Trust also has £1.3m of revenue support loans due for repayment during 2019/20. The Directors consider it reasonable to expect cash support to be available and for the Trust to continue to be able to meet its liabilities as they fall due.

The Directors recognise the significant level of risk within the 2019/20 plan, in particular, the level of internal and system CIP's needed to achieve the control total. The Trust is working to merge with North Cumbria University Hospitals NHS Trust and is also going to divest its mental health services to Lancashire Care NHS Foundation Trust and

Northumberland, Tyne and Wear NHS Foundation Trust. The Trust is working with North Cumbria CCG, key local partners, 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.

Performance Analysis

Measuring performance

We measure our 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 (SOF), and also metrics that enable us to monitor our quality governance. This report is now in a joint performance report monitoring the performance of the NCUH and CPFT in a developing System aligned report. Performance is monitored and managed through the Joint Trust Management Board and overseen by the Board Committee, Finance Investment and Performance Committee.

We measure our performance against against the core CQC domains of responsive, caring, effective, safe and well led. These are included across the core SOF domains and across the operating plan objectives.

Performance during 2018/19

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

NHS Improvement's Single Oversight Framework (SOF) targets

	Measure	National Standard	Latest National average YTD (to Feb-19)	Trust actuals 15/16	16/17	17/18	18/19	RAG comparisons: Compared to National standard	Compared to National average	Compared to 15/16	Compared to 16/17	Compared to 17/18
A&E	% of patients who waits 4 hours in A&E (Type 3 only)	95%	98.9%*	97.8%	97.0%	95.3%	**99.9%**					
IAPT	Recovery Rate	50%	50.7%	53.5%	53.7%	55.1%	**54.4%**					
	People with common mental health conditions referred to the programme will be treated within 6 weeks of	75%	89.4%	58.9%	73.6%	72.3%	**99.7%**					
	People with common mental health conditions referred to the programme will be treated within 18 weeks of	95%	98.7%	99.0%	99.2%	99.7%	**100.0%**					
Waiting times	% of patients treated within 18 weeks from Referral to Treatment	92%	87.0%	86.0%	97.2%	90.8%	**96.3%**					
	% of patients receiving a diagnostic test within 6 weeks of referral	99%	97.7%	98.5%	100.0%	100.0%	**100.0%**					
EIP	People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of	50%	76.70%	55.60%	76.20%	68.4%	**69.2%**					
CYPMH	Improving Access to CYPMH	32%	30.5%**	N/ap	N/ap	21.3%	**23.1%**			**N/ap**	**N/ap**	

*National average Mar-19 **National average 17/18

Comparisons key:	
Significantly worse than	
Slightly worse than (within 2%)	
Same as or better than	

We have informed our Regulators and Commissioners 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 Care Group Boards which are as a sub group of the Clinical Management Group, and are closely monitored at Board level through the Finance Investment and Performance Committee.

Workforce performance

Recruitment and the use of temporary staff

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. Throughout the year we have worked collaboratively with North Cumbria University Hospitals NHS Trust (NCUH) on a number of attraction initiatives. Examples include:

- Attendance at various national recruitment fayres with partners including attendance at the British Medical Journal careers fair, 20 + university nursing events and a number of nurse job fairs including various Health Service Journal events

- Local recruitment events
- Use of social media to promote specialist vacancies
- International recruitment for clinical posts (including successful trips to Poland for nurses and India for doctors)
- On-site Collaborative Nurse/Midwife and Paramedic Recruitment Days, held in conjunction with the North West Ambulance Service NHS Trust and University of Cumbria.
- Joint BMJ Adverts

We have 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 temporary recruitment agencies.

Since April 2018 our recruitment agency spend and management has been managed by the NCUH in-house team. This team's work has been recognised by NHSI who described the team's work as a 'national exemplar' and the team has recently been nominated for a HPMA award.

During 2018/19 we have delivered agency spend savings of £616k, with NCUH delivering a saving of £2.32 million. Although saving money and delivering efficiencies is a priority processes are committed to patient safety improvements and the team has worked closely with NHS Counter-Fraud to advise on reference and time-sheeting security.

The booking of agency workers is now linked to the requirement to action permenant or fixed term recruitment to ensure that the most cost-effective staffing solution is identified.

Sickness absence

Sickness absence is reported at Board level on a monthly basis. Our sickness absence level has been above our internal target level of 4% throughout the year. Sickness absence rates are 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. We have an Attendance Management policy and a number of programmes in place to support staff.

Staff survey

The response rate for the 2018 NHS staff survey was high, 49% compared to a national average of 41%. The results from the Staff Survey show that staff engagement is the same as similar Trusts (7.0); staff recommendation of the Trust as a place to receive treatment is slightly higher than average (66.4%) and recommendation as a place to work is lower than average (57.9%). 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 our mandatory training programmes is managed and monitored by the Board and sub-Committees. We set ourselves a target of achieving 85% 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 85% target consistenly month on month with compliance increasing from a rate of 85.9% in April 18 to 90.9% at the end of February 19.

Appraisals
We have a values based approach to appraisal's supported through training for managers which aims to ensure:

- 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

We have an appraisal window which links with the business planning cycle to ensure objectives are aligned to our priorities and staff can understand how they are contributing. We increased our targets for all staff to have an appraisal within the last 12 months from 80% to 85% and achieved 82% in year.

Delivery of 2018/19 Annual Business Plan
Our 2018/19 Annual Business Plan, which was developed in accordance with NHS Improvement's requirements was produced as a joint plan with North Cumbria University Hospitals NHS Trust. The Board received quarterly updates on delivery against 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 our direct control, and will continue into the next financial year. Performance against the 2018/18 plan is summarised as follows:

Care Group / Support Service	Red	Amber	Green/ Complete	Not Started / no milestones to complete	Grand total
Children and Families	0	2	2	1	**5**
Community	1	3	3	0	**7**
Medicine	0	3	0	6	**9**
Mental Health Care Group	0	1	2	0	**3**
Surgery	0	2	1	0	**3**
Support Services	1	4	8	0	**13**
Grand total	2	15	16	7	**40**

Financial performance

The financial climate continued to be challenging during 2018/19. Our net deficit for the year (excluding impairments, donation and transfer by absorption) was £5.0m against a control total of £2.1m, this was as a result of an adjustment made under the local risk sharing arrangement of £5.4m. Before making this adjustment we would have achieved a surplus of £2.5m.

The financial challenge will continue during 2019/20 and for the foreseeable future. This is common to all health and social care partners. We have accepted NHSI's control total for 2019/20 and plan to incur an income and expenditure breakeven position.

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 we have 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 we are able to stabilise our financial position.

A summary of 2018/19 actual and 2019/20 plan is set out below.

£ million	**2018/19 Actual**	**2019/20 Plan**
Income & expenditure		
Income	160.4	165.5
Operating expenditure	165.6	163.3
EBITDA	**(5.2)**	**2.2**
Depreciation, dividend & interest	1.8	2.2
Net surplus/(deficit) before exceptional items	**(7.0)**	**0.0**
Exceptional items	0.6	0.0
Net surplus/(deficit)	**(7.6)**	**0.0**
Capital expenditure	7.0	5.5
Closing cash balance	7.2	3.2
Revenue support loan balance	4.1	8.9

Details of our financial performance for 2018/19 are set out in the annual accounts that accompany this Annual Report.

Environmental considerations

We are 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. We have 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 2018/19 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 performance management reporting framework.

Significant events since the end of the financial year

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

Overseas operations

We do not have any overseas operations.

Signed..... Date: 23 May 2019

Prof. Stephen Eames

Chief Executive for CPFT and NCUH

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: 23 May 2019

Prof. Stephen Eames
Chief Executive for CPFT and NCUHT

Directors' Report

NHS Improvement's Well-Led Framework

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 we are 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.

Our business 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 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 2018/19 in the Annual Governance Statement.

The balance between Executive and Non-Executive Directors on the Board remains in line with the Code of Governance for NHS Foundation Trusts and with our 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 2019 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 2018/19. 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 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 our Standing Orders and the 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 & Risk (A&R) Committee
- 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 our performance, business model and strategy.

As part of the evolution of the North Cumbria Integrated Health and Care System, all Executive Directors have responsibility for both the Trust and NCUH. During the year three of our seven Non-Executive Directors (NEDs) held appointments in both Trusts. In April 2019 a joint Chair was appointed to both Trusts, taking the current number of NEDs with responsibilities for both Trusts to four. Formal confirmation has been received from NHSI that 'cross-directorships' do not compromise independence as conflicts should be minimal as the interests of the two Trusts should in most cases align. All NEDs are therefore considered to be independent in character and judgement and have no other 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 'joint' NED appointments. 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. You can find out more about our collaborative working with NCUH 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 our website https://www.cumbriapartnership.nhs.uk/the-trust/publications/declarations-of-interest

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 is responsible for ensuring that NEDs have the necessary skill set and experience. 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's 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 NEDs is 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 and their remuneration can be found in the Remuneration Report. The appointment of a NED may be terminated in line with guidance issued by our regulator NHSI. The accounting policies for pensions and other retirement benefits are set out in note 1.8 to the accounts.

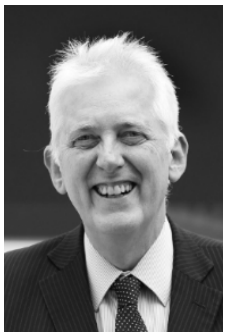
Table 3.1 Board of Directors and attendance at Board and Governors Council General meetings 1 April 2018 – 31 March 2019

Name	**Attendance – Board of Director meetings (max 10) (actual/potential)**	**Attendance* – Governors Council General meetings (max 6) (actual/potential)**
Current Non-Executive Directors		
Prof. Robin Talbot, PhD, BA, Cert Ed	11/12	6/6
Alan Moore, BSc (Hons), CEng, MIMechE, MBA, FAPM	10/12	2/6
Heike Horsburgh, MBE	8/12	6/6
Brian Hetherington BSc(Hons) MSc MBA(Comm) CEng FIMechE DipIM FCMI MIoD	9/12	3/6
Dr Louise Nelson PhD	11/12	4/6
George Liston	8/8	2/4
Malcolm Cook	8/8	4/4
Prof. Stephen Eames	11/12	4/6
Prof. John Howarth MBBS, DTM&H, FRCGP, FFPH	11/12	2/6
Michael Smillie, BSc (Hons), FCPFA	11/12	2/6
Alison Smith	5/8	1/4
Mandy Nagra	8/9	1/4
Judith Toland	5/5	0/2
Gary O'Hare	5/9	n/a
Ramona Duguid	1/1	n/a
Other Executive Directors in post during 2018/19		
Dr Andrew Brittlebank MBBS, MA, FRCPsych	6/8	0/4
Rod Harpin	4/4	0/2
Esther Kirby	3/4	1/2
Helen Ray	3/3	0/2
Clare Parker	1/1	

* There is not a requirement for Board members to attend the Governors Council meetings. However there is an open invitation. 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



Prof. Robin Talbot PhD, BA, Cert Ed
Chair

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, and a member of Independent Monitoring Board for HM Prisons. He also chairs the Health and Education Co-operative (a social enterprise hosting/producing online learning materials for universities and the Health Service).

Robin is Chair of the Board of Directors and member of the North Cumbria Health & Care System Leadership Board.

Heike Horsburgh MBE
Non-Executive Director/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's qualifications include; MSc International Development, MSc Human Resource Management, Diploma Community Education.

Heike is Vice Chair and the Senior Independent Director. Heike is a member of the Finance, Investment & Performance Committee, Audit and Risk Committee and North Cumbria Health & Care System Leadership Board. In addition, Heike is Chair of the Charitable Funds Committee.

Alan Moore BSc (Hons) C.Eng, 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 also a member of the Executive Board of the Defence Safety Authority.

Alan is Chair of the Finance, Investment & Performance Committee and a member of Audit & Risk Committee.

Brian Hetherington BSc(Hons) MSc MBA(Comm) CEng FIMechE DipIM FCMI MIoD

Non-Executive Director

Brian has recently retired after being employed at BAE SYSTEMS, and its predecessor companies, in Barrow, for forty two years, where latterly he was Head of Engineering Capability. In addition to his BAE role, Brian was a Non-Executive Director of the University of Cumbria for 6 years, Chairman of Cumbria Business Education Consortium for 11 years, Non-Executive Director of Morecambe Bay NHS PCT for 4 years, Director of Young Enterprise North West and Chairman of Cumbria Young Enterprise for 6 years, and Member of the Management Board of the Marine Technology Education Consortium for 14 years. He is currently a Member of the Common Purpose Advisory Board for Cumbria and a Governance & Compliance Consultant for a firm of Independent Financial Advisers.

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 member of the Quality & Safety Committee.

Louise Nelson PhD

Non-Executive Director

Dr Louise Nelson completed training as a mental health nurse in 1987, Louise completed an MBA whilst working as a Senior manager in the NHS and has since 2005 worked in higher education as a senior lecturer/programme leader for mental health nursing, a principal lecturer and, currently as Head of Nursing, Health and Professional Practice with the University of Cumbria. Louise obtained her PhD in 2014, based on Service users experiences of Mental Health Services and in 2018 completed a qualification as an Executive Coach.

Louise is involved in education-focused meetings with all local provider trusts in Cumbria and a Non-Executive Director at North Cumbria University Hospitals NHS Trust.
Louise is Chair of the Quality & Safety Committee.

George Liston
Non-Executive Director
George served in the Royal Air Force for over 30 years and travelled all over the world as an engineer officer. He retired from the Royal Air Force in January 2015 and is currently President and Chair of the Scottish Fencing Ltd. George is a Non-executive Director at North Cumbria University Hospitals NHS Trust since July 2015. George is a member of the NCUH Audit and Risk Committee.

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George is a member of the Finance, Investment & Performance Committee and Quality & Safety Committee.

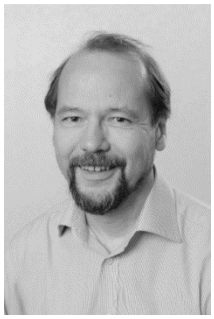
Malcolm Cook
Non-Executive Director
Malcolm has significant business experience having worked 26 years within British Telecom in a variety of roles including Head of Service Excellence and Customer Research. More recently Malcolm was responsible for negotiating the largest HR outsource contract ever which received worldwide recognition and a World Class Leader award.
Malcolm has significant experience in the NHS as Vice Chair and Non-Executive Director of NHS County Durham between 2007- 2013 and since 2013 as Vice Chair and Non-Executive Director of North Cumbria University Hospitals NHS Trust. Malcolm is Chair of NCUH Charitable Funds Committee and Chair of NCUH Finance Investment and Performance Committee. Malcolm has a Law Degree from Northumbria University.

Malcolm is a member of the Finance, Investment & Performance Committee and North Cumbria Health & Care System Leadership Board.

EXECUTIVE DIRECTORS

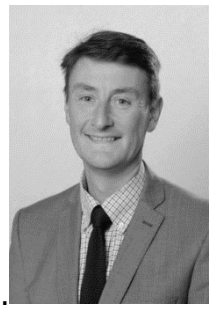
Professor Stephen Eames
Chief Executive

Stephen was appointed in September 2017.
Stephen is a 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. Degree in Professional Coaching Practice from Middlesex University.



Professor John Howarth MBBS, DTM&H, FRCGP, FFPH
Deputy CEO for NCIHT and CPFT / System Clinical Lead / Professor of Primary Care UCLAN

John's post covers Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust.
John was a GP in Cockermouth for 24 years. He was Clinical Director for community services and elderly care lead for NHS Cumbria. Prior to this he spent 7 years as medical director of Cumbria's GP out of hours cooperative, chaired the primary care research group and was a GP trainer for over 10 years. He was medical adviser to the local hospice at home charity and co-authored a textbook in Palliative Care.
During the 1990s he trained in tropical medicine and worked in 11 different wars and natural disasters. He became medical director and head of operations of an international disaster relief charity. In 2010 he was a runner up in the national NHS Leadership Awards from over 1000 entries. In 2011 he received a Fellowship in Public Health through distinction and in 2013 he received a Fellowship to the Royal College of General Practitioners.



Michael Smillie BSc (Hons) FCPFA
Executive Director of Finance & Estates
Michael's role covers Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust.
Michael joined the Trust in January 2007 and has over 25 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 in England. Michael is passionate about ensuring high quality services are delivered in the most effective way and that leadership of our health and care system demonstrates the courage and ambition that matches the vitality and needs of our communities.
Michael grew up and now 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 and facilities are all fit for purpose and developed to support clinical care effectively.

Alison Smith
System Executive Chief Nurse
Alison's post covers North Cumbria University Hospitals NHS Trust and Cumbria Partnership NHS Foundation Trust.
Alison has been a registered nurse for 34 years and has worked in a variety of clinical, managerial and educational roles. Alison worked at South Tees Hospitals NHS Foundation Trust for a significant part of her career including as assistant director of nursing and children's lead. After leaving South Tees, Alison then spent the next five years working in wider health system roles as deputy director of nursing & quality at NHS England for the North East & Cumbria then as senior clinical lead at NHS Improvement, taking the lead role for the quality agenda.
In both of her roles with NHS England and NHS Improvement, Alison has worked closely with colleagues in the NHS in Cumbria.

Mandy Nagra
System Executive Chief Operating Officer
Mandy was previously the delivery & improvement lead for NHS Improvement (NHSI) in Cumbria and the North East. She has been instrumental in improving patient flow across the system and embedding the first phase of integrated care communities.
Prior to joining the Trust Mandy worked in the health and social care system for 24 years in a range of roles including clinical and managerial experience both nationally and regionally. She brings a vast amount of experience from her work with NHS Improvement and NHS England where a key part of her role was to support north Cumbria.

Gary O'Hare

Interim Executive Director of Mental Health & Learning Disabilities

Gary is a Mental Health Nurse and is currently the Interim Executive Director of Mental Health and Learning Disabilities at Cumbria Partnership NHS Foundation Trust on a part time basis. He is also Executive Director of Nursing and Chief Operating Officer at Northumberland, Tyne and Wear NHS Foundation Trust.

Gary has worked in the NHS for over 36 years, and held a number of senior nursing and managerial positions during this time. He has been an Executive Director of Nursing and Safer Care at Northumberland, Tyne & Wear for 16 years and for the last 10 years he has also been the Trust's Chief Operating Officer. He has been involved in two complex mergers and led Operational Services through the Trust's CQC Comprehensive Inspection, achieving a rating of "outstanding".

Gary spent four years at the Department of Health advising ministers and senior civil servants, working across both the policy and delivery arms of the DoH as well as working for the National Patient Safety Agency. He led a number of national initiatives during his time in this role.

He is a CQC Executive Reviewer for Well Led Inspections, a member of the National Mental Health Nurse Directors Steering Group and a member of the NHSI Clinical Reference Group.

Judith Toland

Executive Director of Workforce & Organisational Development

Judith joined in November 2018 and her post covers North Cumbria University Hospitals NHS Trust, Cumbria Partnership NHS Foundation Trust and the wider North Cumbria Health and Care system.

She has extensive experience in human resources, organisational development and transformation projects in a number of sectors including health, education and

private sector. Some of her previous posts include Director of Business Transformation at Durham University, Change Director/Director of Operations at the Independent Parliamentary Standards Agency and a Business Change Consultant at British Airways.

Dr Vincent (Vince) Connolly
System Medical Director
Dr Vincent Connolly, System Executive Medical Director, North Cumbria Integrated Health & Care System, 1 April 2019, on secondment pending substantive appointment & Acute Physician at the James Cook University Hospital, Middlesbrough.

Medical Director North, NHS Improvement 2016-2019;President of the British Association of Ambulatory Emergency Care. Dr Connolly is currently Regional Medical Director (North) NHS Improvement. Vince completed a doctorate on the Impact of social deprivation on diabetes, cardiovascular risk & mortality. He has published papers on diabetes epidemiology & ambulatory emergency care. Medical Director, Emergency Care Improvement Programme. Clinical Lead for the Emergency Care Intensive Support Team since 2010, was a Clinical Advisor to the Ambulatory Emergency Care Delivery Network. Chair of the North East SHA, Clinical Innovation Team for Acute Care.
Dr Connolly was a recipient of the Hospital Doctor Acute Medicine Team of the Year Award 2004.

Ramona Duguid
System Executive Director of Strategy
Ramona Duguid was previously Director of Integration for the Trust and NCUH and has played a key role in establishing north Cumbria as one of the 14 nationally recognised systems for leading integration. Ramona has worked in a range of roles across the NHS over the last 20 years, including leading improvements in

governance and quality within the acute sector in north Cumbria as part of the special measures process.
Ramona was born in Cumbria and still lives in the county she is passionate about helping to improve and develop our health and care services, with our partners for the communities we serve.

Income

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.

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

Political or charitable donations

We have not made any political or charitable donations during 2018/19.

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 we have built upon the work described in previous years' annual reports to improve and integrate our governance arrangements with NCUH. This has included refreshing our meetings structures and further developing our quality and safety dashboards so that our managers have access to virtually real-time risk and safety related information which aids effective clinical and quality governance.

Our 2018/19 self-assessment against the Well Led framework commenced March 2019 and is due to be approved by the Board in June 2019. During the year a Well Led 'peer

review' by Northumberland, Tyne & Wear NHS Foundation Trust (NTW) also took place. We are currently working on implementing recommendations from that review. Delivery of improvement actions will be monitored through relevant governance forums, with board level oversight of many actions through the Quality and Safety Committee and Finance Investment and Performance Committee. Further details on how whad regard for NHSI's Well Led framework can be found in the Annual Governance Statement.

2018/19 is 'year 3' of the 3-year well led review cycle agreed by Board in 2016 during which an external well led assessment was to be undertaken. The Well Led Peer review by NTW partially addresses this, however a full external review is required. This is expected will take place later in 2019/20.

The 2018/19 internal audit programme considered aspects of quality governance such as risk management, board assurance framework, governance framework, policy management and safety alerts, all of which are intrinsic to the well led framework. Progress with improvement actions identified from audits are monitored by the Audit and Risk Committee.

During 2018/19, as part of alignment and integration with NCUH a joint performance management framework was introduced. Throughout 2018/19 the Board received quarterly updates on progress against the 2018/19 annual business plan, which was a joint plan with NCUH. The Board also received integrated performance reports on a monthly basis, which compared and analysed information relating workforce, finance and quality. Further details on how the performance management framework and our performance during the year can be found in the Performance Report.

Throughout the year we have reported compliance against NHSI's SOF in accordance with NHSI's reporting requirements. There have been no exceptions to report during the year. We meet with NHSI on a quarterly basis to review performance and quality. 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 2018/19 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 Report.

The Board agreed the 2017/18 annual report, including annual accounts and quality report at its meeting in May 2018. The 2017/18 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 2018.

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 CQC's reports.

In November 2017 we underwent a formal Well Led inspection by the CQC. 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 we were rated as Requiring Improvement. Immediately following the inspection we 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 received regular updates on progress against these actions throughout the year. The CQC will be undertaking their next Well Led inspection of the Trust in June 2019. 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 and integrated system-wide care

We are a partner in the two major transformation programmes covering the Cumbria geographical footprint: Better Care Together in the south of the county; and the North Cumbria Integrated Health and Care System (IHCS). Throughout 2018/19 we have worked with our partners on the development of plans for the Cumbria health economy.

As part of plans developed during 2016/17 and 2017/18, on 1 April 2018 some of our community-based services operating in south Cumbria transferred to University Hospitals Morecambe Bay NHS Foundation Trust.

In collaboration with our system partners and communities, Integrated Care Communities (ICCs) were introduced in Quarter 2 of 2018/19. ICCs 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. The ICCs have delivered benefits in removing or reducing the number of overnight beds in some of our community hospitals and avoiding admissions to hospital enabling improved and different ways for patients to be cared for at home. Through the ICCs, and in collaboration with local Alliance groups, we have implemented changes to services delivered from our community hospitals, reducing or removing inpatient beds in accordance with decisions made by North Cumbria Clinical Commissioning Group in April 2018 following public consultation.

During the latter part of Quarter 4 of 2017/18 our commissioners confirmed changes would be needed to our countywide mental health, learning disability and children and adolescent mental health services, which are to be delivered into the IHCSs covering north and south Cumbria. Throughout 2018/19 we have worked with our commissioners to improve the quality of these services and to ensure these changes happen safely and in the best interests of patients and staff. From 1 October 2019 these services in north Cumbria will

be delivered by Northumberland Tyne and Wear NHS Foundation Trust and these services in south Cumbria will be delivered by Lancashire Care NHS Foundation Trust. Following these changes we will continue to deliver some services countywide, such as children's services, neurology and dental services.

As referred to earlier, all Executive Directors and four Non-Executive Directors hold posts and have responsibilities across both CPFT and NCUH. 2018/19 has seen the alignment and integration of governance arrangements and of many clinical and support services across both Trusts. 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 for us as a Foundation Trust and NCUH as an NHS Trust.

To further cement our integrated working, in February 2019 the Organisational Form Transaction strategic case was approved by NHSI for both Trusts to merge into a single organisation. At the time of writing the Full Business Case for this transaction (which technically is an acquisition of NCUH by CPFT) is under preparation and is due to be formally agreed by the Board and submitted to NHSI by the end of June 2019. Engagement on the name of the new Trust has taken place with our staff, members, governors, key stakeholders and the public. Subject to formal approvals from NHS Improvement, it is expected that the new Trust will be authorised as from 1 October 2019. The name of the Trust will be confirmed as part of the authorisation process.

We have worked with the Governors Council to consider the impacts of the merger and transfer of mental health, learning disability and children and adolescent mental health services on our Constitution and composition of the Governors Council. Proposals have been agreed by Governors Council and are due to be approved by the Board in May 2019. Changes will take effect upon authorisation of the new Trust.

We are a key partner in the System Leadership Board (SLB), working with system partners to develop and implement strategic transformation plans across the North Cumbria IHCS. Our Executive and Non-Executive Directors represent us at SLB meetings, although strategic decisions continue to require approval by our Board. Consultation has begun on developing a system-wide clinical strategy, on which 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 meetings to ensure that the patient voice is at the heart of everything we do.

Creating local partnerships

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

have also engaged with, and provided regular updates to, the Local Authority's Health Scrutiny Committee on merger plans and transfer of mental health, learning disabilities and children and adolescent mental health services.

Statement as to Disclosure to auditors (s418)
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 disclosures required by Section 43(2A) of the NHS Act 2006

Provision of goods and services for the purposes of the health service in England
During 2018/19, 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 1.0% of total income in 2018/19 (0.46% 2017/18) 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 we have 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.

Remuneration Report

Section One – Annual statement on remuneration

The purpose of the Board's Remuneration Committee 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 our Trust and North Cumbria University Hospitals NHS Trust (NCUH). We are working closely together and are currently exploring options to join the organisations together formally in order to further improve our long term aims of integrated working across the communities we serve.

The changes within the Executive team over the past year are outlined below:

Role	Change
Michael Smillie Executive Director of Finance & Estates	Moved from a role with CPFT only into a joint role across CPFT and NCUH on 18 April 2018.
Esther Kirby Executive Director of Nursing	Esther joined as interim joint Executive Director of Nursing on the 18 April 2018, she left on 31 July 2018.
Clare Parker Executive Director of Nursing	Clare left the Trust on the 20 May 2018.
Helen Ray Executive Chief Operating Officer	Helen left the Trust on the 15 July 2018.
Alison Smith System Executive Chief Nurse	Alison joined the Trust on 3 September 2018. This was a joint appointment across CPFT & NCUH.
Mandy Nagra System Executive Chief Operating Officer	Mandy joined the Trust on 1 July 2018.
Dr Rod Harpin Executive Medical Director	Rod, previously the Medical Director for NCUH, took up the role as interim Joint Medical Director in December 2018. He stood down from this role on 31 March 2019.
Dr Andrew Brittlebank Executive Medical Director	Andy stood down as Medical Director in December 2018.

Mrs Judith Toland System Executive Director of People & Digital	Judith joined the Trust on 5 November 2018. This was a joint appointment across CPFT & NCUH.

Changes to Executive Directors' Remuneration

There were no changes to Executive remuneration in 2018/19.

Non-Executive Directors

The changes within the Non-Executive team over the past year are outlined below:

Role	Change
George Liston	Appointed as Non Executive Director to CPFT in addition to his NED role at NCUH on 1 August 2018.
Malcolm Cook	Appointed as Non Executive Director to CPFT in addition to his NED role at NCUH on 1 August 2018.

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 2018/19.

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 & Risk 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**
Professor Stephen Eames Joint Chief Executive	Appointed 1 September 2017	Secondment	3 months	3 months
Dr Andrew Brittlebank Medical Director	Appointed 14 July 2014. He stood down from his role in December 2018.	Permanent	3 months	3 months
Dr Rod Harpin Interim Executive Medical Director	Appointed into interim joint role December 2018. He stood down from this role on 31 March 2019.	Permanent	3 months	3 months
Michael Smillie Executive Director of Finance & Estates	Appointed January 2007	Permanent	6 months	3 months
Professor John Howarth Deputy CEO / System Clinical Lead	Appointed January 2012. Appointed to current role of Joint Deputy Chief Executive across both Trusts from 1 September 2017.	Permanent	3 months	3 months
Judith Toland System Executive Director of People & Digital	Appointed 5 November 2018	Permanent	3 months	3 months
Mandy Nagra System Executive Chief Operating Officer	Appointed into Interim position on 1 July 2018 then appointed into permanent Executive System Chief Operating Officer in March 2019.	Permanent	3 months	3 months
Alison Smith System Executive Chief Nurse	Appointed on 3 September 2018.	Permanent	3 months	3 months

Executive Directors				
Name	**Date of appointment or departure**	**Contract**	**Notice Period from Trust**	**Notice period from individual**
Gary O'Hare Interim Executive Director of Mental Health & Learning Disabilities	Appointed on a secondment basis on 23 July 2018	Seconded	Secondment ends October 2019	Secondment ends October 2019
Ramona Duguid System Executive Director of Strategy	Appointed in March 2019	Permanent	3 months	3 months

Non-Executive Directors and Chair		
	Date Term of Office Commenced	**Date term of Office Ends/Ended**
Professor Robin Talbot (Chair)	September 2017	March 2021
Heike Horsburgh	February 2013	January 2020
Alan Moore	December 2014	November 2019
Brian Hetherington	February 2017	January 2020
Dr Louise Nelson	March 2018	February 2020
Mr Malcolm Cook	August 2018	July 2020
Mr George Liston	August 2018	July 2020

Remuneration Committee

The Remuneration Committee operates in accordance with documented Terms of Reference, as a subCommittee to the Board. This is chaired by the Trust's Chair 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 2018/19

There were a total of 9 meetings held.

Name	Position (e.g. Chair, Deputy Chair, member or other)	Committee Attendance - (total of 9 meetings held during 2018/19)
Remuneration Committee members		
Professor Robin Talbot	Chair (Joint)	9
Ms Heike Horsburgh	Vice Chair and Senior Independent Director	7
Mr Alan Moore	Non Executive Director	8
Mr Brian Hetherington	Non Executive Director	8
Ms Louise Nelson	Non Executive Director (Joint)	9
Mr Malcolm Cook	Non Executive Director	7
Mr George Liston	Non Executive Director (Joint)	7

In attendance (Executive Directors and Senior Managers)		Committee Attendance (based on requirement)
Daniel Scheffer	Associate Director for Corporate Governance/Joint Company Secretary	9

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

	Total Number		**Number claiming expenses**		**2017/18**	**2018/19**
	2017/18	**2018/19**	**2017/18**	**2018/19**	**£00s**	**£00s**
Non Executive Directors	9	7	7	5	120	11
Executive Directors	8	9	4	5	43	4
Governors	47	36	23	19	81	6

The information below is subject to audit.

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

Table 4E: Single total figure table		2018/19			2018/19	2018/19			2018/19			2018/19			2018/19		
		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 (Band of £5k)			£s (nearest £100)	£000s (Band of £5k)			£000s (Band of £5k)			£000s (Band of £2.5k)			£000s (Band of £5k)		
Dr A Brittlebank	Joint Medical Director (to March 19)	130	-	135			-			-		0.0	-	0.0	130	-	135
Mrs J Brown-Toland	Joint Director of Workforce and OD (from Oct 18)	25	-	30								5.0		7.5	30		35
Mr M Cook	Non Executive Director (from Aug 18)	0	-	5			-			-			-		0	-	5
Mrs R Duguid	Joint Director of Integration (from May 18)	45	-	50								22.5		25.0	70		75
Mr S Eames	Joint Chief Executive (from Sept 17)	130	-	135	8,700							0.0		-	135		140
Mr R Harpin	Joint Medical Director (from April 18)	50	-	55								17.5		20.0	70		75
Mr B Hetherington	Non Executive Director	15	-	20			-			-			-		15	-	20
Ms H Horsburgh	Non Executive Director	10	-	15			-			-			-		10	-	15
Prof. J P Howarth	Director of Service Improvement (to Sept 17) Joint Deputy Chief Executive (from Sept 17)	80	-	85	1,500		-			-		0.0	-	0.0	85	-	90
Ms E Kirby	Joint Director of Nursing (to July 18)	15	-	20								0.0		-	15		20
Mr G Liston	Non Executive Director (from Aug 18)	0	-	5			-			-			-		0	-	5

Mr A Moore	Non Executive Director	10	-	15			-			-			-		10	-	15
Mrs M Nagra	Joint Chief Operating Officer (from July 18)	35	-	40								0.0		-	35		40
Dr L Nelson	Non Executive Director (from March 18)	5	-	10			-			-			-		5	-	10
Mr G O'Hare	Interim Director of Mental Health and Learning Disabilities (from July 18)	30	-	35								95.0		97.5	125		130
Mrs C Parker	Director of Quality & Nursing (to May 18)	15	-	20	300		-			-		207.5	-	210.0	225	-	230
Mrs H Ray	Joint Chief Operating Officer (to July 18)	15	-	20								27.5		30.0	45		50
Mr D Scheffer	Joint Company Secretary (from April 18)	90	-	95	200							17.5		20.0	110		115
Mr M Smillie	Joint Director of Strategy & Support Services (from April 18) and Executive Lead for Workforce and OD (to Oct 18)	65	-	70			-			-		152.5	-	155.0	220	-	225
Mrs A Smith	Joint Executive Chief Nurse (from July 18)	35	-	40								142.5		145.0	175		180
Prof. Robin Talbot	Chairman (from Sept 17)	45	-	50											45		50

Notes:

- There are no performance- related bonuses or long term performance related bonuses
- The Trust has a joint Board arrangement with North Cumbria University Hospital NHS Trust and there are recharges between the 2 Trusts for all posts excluding the Chair, Non Executive Directors and the Joint Company Secretary
- Mr Eames is on secondment from The Mid Yorkshire Hospitals NHS Trust and the Trust is invoiced for his salary costs. Since 1 September 2017 Mr Eames has worked as Joint Chief Executive for both North Cumbria University Hospitals NHS Trust and Cumbria Partnership NHS Foundation Trust (CPFT) and the Trust has only been invoiced for 50% of his costs since that date.
- Dr A Brittlebank's remuneration includes an element from the Trust that relates to his clinical role. This amounts to £82,722 in 2018/19 and £87,244 in 2017/18

- Mr Scheffer worked as the Joint Company secetary across both North Cumbria University Hospital NHS Trust and Cumbria Partnership NHS Foundation Trust however the Trust paid his full costs during 2018/19
- Mr O'Hare is on secondment from Northumberland Tyne and Wear NHS Foundation Trust at one day per week commencing July 2018
- Mr Cook, Mr Liston and Dr Nelson are Joint Non Executive Directors for North Cumbria University Hospitals NHS Trust and Cumbria Partnership NHS Foundation Trust. They are paid a salary by each of the Trusts directly.

The information in the below is subject to audit.

Table 4E: Single total figure table		**2017/18**			**2017/18**	**2017/18**			**2017/18**			**2017/18**			**2017/18**		
		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 (Band of £5k)**			**£s (nearest £100)**	**£000s (Band of £5k)**			**£000s (Band of £5k)**			**£000s (Band of £2.5k)**			**£000s (Band of £5k)**		
Mrs H Bingley	Non Executive Director (to Aug 17)	0	-	5			-			-			-		0	-	5
Dr A Brittlebank	Joint Medical Director (to March 19)	185	-	190			-			-		20.0	-	22.5	205	-	210
Mr S Eames	Joint Chief Executive (from Sept 17)	75		80	6,300							0.0			80		85
Mrs J Forster-Adams	Director of Operations (to Jul 17)	25	-	30			-			-		167.5	-	170.0	195	-	200
Ms J Fretwell	Non Executive Director (to Nov 17)	10	-	15			-			-			-		10	-	15
Mr B Hetherington	Non Executive Director	10	-	15			-			-			-		10	-	15
Ms H Horsburgh	Non Executive Director	10	-	15			-			-			-		10	-	15
Prof. J P Howarth	Director of Service Improvement (to Sept 17) Joint Deputy Chief Executive (from Sept 17)	150	-	155	2,700		-			-		0.0	-	-	150	-	155
Mrs L Marsland	Director of WF & OD (to Dec 17)	230	-	235	5,600		-			-		12.5	-	15.0	250	-	255
Mrs C Molloy	Chief Executive (to Sept 17)	55	-	60	1,500		-			-		72.5	-	75.0	130	-	135
Mr A Moore	Non Executive Director	10	-	15			-			-			-		10	-	15

Dr L Nelson	Non Executive Director (from March 18)	0	-	5			-			-			-		0	-	5
Mrs C Parker	Director of Quality & Nursing (to May 18)	120	-	125	4,200		-			-		177.5	-	180.0	305	-	310
Mr M Smillie	Joint Director of Strategy & Support Services (from April 18) and Executive Lead for Workforce and OD (to Oct 18)	120	-	125			-			-		57.5	-	60.0	180	-	185
Ms J Stannard	Non Executive Director (to Dec 17)	10	-	15			-			-			-		10	-	15
Prof Robin Talbot	Chairman (from Sept 17)	25		30											25		30
Mr M Taylor	Chairman (to July 17)	15	-	20			-			-			-		15	-	20

* Note: All Penension related benefits have been restated in line with new guidance

Total salary across all organisations for Senior Managers within the Trust who are apart of staff sharing arragements:

Name of Senior Manager	***Total Salary***
Dr A Brittlebank - Joint Medical Director (to March 19)	184,437
Mrs J Brown-Toland Joint Director of Workforce and OD (from Nov 18)	53,833
Mr M Cook - Non Executive Director (from Aug 18)	10,052
Mrs R Duguid - Joint Director of Integration (from May 18)	91,973
Mr S Eames - Joint Chief Executive (from Sept 17)	262,400
Mr R Harpin - Joint Medical Director (from April 18)	178,159
Prof. J Howarth - Director of Service Improvement (to Sept 17) Joint Deputy Chief Executive (from Sept 17)	169,293
Ms E Kirby - Joint Director of Nursing (to July 18)	37,978
Mr G Liston - Non Executive Director (from Mar 18)	10,052
Mrs M Nagra - Joint Chief Operating Officer (from July 18)	95,584
Mrs L Nelson - Non Executive Director (from Mar 18)	12,512
Mr G O'Hare - Interim Director of Mental Health and Learning Disabilities (from July 18)	150,000
Mrs H Ray - Joint Chief Operating Officer (to July 18)	38,900
Mr M Smillie - Joint Director Strategy & Support Services (from April 18), Executive Lead for Workforce and OD (to Oct 18), Executive Director of Finance & Estate (from April 19)	132,257
Mrs A Smith - System Executive Chief Nurse (from July 18)	89,533

Fair pay multiple (**The information below is subject to audit)**
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 2019	**Year ended 31 March 2018**
Median Total Remuneration £	28,098	27,804
Mid-point of the Highest Paid Director £	279,799	283,775
Ratio	10.0	10.2

Notes:

- The banded remuneration of the highest paid director in the financial year 2018/19 was £275-2805k (2017/18 was £280k-£285k)
- This was 10.0 times (2017/18, 10.2) the median remuneration of the workforce was £28,098 (2017/18 £27,804)
- The highest paid director for both 2018/19 and 2017/18 was the Chief Executive
- In 2018/19 nil employees (2017/18, nil) received remuneration in excess of the highest paid director
- Remuneration ranged from £6,277 to £279,799 in 2018/19 (2017-18 £6,843-283,775)
- 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.

Total Pension Entitlement (**The information below is subject to audit)**

Pension benefits 2018/19	**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 2019 (bands of £5,000)**	**Cash Equivalent Transfer Value at 1 April 2018**	**Real increase in Cash Equivalent Transfer Value**	**Cash Equivalent Transfer Value at 31 March 2019**
Name and Title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Dr A Brittlebank Joint Medical Director (to March 19)	0-2.5	0-2.5	65-70	200-205	1,526	0	0E
Mrs J Brown-Toland (from Nov 18)	0-2.5	0	0-5	0	0	0	14
Mrs R Duguid Joint Director of Integration (from May 18)	0-2.5	0-2.5	20-25	50-55	242	27	330
Mr S Eames Joint Chief Executive (from Sept 17)	0A	0A	0A	0A	0A	0A	0A
Mr R Harpin Joint Medical Director (from April 18)	0-2.5	0	10-15	0	125	20	193
Prof. J Howarth Director of Service Improvement (to Sept 17) Joint Deputy Chief Executive (from Sept 17)	0B	0B	0B	0B	0B	0B	0B
Ms E Kirby Joint Director of Nursing (to July 18)	0C	0C	0C	0C	0C	0C	0C
Mrs M Nagra Joint Chief Operating Officer (from July 18)	0D	0D	0D	0D	0D	0D	0D
Mr G O'Hare Interim Director of Mental Health and Learning Disabilities (from July 18)	2.5-5	7.5-10	80-85	240-245	1160	95	1805
Mrs C Parker Director of Quality & Nursing (to May 18)	0-2.5	0	50-55	0	426	30	639

Mrs H Ray Joint Chief Operating Officer (to July 18)	0-2.5	0-2.5	55-60	140-145	964	20	1148
Mr D Scheffer Joint Company Secretary (from April 18)	0-2.5	0-2.5	15-20	35-40	282	44	347
Mr M Smillie Joint Director of Strategy & Support Services (from April 18) and Executive Lead for Workforce and OD (to Oct 18) Executive Director of Finance & Estates (from April 19)	5-7.5	15-17.5	45-50	100-105	446	143	759
Mrs A Smith System Executive Chief Nurse (from July 18)	2.5-5	12.5-15	40-45	120-125	512	105	857

Notes:

- Note A: S Eames does not contribute to the NHS Pension scheme
- Note B: J Howarth commenced claiming his NHS Pension in 2017/18
- Note C: E Kirby does not contribute to the NHS Pension scheme
- Note D: M Nagra does not contribute to the NHS Pension scheme
- There was no employer's contribution to stakeholder pensions

Signed..... Date: 23 May 2019

Prof. Stephen Eames, Chief Executive for CPFT and NCUH

Staff Report

The information in the tables below is subject to audit.

Analysis of staff costs

	Permanent £000	Other £000	2018/19 Total £000	2017/18 Total £000
Salaries and wages	92,261	8,124	**100,385**	108,071
Social security costs	8,605	756	**9,361**	9,999
Apprenticeship levy	442	39	**481**	519
Employer's contributions to NHS pensions	11,705	1,028	**12,733**	14,064
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	193	-	**193**	239
Temporary staff	-	5,237	**5,237**	5,482
Total gross staff costs	**113,206**	**15,184**	**128,390**	**138,374**
Recoveries in respect of seconded staff	(1,318)	-	**(1,318)**	(728)
Total staff costs	**111,888**	**15,184**	**127,072**	**137,646**
Of which				
Costs capitalised as part of assets	583	149	**732**	136

Analysis of average staff numbers

	Permanent Number	Other Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	89	18	**107**	128
Ambulance staff	-	-	**-**	-
Administration and estates	631	91	**722**	771
Healthcare assistants and other support staff	760	109	**869**	728
Nursing, midwifery and health visiting staff	808	68	**876**	1,080
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	473	37	**510**	700
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	-	-	**-**	1
Total average numbers	**2,761**	**323**	**3,084**	**3,408**
Of which:				
Number of employees (WTE) engaged on capital projects	15	-	**15**	3

Male/female staff numbers as at 31/03/19 (The information below is not subject to audit)

Role	Female Headcount	Male Headcount
Directors (Executive and Non-Executive Directors)*	5	10
Other Senior Managers	0	0
Employees	3097	493

*****The numbers reported are the full Joint Transitional Executive and Non-Executive Team for Cumbria Partnership NHS Foundation Trust (CPFT) and North Cumbria University Hospitals NHS Trust (NCUH), not all individuals are employed by CPFT but the data is included for completeness.

Sickness absence data

Figures Converted by DH to Best Estimates of Required Data Items			Statistics from ESR	
Average FTE 201	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
3,054.56	32,964.08	10.79	1,114,913	53,475

Source: statistics published by NHS Digital, using data drawn for January 2018 to December 2018 from the ESR national data warehouse

Staff policies and actions applied during the financial year

Policies relating to our staff continued to be reviewed and updated throughout 2018/19. Both Trusts also continued the joint consultation process to develop and agree workforce related policies across both Trusts to ensure consistency in how staff are treated across both organisations. The first policy agreed was the Joint Organisational Change Policy and subsequently all of the main workforce related policies have been developed and agreed including Absence Management, Disciplinary, Grievance and Pay Protection.

All revised policies went through local Equality Impact Assessment processes, and the HR team work in conjunction with the occupational health service 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 where appropriate as quickly as possible.

We continue to operate an equal opportunities policy and have maintained our Disability Confident status which replaced the Two Ticks Positive Action Scheme in 2016. We have been awarded level 2 Disability Confident – Employer status and are committed to ensuring we meet the requirements of the scheme which includes continuing to support candidates that identify themselves as having a disability apply for posts under the guaranteed interview scheme.

During the financial year 2018/19 staff consultation, engagement and involvement has continued through the well-established and well attended monthly Joint Partnership Forum. This is a joint forum which represents both Trusts.

Significant staff consultation and engagement has been targeted around the integration of services across both Trusts with the first phase commencing in 2018/19 in relation to support services. Integration of other services, including clinical services, will continue throughout 2019.

Trade Union facility time
We are currently working closely with staff representatives on the Joint Partnership Forum to collate and publish the data required under the regulations.

Staff engagement
Our core objective is to embed the right culture and make the organisation a great place to work. Staff engagement is essential because we know that when staff are happy and fully engaged they provide the best possible care for our patients. 'This is Us' is our approach to staff engagement. Staff have the opportunity to meet with the CEO each quarter, in a variety of locations, to hear about our plans, raise any concerns and ask questions. The annual business plan and priorities are shared at the start of the financial year and cascaded to individuals through 'This is me', values based appraisal. Staff are also kept informed through a weekly CEO Blog, a newly developed staff intranet portal, email and 'Trust Talk' printed magazine.

NHS Staff Survey
The NHS Staff Survey is the largest survey of staff opinion in the UK; it is carried out annually to gather the views on staff experience at work in ten key indicators. The survey is administered electronically and completely anonymous. Indicators are measured on a scale of 10 and we are benchmarked against the average score of other similar trusts.

The response rate for the 2018 NHS staff survey was high, 49% compared to a national average of 41%. The scores for each indicator, together with comparison against the average for combined mental health / Learning disability and community trusts are presented in the table below:

Indicators	2018/19		2017/18		2016/17	
	Trust	Average	Trust	Average	Trust	Average
Equality, diversity and inclusion	9.2	9.2	9.4	9.2	9.3	9.2
Health and wellbeing	5.9	6.1	6.1	6.1	5.9	6.2
Immediate managers	7.1	7.2	7.2	7.1	6.9	7.1
Morale	6.2	6.2	x	x	x	x
Quality of appraisals	5.5	5.5	5.7	5.4	5.3	5.4
Quality of care	7.2	7.4	7.5	7.4	7.4	7.5
Safe environment – bullying and harassment	8.2	8.2	8.3	8.3	7.7	8.2
Safe environment – violence	9.6	9.5	9.5	9.5	9.4	9.5
Safety culture	6.7	6.8	6.7	6.7	6.5	6.7
Staff engagement	7.0	7.0	7.1	7.0	7.1	7.0

The results from the Staff Survey show that staff engagement is the same as similar trusts (7.0); staff recommendation of the Trust as a place to receive treatment is slightly higher than average (66.4%) and recommendation as a place to work is lower than average (57.9%).

Indicators for safe environment from violence and bullying and harassment, staff morale, equality and diversity and quality of appraisal are average or above average when compared to similar trusts. The survey shows that staff feel safe to speak out and do not feel discriminated against at work. They receive more training than similar trusts and report high rates of annual appraisal with quality of appraisal similar to other trusts. We benchmarked below average in the health and wellbeing, immediate management, quality of care and safety culture indicators. Staff have particularly highlighted their lack of involvement in decision making and inability to undertake improvements in their area of work. They also express uncertainty in who the senior managers are and lack of communication. They do not feel the organisation takes positive action on health and wellbeing.

Since the last NHS staff survey we have achieved the bronze Health and Wellbeing at Work award which recognises the achievements of managers and health advocates in promoting health and supporting staff wellbeing. 23 staff health advocates delivered a twelve month campaign of health promotional activities based on the results of a staff health needs assessment, including awareness of enhancing sleep and reducing alcohol consumption. We changed our occupational health service provider and now all staff and their families have access to an employee assist programme.

Closer working and integration with NCUH over the past 12 months has brought about change and aligned governance arrangements. Local pulse surveys, which monitor staff engagement throughout the year, indicate that clarity and work relationships have potential to impact on staff engagement.

Future Priorities and Targets

The results of the NHS Staff survey are reviewed in light of feedback from pulse surveys and exit interviews and themes from issues raised with the Freedom to Speak Up Guardians. These themes inform our organisational development plan and initiatives. In 2019/20 we will continue to support staff health and wellbeing and continue to work towards achieving the silver Health and Wellbeing at work award.

Our other priorities include:

- Enhancing opportunities for more flexible working.

Whilst survey results show that opportunities for flexible working are improving, they are still below average when compared to other trusts. An Engaging for Improvement project will see HR and staff working together to explore options for flexible working and better work life balance.

Opportunities for flexible working – NHS staff survey 2018				
	2015	2016	2017	2018
CPFT	50.8%	52.8%	55.8%	56.5%
Average	56.5%	58.2%	58.1%	60.4%

- Improve relationships and positive behaviours at work.

Staff have been involved in the development of a new set of organisational values. These values and a supporting behaviours framework was launched in April 2019 and forms the basis of a new appraisal process.

Personal experience of harassment, bullying or abuse at work from managers– NHS staff survey 2018				
	2015	2016	2017	2018
CPFT	8.1%	14.2%	10.0%	11.9%
Average	11.0%	11.0%	10.5%	10.8%

- Maintain a focus on communication

This will be particularly important through 2019/20 as we progress towards a merged organisation with NCUH. We will build on the ‘This is Us’ engagement programme and development of the staff intranet portal.

Staff feedback will continue to be monitored through quarterly pulse checks and progress reported to the Quality and Safety Committee, a sub-Committee of the Board of Directors.

Expenditure on consultancy

The total consultancy fees for 2018/19 were £938k.

Off-payroll engagements

The Trust had no off-payroll engagements during the year 2018/19.

Reporting of compensation schemes - exit packages 2018/19:

The table below illustrates exit packages agreed during 2018/19 **which are subject to audit**. 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.

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	1	7	**8**
£10,000 - £25,000	2	1	**3**
£25,001 - 50,000	2	-	**2**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**6**	**8**	**14**
Total cost (£)	£218,000	£44,000	**£262,000**

Reporting of compensation schemes - exit packages 2017/18:

		Number of compulsory redundancies	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**
£10,000 - £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 cost (£)		£356,000	£92,000	**£448,000**

Exit packages: other (non-compulsory) departure payments:

	2018/19			2017/18		
	Payments agreed		**Total value of agreements**	**Payments agreed**		**Total value of agreements**
	Number		**£000**	**Number**		**£000**
Voluntary redundancies including early retirement contractual costs	-		-	-		-
Mutually agreed resignations (MARS) contractual costs	-		-	-		-
Early retirements in the efficiency of the service contractual costs	-		-	-		-
Contractual payments in lieu of notice	8		44	9		92
Exit payments following Employment Tribunals or court orders	-		-	-		-
Non-contractual payments requiring HMT approval	-		-	-		-
Total	**8**		**44**	**9**		**92**
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 Nominations Committee 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
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

Relating to	CoG ref.	Summary of requirement	Location in Annual 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
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

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
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 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.	Audit & Risk Committee
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	Remuneration Report

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
		whether or not the director will retain such earnings.	
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 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.	Membership Report
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 signpost to Register of Interests

Audit and Risk Committee Report

Composition

The Audit and Risk Committee consists of Non-Executive Directors and is chaired by Mr Brian Hetherington. Other members of the Committee are Heike Horsburgh and Alan Moore (member from March 2019).

Meetings

The Committee met on five occasions during 2018/19. 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. 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 was unable to attend the Audit and Risk Committee in 2018/19.

Table: Meetings of the Audit and Risk Committee 1 April 2018 – 31 March 2019

Name	Position	Attendance - (total of 5 meetings held during 2018/19)
Committee members		
Brian Hetherington	Non-Executive Director (Chair)	5/5
Heike Horsburgh	Non-Executive Director	5/5
Alan Moore	Non-Executive Director	1/1
In attendance by invitation (Executive Director)		
Michael Smillie	Executive Director	4/5

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 2017/18 and approved the Local Counter Fraud Specialist Plan 2018/19.

Raising Concerns
The Committee 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 2017/18 annual report and accounts and agreed to recommend to the Board that they be adopted.

Financial Reporting
During 2018/19, 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 2019, were as follows:

- **Valuation of land and buildings** – During 2018/19, 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 18 to the financial statements, we have 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.

- **Contractual dispute** – The Trust has recognised income in respect of the anticipated settlement of a dispute. After obtaining specialist legal and accounting advice we considered and agreed the basis on which this income is assessed.
- **Provisions** – We have a number of provisions as set out in note 17 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 2017/18 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 and embed the risk appetite statement.

Charitable Trust Fund
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 the Trust.

External Audit
At least one representative from Mazars was in attendance at all meetings through 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 considered if non-audit work undertaken by the Trust's External Auditor represented any conflict of interest. We have a policy for appointment of External Auditors to undertake non-audit work approved by the Governors Council. 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 £7,800 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.

Our business 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 our 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 2019 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 10 vacancies on the Governors Council.
Information on governors who held office during 2018/19 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 31 Dec 2019)

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	Vacant	n/a	n/a
		Rachael H Davies	Oct 2016 - Sep 2019	2/6
		Linda Radcliffe	Oct 2016 - Sep 2019	6/6
		Alinson McCourt	Oct 2017 - Sep 2020	4/6
		Mark Hayhurst	Oct 2014 - Sep 2020	0/6
Carlisle	5	2 vacancies	n/a	n/a
		Elizabeth Freeman	Oct 2016 - Sep 2019	4/6
		Christine Logan	Oct 2012 - Sep 2018	3/4
		Jack Smith	Oct 2017 - Sep 2019	1/6
		Garry English	Oct 2013 - Sep 2019	0/6
Copeland	5	2 vacancies	n/a	n/a
		Kerry-Ann Lister	Oct 2013 – Sep 2019	4/6
		Keith Amey	Oct 2012 – Dec 2019	5/6
		Carole Woodman	Jan 2019 – Dec 2019	2/2
Eden	5	Vacant	n/a	n/a
		Mike Taylor	Oct 2017 - Sep 2020	5/6
		Jacqueline Nicol	Oct 2017 - Sep 2020	6/6
		David Pollitt	Oct 2014 - Sep 2020	6/6
		Hilary Carrick	Oct 2014 - Sep 2020	3/6

Constituency	* No. of Governor positions	Name	Appointment	** No. of Mtgs
Furness	5	3 vacancies	n/a	n/a
		Tony O'Malley	Oct 2017 - July 2018	1/2
		Maggie Harrison	Jun 2013 - Sep 2018	0/3
		Stephen Newton	Jun 2013 - Sep 2019	5/6
		Shahnaz Asghar	Jan 2019 - Dec 2019	2/2
Lancashire	1	Derek Seber (Rev)	Oct 2017 - Sep 2020	5/6
North East England	1	Vacant	n/a	n/a
South Lakeland	5	2 vacancies	n/a	n/a
		Patricia Turton	Oct 2016 - Sep 2019	2/6
		Patricia Davey	Oct 2017 - Jan 2019	2/5
		Catherine Gleeson	Oct 2015 - Sep 2018	1/3
		Stephen Johnson	Oct 2016 - Jun 2018	1/1
		George Butler	Jan 2019 - Dec 2019	0/2
		Jim Ring	Oct 2017 - Sep 2020	5/6
Staff constituency (elected)				
Allerdale and Copeland	3	Leslie Blacklock	Oct 2017 - Dec 2019	6/6
		Tricia Goldwater	Oct 2013 - Sep 2019	5/6
		Jane Smith	Oct 2011 - Sep 2020	3/6
Carlisle and Eden	3	Vacant	n/a	n/a
		Peter Farrell	Oct 2016 - Sep 2019	2/6
		Robert Donlevy	Oct 2017 - Sep 2020	6/6
Furness and South Lakeland	3	2 vacancies	n/a	n/a
		Kevin McVeigh	Oct 2015 – Dec 2019	5/6
Appointed Governors				
Cumbria County Council	2	Vacant	n/a	n/a
		Cllr Mark Wilson	Mar 2016 - Feb 2019	2/6
University of Cumbria	1	Alison Hampson	Apr 2017 - Apr 2020	4/6
Cumbria CVS	2	2 vacancies	n/a	n/a
		Helena Morris	Nov 2017 – Jun 2018	1/1
Leagues of Friends	1	James Porter	May 2018 - Apr 2021	1/6
	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 2018/19.

****** 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 (GC) work closely together. All members of the Board have an open invitation to attend the GC meetings. Executive and Non-Executive Directors (NEDs) are invited to make formal presentations at these 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. There are also adhoc meetings and discussions between individual Board members and governors on specific subjects of interest.

The Senior Independent Director (SID) attends the GC 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 and Non-Executive Directors attending the GC 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 GC or members. The Board meetings include a quarterly standing item on the activities and views of the GC presented by the Lead Governor. Governors and members can attend Board meetings and ask questions on notice or about the agenda items.

The GC meeting is held in public and advertised on our website. The public has an opportunity at the meeting to give their views or ask questions on the agenda. NEDs

attend GC meetings to feedback on progress of issues from the Board Committees to help governors fulfil their role in 'holding Non-Executive Directors to account'.

The following information details the steps taken during the year by the Governors Council to engage with members and the public on our forward planning, our objectives, priorities and strategy, and their views are shared with the Governors Council and included in their activity report presented to the Board.

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

Engagement Groups - North and South groups maintain communications with members, third sector organisations and local ICCs. Governors are involved with the development of their local ICC.

Joint Non-Executive Director (NED) and Governor Visiting programme - The purpose of visiting services is to provide staff the opportunity to openly discuss service developments and improvements, and to highlight any key issues/risks in their service that may prevent patients from receiving high quality, safe care, and having the best experience whilst using our services. These monthly 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 (SIGs) - Early in 2018 the GC approved a re-design of the structure of these groups to make them more focused on engaging with members and the public supporting the development of the integrated health and care system (IHCS).

- The Governance SIG acts as the forum that is engaged with, and leads on the process about the potential merger transaction between our Trust and NCUH.
- The Mental Health SIG has a similar role in relation to the mental health, learning disability and CAMHS service transactions being proposed by the Clinical Commissioning Groups.

These groups report to the GC through the Governors Advisory Committee.

Organisational Form transaction

The Board approved the recommendation from GC for Governors to take a lead role in engagement across both Trusts in April 2019. The GC have been engaged in the process and have received updated and discussed the proposals at all meetings of the GC. As part of this transaction the GC in the review and development of the Constitution, including the review of the structure of the membership and Governors Council for the new Trust.

Mental Health/Learning Disability and CAMHS service transaction
The GC have attending meetings with staff to hear their views and met with Lancashire Care NHS Foundation Trust to hear their proposals. Four governors were involved in the MH Stakeholder Advisory Group. The SIG fed back their views to the GC and the Board.

Annual Members meeting – the first joint meeting with North Cumbria University Hospitals NHS Trust was held on 9 October 2018. Fifty-six people attended, including governors, members, staff and the public to hear about our achievements and challenges over the past year and our future plans as part of the developing the North Cumbria integrated health and care system (IHCS). Keith Amey, Deputy Lead Governor launched the new 'beinvolved' membership campaign encouraging attendees to take some 'golden invites' to share with interested friends and colleagues.

Patient Led Assessment of the Care Environment – This is a national annual programme of assessment of all inpatient areas and eleven governors took part in 2018.

Quality Peer Reviews - Governors are involved in service quality peer reviews to improve the care for our patients. A standardised review tool is used that is based around the CQC Key Lines of Enquiry (KLOE) and the Fundamental Standards of Care.

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 are published on our website. This provides a clear audit trail of engagement and communication between members, Governors and the Board.

Dispute between the Governors Council and the Board of Directors
There were no disputes during 2018/19. 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.
- Ensures that an appropriate record of any unresolved dispute is made in our annual report for the relevant period including a summary of the issues in dispute and the action taken by the Board and the GC to attempt to resolve the dispute.

Nominations Committee Report

The Nominations Committee is a subCommittee of the Governors Council and its 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 Non-Executive appointments, including the Chair, to the Board and that the Board maintains an appropriate balance of skills and experience.

Professor Robin Talbot, Chair is the Chair of the Committee. The Vice Chair is the Senior Independent Director (SID) Heike Horsburgh, Non-Executive Director. The SID is invited to attend when considering the Chair's appraisal and chairs the meeting when considering the Chair's appointment.

The Committee membership includes three Governors: Jane Smith (Staff Governor Allerdale and Copeland/Lead Governor), Linda Radcliffe (Public Governor Allerdale) and Keith Amey (Public Governor Copeland/Deputy Lead Governor). There are two Governors in reserve; Jacqueline Nicol, Public Governor Eden and Elizabeth Freeman, Public Governor Carlisle.

The Committee, met eight times during the year to consider the following areas:

- Board succession planning
- NED appointments
- Chair appointment
- Amendments to the process for appointing/reappointing the Chair and NEDs
- Remuneration review

No Directors were invited to attend the 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 April 2018 the Committee considered the need to recruit two vacant NED positions on the Board together with two Associate Directors which aimed to support succession planning working across

to both the Trust and North Cumbria University Hospitals NHS Trust (NCUH). Gina Tiller, Chair of NCUH was involved in the shortlisting of the Associate NED posts but following a recruitment campaign, no candidates were shortlisted.

The Committee undertook the recruitment process in line with the agreed procedure and identified preferred candidates for the NED positions which were recommended to the Governors Council meeting on 5 July 2018. The GC unanimously approved the appointments of Malcolm Cook and George Liston, for 2 years to 31 July 2020.

Non-Executive Directors (NEDs) Re-appointment
In November 2018, the Committee considered the re-appointment of Heike Horsburgh for 1 year to the 31 January 2020. The Governors Council approved the extension.

Chair in Common Appointment
The recruitment process was a joint process with NHS Improvement (NHSI) who are the responsible body for recruiting Non-Executive Directors, including Chairs, to NHS Trusts. The vacancy arose because Gina Tiller was retiring as Chair of NCUH with effect from 31 March 2019.

As part of the integration agenda in North Cumbria, the trusts are in the process of forming a single NHS provider organisation. The post of Chair in Common leads both Boards and the Governors Council of our Trust to ensure the trusts are guided by a shared ambition to transform services and improve outcomes for local communities that we serve. The Chair plays a significant role in designing and developing the architecture for the integrated care system. The matter of independence relating to the appointment of a Chair in Common for our Trust and NCUH was explored and agreed with NHSI.

Whilst the Trust's SID chaired the Nominations Committee to agree the recruitment process for the appointment in conjunction with NHSI, it was agreed that the SID would not be involved in the interviews. The interview process was chaired by NHSI and included an independent panel member together with members of the Nominations Committee. The Committee undertook the recruitment process in line with the agreed procedure and recommended the preferred candidate as Professor Robin Talbot for the appointment for 2 years to 31 March 2021 with a remuneration of £50,901 per annum which will be paid 50/50 by both trusts. The Governors Council approved the appointment on 21 February 2019.

Non-Executive Director Remuneration Review
The Committee undertook a review of NED remuneration during the year and recommended that no changes should be made to the existing remuneration levels. The Committee agreed to undertake a further review as part of the potential merger business case work or if not then, within 12 months.

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. We are committed to an engaged and vibrant membership community.

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

We have 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

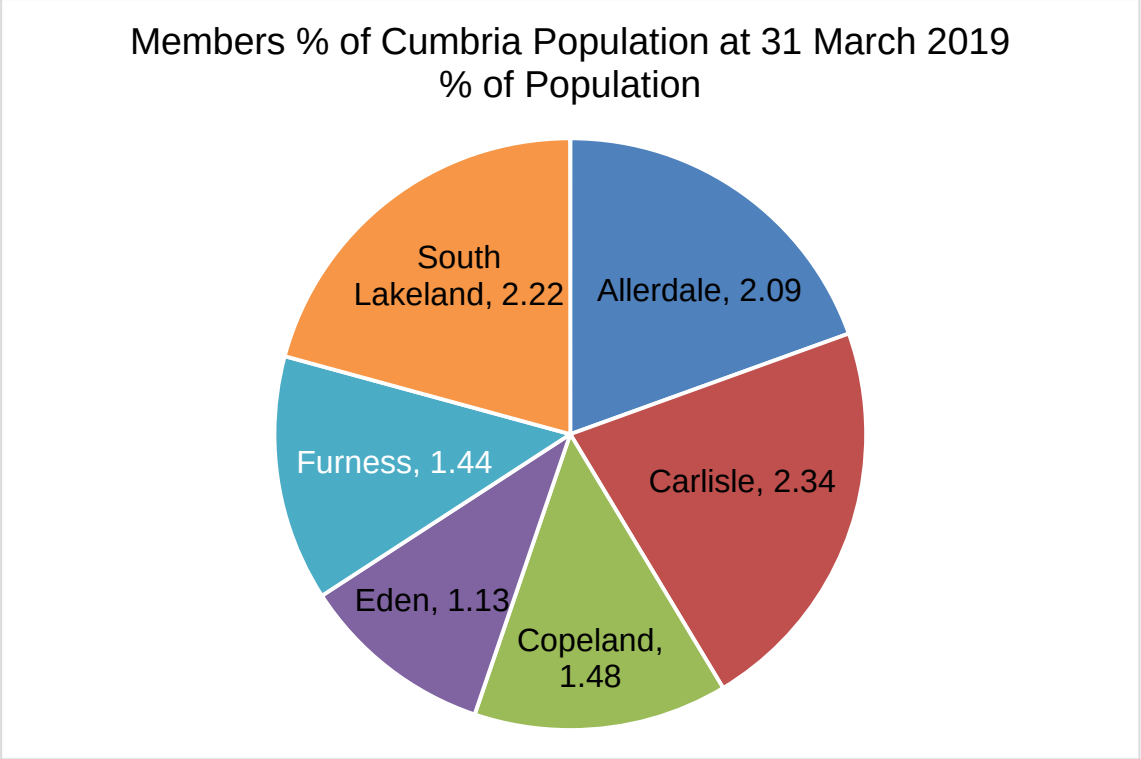
The staff constituency is divided into three classes that are geographically based according to where the member of staff works:

- 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 2019 is shown in the chart below.



There are 6 Public members in North East England which have been attracted through links with North Cumbria University Hospitals NHS Trust and our general communications channels. There are 47 members in Lancashire which have been attracted through our general communications channels, primarily our website. The total public membership figure at 31 March 2019 is 10,905, a reduction of 273 from the previous year following the annual data cleanse exercise, plus 37 new public members, 25 of which joined following the launch of the 'beinvolved' membership campaign.

Membership Engagement Strategy

Our 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.

Our vision: We want to build a new integrated health and care system together, using our collective capabilities for a healthier and happier population. In April 2019 we launched our brand new set of values shared across our Trust, North Cumbria Clinical Commissioning Group, and North Cumbria University Hospitals NHS Trust.

This signals a clear opportunity for real engagement with our members in communities, our patients and staff. 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 set out the ways in which the Governors Council and the Trust should engage with our membership during 2018 which will be refreshed in 2019 to

support governors engaging with members and the public to contribute to coproduction in our developing integration health and care system.

We have over 10,000 public Members, of which currently one third is active. We aim to have as many actively participating members as possible and with this in mind there is a drive to improve engagement. Details of engagement this year can be found in the Governors Council Report.

Membership monitoring
We need to ensure proportional representation of members from our local population in Cumbria. The target in 2018/19 was to maintain 2% of the population of Cumbria as Members, however this was not achieved and is currently 1.8%.

A new 'beinvolved' membership campaign was launched at the joint Annual meeting in September 2018 to increase engagement of members and the public on coproduction and the integration of health and care systems in Cumbria.

The Board monitors the level and effectiveness of membership engagement through the presentation of the GC 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 as part of the strategy refresh.

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.

Segmentation

This segmentation information is the Trust's position at 31 March 2019. Current sementation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website. Cumbria Partnership NHS Foundation 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	2018/19 Q1 score	2018/19 Q2 score	2018/19 Q3 score	2018/19 Q4 score
Financial sustainability	Capital service capacity	4	4	4	4
	Liquidity	3	3	3	4
Financial Efficiency	I&E margin	4	4	4	4
Financial Controls	Distance from financial plan	1	1	2	3
	Agency spend	2	2	2	2
Overall scoring		**3**	**3**	**3**	**3**

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: 23 May 2019

Prof. 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 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk and risk management arrangements

The Chief Executive has overall accountability for risk management and discharges that duty through the Executive Team and their respective portfolios.

During 2018/19 we have worked increasingly collaboratively with North Cumbria University Hospitals NHS Trust (NCUH) and together we have introduced shared governance and leadership structures across all of our services. Senior clinical leaders are in place throughout each of our care groups. They are responsible for driving improvements to quality and safety, and actively support 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. During the year we have integrated most of our support service teams with those in NCUH and have aligned our systems and processes so that, collectively, our Corporate and Support Service teams provide support across both Trusts.

A 'best of both' principle was adopted in the work to refresh and align our quality governance, clinical risk management and leadership frameworks to ensure good practice in both Trusts formed the basis of our aligned arrangements to identify, manage, escalate

and report risks, as appropriate to the scale and nature of the risk. The Board of Directors (the Board) 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.

Risk management is part of our 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 on our intranet site.

We benefit 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 System Executive Chief Nurse. 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.

The Risk and Control Framework

Board Membership

There were a number of changes to Board membership during the year. Substantive appointments were made to the System Executive Chief Nurse, Executive Director of Workforce & Organisational Development, Executive Chief Operating Officer Officer, Executive Medical Director and Executive Director of Strategy. All Executive Directors have the remit across both Trusts. An Interim Executive Director of Mental Health, Learning Disabilities and CAMHS (non-voting Director) was also appointed during the year to manage the transition of mental health, learning disabilities and CAMHS services to alternative providers. Two Non-Executive Directors were appointed into vacant posts and have roles across both Trusts bringing the total number of Non-Executive Directors appointed to both Trusts to three. In February 2019, the Governors Council, agreed the appointment of Prof. Robin Talbot as Chair of both Trusts for a two-year term, to take effect on 1 April 2019 following the retirement of NCUH Chair. These changes reflect and

demonstrate our commitment in moving toward an integrated health and care system, but do not diminish our responsibilities and accountabilities as a NHS Foundation Trust.

As at 23 April 2019 we have:

- Seven Non-Executive Directors (the Chair plus six other Non-Executive Directors, three of whom also have NED roles within NCUH)
- Seven Executive Directors, six of whom have voting rights
- No Executive Director or Non-Executive Director vacancies

The balance between Executive and Non-Executive Directors on the Board remains in line with the Code of Governance for NHS Foundation Trusts and our Constitution and 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 2017/18 a review was undertaken of the corporate governance structures that support Board Committee effectiveness in order to prepare for and implement aligned board-level governance arrangements across both trusts which took effect in April 2018. During Quarters 1 and 2 activity focussed on the alignment of clinical and corporate governance meetings structures to support the aligned board level arrangements. These took full effect from October 2018.

At the time of writing, following agreement from the Governors Council in November 2018 and approval of the Strategic Case by NHS Improvement (NHSI) in February 2019, activity is underway to prepare for both Trusts to merge to become a single organisation. The aim is that the new Trust will ‘go-live’ in October 2019 following approval of the Full Business Case by the Board in June 2019, and subject to successful progress through the Transactions process with NHSI. As this transaction is technically an acquisition of NCUH by CPFT the merged Trust (name not yet confirmed at time of writing) will be a Foundation Trust.

A programme management approach has been adopted to prepare for and manage the merger transaction. Work streams led by Executive Directors deliver the required activity and report progress into the Programme Board which is chaired by the Chief Executive. The Governors Council are engaged in the process and have been involved in the review and development of the Constitution for the new Trust.

At the time of writing a further review is ongoing to explore opportunities to enhance the effectiveness of the Trusts’ governance framework, taking into consideration feedback received in March 2019 from NHS Improvement as part of their supportive ‘Moving to Good’ programme, as well as for integrating aspects of corporate governance with the North Cumbria Clinical Commissioning Group as part of moves toward an integrated health and care system. These reviews are likely to result in some changes to the

governance framework and associated meetings structures which will be implemented during 2019/20 having due regard to impacts on, and from, merger and CCG integration activities.

Meetings that have been in place during 2018/19, and any changes or adjustments to their arrangements within the year, are set out below.

Board and Board level Committee

The Board is supported by a governance structure as follows, which deals with various components of corporate governance and risk. With the exception of the Audit and Risk Committee and Charitable Funds Committee all meetings described below happen in an aligned manner with NCUH (meeting at the same place, at the same time). These aligned arrangements recognise the statutory duties of both Trusts as separate legal entities whilst also enabling efficiencies through avoiding duplication of senior managers' attendance at meetings.

- Quality and Safety Committee (Q&S) – the designated Board Committee 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 Committee 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 Committee which oversees the management of Charitable Funds held by the Trust.
- Audit & Risk Committee (A&R) – an independent Committee and senior Board Committee, 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.
- Remuneration Committee – wholly NED membership.
- Mental Health Legislation Committee – membership is Mental Health Act Managers, and is chaired by a Non-Executive Director. In December 2018 the Board of directors agreed to introduce this meeting as a formal Board level sub-Committee. At the time of writing transition arrangements are underway for the first meeting of this Committee to take place led by the Executive Director of Mental Health.
- 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 Committee effectiveness

- Clinical Management Group (CMG) (formerly Trust Management Board (TMB)) - the senior operational management group led by the Chief Executive and attended by Executive Directors, senior operational and clinical leaders within care groups and Heads of Support Services. CMG monitors risks to operational, clinical and financial performance and escalates issues and risks to Board level Committees as appropriate.
- Trust Wide Clinical Governance Group (TWCGG) – the senior forum for clinical governance, led by the Deputy Director of Nursing and Quality (April 2018 - September 2018) and System Executive Chief Nurse (October 2018 - April 2019). This group 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 following the substantive appointment of the System Executive Chief Nurse. In April 2019 this meeting was 'stood down' with alternative arrangements taking effect from May 2019 as part of changes to the governance framework.
- Joint Leadership Development Group – 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 our strategy. During the year membership of this group expanded to also include senior managers from the North Cumbria Clinical Commissioning Group.
- Compliance Board - led by the Executive Chief Operating Officer and including Executive Directors and senior managerial and clinical leaders, with a specific focus on CQC compliance.

During 2018/19 the effectiveness of our Board and Committees was evaluated through a survey involving Board members and members of each Board 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 although identified the need to review the future format of board effectiveness surveys.

Risk Management Strategy

The annual review of our Risk Management Strategy was undertaken with the Board agreeing the updated Risk Management Strategy in November 2018. The Risk Management Strategy will be reviewed again during the first half of 2019/20 as part of further alignment activity with NCUH and the move toward an integrated health and care system.

The strategy 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

Central to our integrated approach to risk governance is risk appetite. In June 2018 we agreed a joint risk appetite statement, joint strategic objectives and joint strategic risks. In setting out our appetite for risk, we use a risk appetite framework based upon that promoted by the Good Governance Institute but which has been expanded to include wider range of risk domains that reflect complex sustainability challenges currently facing the NHS. Board members' individual risk appetites inform a collective debate on the organisational risk appetite which is then agreed by the Board.

The System Executive Chief Nurse is accountable for ensuring appropriate systems and processes are in place to enable the implementation of our 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 through our 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 our governance frameworks. Training on the Risk Management Policy was delivered to team leads during the year as part of our risk management training programme. The Board Development

programme during the year has also incorporated risk management training for board members through activity to review and update strategic risks that underpin the Board Assurance Framework (BAF), review and development of the risk appetite statement, and most recently in March 2019, a review of the risk and assurance escalation flows to inform the development governance framework.

During 2018/19 elements of our risk management processes started to become aligned with those of NCUH, with the aim that during 2019/20 they will become fully aligned. This includes the bringing together of both Trusts' risk management policies into a single joint policy.

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 and the use of dashboards within governance forums is becoming embedded.

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.

During the year, our Integrated Governance Manual was refreshed to recognise how we have aligned our governance and performance management frameworks with NCUH, and also sets out our joint arrangements for priority setting, business planning and our aligned Board Assurance Framework.

Quality governance

Quality governance is a key activity of the Board 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 we have undertaken an annual self-assessment against NHSI's Well Led Framework which informs our evaluation of our quality governance arrangements. Our self-assessment against the Well Led framework, conducted during Quarter 4 of 2017/18, took into consideration the findings and recommendations from the CQC's inspection and our progress with improvement actions identified in our 2016/17 self-assessment.

In Quarter 3 of 2018/19 we commissioned a peer-review against NHSI's Well Led framework, led by Northumberland Tyne and Wear, and which was undertaken between October 2018 and February 2019. Delivery of improvement actions has been monitored through relevant governance forums and with Board level oversight. Our 2018/19 annual self-assessment against the Well Led framework commenced in March 2019, with the outcome of that assessment due to be formally considered by the Board in June 2019. The self-assessment takes into consideration feedback from the external peer review. Areas identified for improvement included strengthening arrangements for workforce planning, strengthening our arrangements for corporate risk management, and strengthening our quality impact assessment (EQIA) arrangements to understand whether impacts identified within EQIAs materialised as expected.

Our last formal Well Led external review was undertaken by Deloitte in 2015. The timeframe for our next formal external review is likely to be during 2019/20.

We last underwent a formal Well Led inspection by the CQC in November 2017 and will be inspected again in June 2019. The CQC inspection report assessed us as 'requires improvement' overall with 22 'must do' actions requiring immediate attention. Details of how we have responded to their recommendations can be found in the Quality Report.

Risks logged within our risk registers continue to be managed and regularly monitored through our governance frameworks. Scrutiny of the corporate risk register is undertaken monthly by the Clinical Management Group (CMG). Monthly monitoring is also undertaken to ensure risks within risk registers are reviewed and updated in a timely manner. As at 23 April 2019 10.2% of 'open' risks within our risks registers were overdue for review, compared with 4.31% on 31 March 2018. This aspect of risk register management is now incorporated into our performance management framework and is a regular aspect of quality governance within care groups and support services.

During the year we have continued to strengthen our operational and strategic risk management processes through the inclusion within our BAF reports, of a visual representation of how risks within the corporate risk register impact upon, or are impacted by, strategic risks within the BAF. This, together with developments to our quality and safety dashboards and reporting on risk management to aid understanding and thematic analysis of how risks within risk registers have changed over time, enable a better understanding of our risk profile. The BAF continues to be shared with our care group and support service leadership teams after each quarterly update to enable cascading throughout the Trust of how the most significant risks to our objectives are being managed.

Longer term actions which collectively will strengthen the quality of our risk management arrangements during 2019/20 include building on work commenced in 2018/19 to refresh 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.

As part of our integration with NCUH, some changes were made during the year to care group structures. Some of our care groups now incorporate services from both Trusts, an example of this is the Children and Family Care Group. Activity to align quality governance arrangements has also taken place during the year through alignment of policies and meetings structures. Further integration and alignment work will be undertaken during 2019/20 to refocus clinical governance arrangements within our integrated structures and to embed quality improvement as the driving principle of our governance frameworks. Staff surveys and staff engagement activities give us rich information that we are 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 integrated performance management framework.

To comply with the governance conditions of the Provider Licence, we are required to provide a Corporate Governance Statement to NHSI. The Corporate Governance Statement relating to 2018/19 was presented to the Board for formal acceptance in May 2019. 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 our 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 CMG.

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. No exception reports have been required during 2018/19.

We expect to comply with all of the Provider Licence conditions in 2019/20. 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 our 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 our policies and procedures. We continue 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.

We encourage the reporting of incidents or concerns and use as a tool to learn and improve. We have 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.

Our approved Raising Concerns (Whistleblowing) policy is published on our website. The Audit & Risk Committee oversees our Raising Concerns process and our Freedom to Speak Up Guardian provides regular updates to the Board.

Risk reporting

Risk management is fundamental to how we operate. Our 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 our risk management information system (Ulysses). Those risks recorded within Ulysses collectively form our risk register. The risks recorded on our 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 our risk register. Individual responsibilities include ensuring appropriate arrangements are in place for effective risk management and mitigation.

During Quarter 1 the Boards of both Trusts agreed joint strategic objectives, joint strategic risks and an aligned approach to the Board Assurance Framework (BAF). The first 'joint' BAF was agreed in July 2018 and is reviewed on a quarterly basis.

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 CMG 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.

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 in 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

We have recognised for some time that data quality is an underpinning issue in most things that we and this has been highlighted by both our Internal and External Auditors over recent years. In July 2016, the A&R Committee endorsed a three-year Data Quality Strategy to systematically improve data quality across all of our information systems. The A&R Committee received updates on progress against the strategy throughout 2018/19 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 partners in the IHCS 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 future provision of mental health services across Cumbria which we are working with our commissioners and regional partners to progress, and partnership working with GP practices to enable a more sustainable model for primary care across north Cumbria.

In June 2018, in collaboration with the Board of NCUH, our Board reviewed the top strategic risks and major operational and clinical risks facing the organisations, and agreed the following top strategic risks which form the basis of our aligned Board Assurance Framework. In January 2019 the Board agreed the inclusion of an additional risk (Risk 10) within the BAF relating to the impacts on support services from transferring mental health services to alternative providers in line with Commissioner Intentions.

Risk 1	Leadership and workforce is not sufficient to deliver the scale and pace of transformative change
Risk 2	Cultural change to improve quality and empower people is not sustained
Risk 3	Engagement with the public and partners is not effective in achieving positive change that improves or transforms services
Risk 4	Quality of services (experience, safety, outcomes) are not improved because programmes to transform, integrate and save have adverse quality impacts
Risk 5	Financial sustainability is not achieved as the effectiveness of cost reduction plans and implementation of new service models does not deliver the anticipated financial benefits set out in our long term plans
Risk 6	Health and Health Service improvement plans are impeded by dependency on key partners who are not sufficiently ready / able to support our plans
Risk 7	Vulnerable services become too unstable to continue during the implementation of wider transformation programmes across Cumbria and North East
Risk 8	Infrastructure developments are not sufficiently enabling of transformation
Risk 9	Fragility within primary care impacts our ability to effectively manage patient flow
Risk 10	Support services are insufficiently resilient to effectively support the Trust following transfer of mental health services to an alternative provider

The Board Assurance Framework is reviewed on a quarterly basis, with the framing of top strategic risks being reviewed on at least an annual basis, usually during Quarter 3.

Significant operational and clinical risks

Risks are identified, managed and monitored through our governance frameworks, in accordance with the Risk Management Policy and the aligned performance framework. 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 us include:

- 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
- short and medium term disruption to the resilience of support services associated with the transfer of mental health, learning disabilities and children & adolescent mental health services (CAMHS) to alternative providers.
- delays in patients accessing specialist dental services due to lack of availability in specialists to support the delivery of care during treatments
- 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

As part of our increasingly integrated working with NCUH, both Trusts are working together to implement aligned processes for policy management. Initial work commenced during Quarter 4 of 2017/18 and has continued throughout 2018/19. The aim is for fully integrated arrangements by the end of Quarter 1 of 2019/20. Activity has taken place throughout 2018/19 to align policies with NCUH, and where appropriate to have joint policies spanning both Trusts. This work continues into 2019/20 and may result in adjustments and extension to review timeframes for some policies.

During 2018/19 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 1 April 2019 was 27. This compares to 36 as at 31 March 2018. Policy management performance is monitored by Trust Wide Clinical Governance Group (TWCGG) and the Compliance Board, 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.

Quality Impact Assessments

As part of our collaborative working with NCUH, an aligned approach to undertaking quality impact assessments was agreed by the Q&S Committee in April 2018 and has been applied throughout the year. The approach to undertaking quality impact assessments takes a holistic approach to assessing the impacts of major change schemes, including those proposed within our efficiency programme. The impact assessment approach enables decisions to be made based upon a balance of risks to quality, equality and the clinical and financial sustainability of services. The process is jointly led by the System Executive Chief Nurse and Executive Medical Director and overseen by the Q&S Committee. It is also integrated into our business planning process, which evolved during the year to integrate and incorporate the trust's approach to workforce planning.

Board level assurance on the timely undertaking of impact assessments is provided through the Q&S Committee who also have a role in the EQIA approvals process. During 2019/20 the EQIA process will be strengthened further through undertaking evaluations of post-change impacts compared with anticipated impacts.

Workforce strategies

The Q&S Committee receive routine 'hard truths' nurse staffing reports throughout the year, including fill rates and care hours per patient day (CHPPD).

The People Plan for the North Cumbria Integrated Health and Care System, approved by the Board in March 2019, sets out the strategic delivery approach to ensure a sustainable workforce. It also states the annual delivery plan priorities for 2019/20. Priorities for 2019/20 include developing an attraction plan and improving recruitment processes, also designing an effective, inclusive and engaged workforce through local plans that meet the needs of the population built on multi professional working and new roles. Delivery of the People Plan will be overseen through the Q&S Committee.

We use the population centric model for workforce planning and have a draft workforce plan. The model hospital approach is being used to identify opportunities for workforce efficiencies, although this is at an early stage of development and will be incorporated into our workforce planning approach during 2019/20.

A workforce planning group is in place, chaired by the Executive Director of Workforce & OD and has representation from primary care, nursing and Allied Health Professions. Our lead officer for workforce planning is a member of the workforce planning group. A workforce planning summit is planned to take place during 2019 and will involve a wide range of stakeholders.

In summary, we have staffing governance processes in place although these are currently immature and will be strengthened to become embedded over 2019/20.

Business conduct / conflicts of interest

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS guidance: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/.

Our Standards of Business Conduct policy was updated in 2018 to reflect changes to legislative requirements and to become a joint policy with NCUH. Policy requirements are being implemented on a phased approach during 2018/19 and 2019/20. This commenced with an update of Board members' and the Lead and Deputy Lead Governors' declarations in Quarter 3 of 2018/19, medical and senior clinical and non-clinical decision makers in Quarter 4 of 2018/19, with declarations for the remainder of individuals and groups stated

within our policy being updated during 2019/20. Information on our 'declarations of interest' internet page will be updated on a progressive basis during the phased implementation period. Delivery of the phased implementation plan is being overseen by the A&R Committee.

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 foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Further details can be found in the Performance Report.

Emergency preparedness
Our emergency planning and business continuity consider organisational resilience and our 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 our contingency planning, or wider health or multi-agency planning to which we contribute. We work collaboratively and share information appropriately with responder organisations in furtherance of multi-agency co-operation and co-ordination.

We seek 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, we 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.

We comply with NHS England's requirements by providing an EPRR structure and implementing a business continuity management system through which we 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
We closely monitor budgetary control and expenditure through the Financial Delivery Group, Clinical Management Group and, at Board level, through the FIP Committee. A dedicated programme management team support the identification and delivery of schemes which improve efficiency and positively impact our overall financial efficiency efforts.

The Executive Director of Finance, Digital & Estates presents finance reports to both the FIP Committee and the Board. Through our Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation the Board 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 our operations.

The Board receives both performance and financial reports at each of its public meetings in addition to reports from the Chairs of its Committees, 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, whilst our adjusted year-end financial out-turn was under achievement against our financial control total, through our risk sharing agreements the north Cumbria system will receive, with bonuses, approximately £21.2m from the Provider Sustainability Fund for 2018/19.

We acted within an agreed risk sharing arrangement within the year. Until month 11, the Trust was forecasting delivery against the agreed position. However, in month 12 the Trust reported a year end deficit of £7.632m. After adjusting for items excluded in the control total calculation (such as impairments, donations, transfers by absorption) the Trust

therefore reported that its deficit position was £5m. This is £2.9m higher than the agreed control total. As a result the Trust did not receive the full allocation of Provider Support Fund. The lost income was £1.4m. The increased deficit position arose because of the Trust agreeing a lower than planned contract income with the local Clinical Commissioning Group. This decision was based on the 2018/19 Operational Plan which provided for a system wide risk share agreement. This decision by the Trust allowed the Cumbria system to achieve greater benefits than the £1.4m PSF funding that the Trust could have earned. The risk sharing is agreed formally by the Board through our annual planning process and reviewed through the year by the System Leadership Board of which we are a participant.

The financial plan for 2019/20 has been developed in conjunction with NCUH and North Cumbria Clinical Commissioning Group and was agreed by both Boards in March 2019. There are significant risks to the delivery of the financial plan and many of the caveats notified to NHSI for the 2018/19 financial plan remain relevant into 2019/20.

We were rated as being placed in Segment 2 under NHSI's SOF at 22 April 2019. You can find further details about ratings in the NHS Improvements Single Oversight Framework Report.

We have continued to reduce reliance on agency staff during the year 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

We reported two incidents via the Data Security and Protection Toolkit to the Regulator during 2018/19. One incident related to a clinical letter sent to the wrong address, the other related to health assessment information sent to the wrong patient. Both incidents were investigated and investigation reports sent to the Information Commissioners Office with recommendations completed for improvement. We are committed to learning from all incidents with a view to preventing recurrence in the future. 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*.

We have 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 System Executive Chief Nurse during 2018/19.

We recognise 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, we have 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 our performance and governance frameworks. This includes monthly review by the Board 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.

We currently use 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 NCUH. The Clinical Policies sub group continued to meet in 2018/19 to ensure clinical policies were reviewed in a timely manner. During Quarter 2 its remit was widened to include the ratification of all policies (not just clinical policies) and is now referred to as the Policy Management Group (PMG). The work to review policies is ongoing and is overseen by the A&R Committee. Our governance 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 we measure and monitor our 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, which continue to evolve, also provide the

basis for assuring the Board on the quality, accuracy and completeness of data and enable triangulation of safety data.

In Quarter 2, as part of the alignment of governance arrangements with NCUH, the aligned Performance & Delivery Group was formed to identify, monitor and manage risks to performance. The Group which is a sub group of Clinical Management Group, met intermittently throughout 2018/19, as much of its business was undertaken in practice through care groups' 6-weekly performance review meetings. The ongoing role and function of the Performance & Delivery Group will be considered as part of the governance framework review being undertaken during Quarter 1 of 2019/20.

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.

We achieved a number of quality improvements during the year, including further development and roll out of quality and safety dashboards within integrated care groups to improve quality governance, and improvements introduced through research and development, such as improving hospital discharge arrangements for people who are homeless. 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 System Executive Chief Nurse 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, FIP, A&R and Charitable Funds Committees each have activity schedules framed around enabling the Board to have line of sight to any significant risks to internal control. An annual evaluation of Committee effectiveness is undertaken for each of these Committees. This is a self-assessment by Committee members and regular attendees, the outcome of which is considered by the A&R Committee.

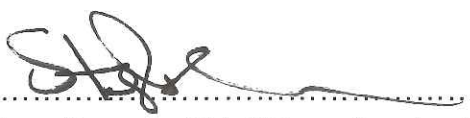
We also has an active programme of internal and external audit. The audit programme, including recommendations from audits, is overseen by the A&R Committee which is a Committee of the Board. The focus of the internal and external audit programme is set to both support and complement our objectives and provide an assessment for the Board on areas of specific risk. The internal audit programme is developed having due regard to the risks and risk controls set out in the BAF 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 CMG.

Our internal auditors awarded substantial, good or reasonable assurance on all audits they undertook during the year, with the exception of our arrangements for business continuity which were awarded limited assurance during the year. We are actively working to review our care groups' and services business continuity arrangements and updating business continuity plans is ongoing. 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 arrangements for business continuity 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: 23 May 2019

Prof. Stephen Eames, Chief Executive for CPFT and NCUH

Voluntary Disclosure

Equality Reporting

This Equality, Diversity and Inclusion (EDI) report provides information on how both Cumbria Partnership NHS Foundation Trust (the Trust) and North Cumbria University Hospitals NHS Trust (NCUH) is meeting their 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 we have made in both Trusts towards these goals during 2018/19, 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 both Trusts in 2019/20.

Compliance

Equality Delivery System Objectives

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

We have joint Actions Plans for EDS2 and Workforce Race Equality Standard (WRES) which have been aligned to avoid duplication and enable a consistent approach to achievement of outcomes.

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	March 2019	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	July 2018	1, 2 & 3
	Develop and implement Staff Networks across CPFT & NCUHT with a supporting communications plan and measurable outcomes	October 2018	1 & 3
Inclusive Leadership at all levels	Work closely with system partners to create joint Equality Objectives as North Cumbria Health & Care Partners	June 2018	1, 2, 3 & 4

The table below shows the grading achieved following our EDS2 Stakeholder Grading event in November 2017. This will be updated following the joint stakeholder grading event which took place in April 2019.

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

Gender Pay Gap Analysis

Following government consultation, it became mandatory from 31 March 2017 for public sectors organisations with over 250 employees to report annually on their gender pay gap. Both Trusts meet the mandatory requirements of the gender pay gap analysis by publishing the reports on our websites and submitting data on to the government website.

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. Our 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.

EDI incidents and Complaints

The table below outlines EDI incidents January 2018 - 19. There has been an increase in EDI related incidents since last year (3) which is considered a positive step forward with staff being more aware and supported of the need to come forward and report incidents.

Type of Incident		Description
1	Gender Reassignment	Inappropriate Language from a member of staff
2	Race	Inappropriate language and behaviour from a member of staff
3	Disability	Building access for group meeting not accessible
4	Disability	Unable to transfer patient
5	Disability	Unable to transfer patient
6	Race	Racially abusive language from a patient
7	Race	Racially abusive language from a patient
8	Disability	Unable to transfer patient

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. Both Trusts undertake 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 at CPFT
Disciplinary Investigations: We had 22 employees entered into formal disciplinary investigations. Of these, 0 were in relation to discrimination. (2 cases were for staff of a non-white British ethnicity)
Grievance Procedure: We had 52 formal grievance cases. Of these, 0 were in relation to discrimination. (2 cases were for staff of a non-white British ethnicity)
Capability Procedure: We had 5 employees entered into capability. Of these, 0 were in relation to discrimination.

Policies and Procedures Trusts
A joint Equality, Diversity and Inclusion Policy has been developed and once approved and implemented will replace the existing policies for the individual Trusts. This year we also implemented our Gender Identity and Inclusion Policy which was rolled out together with Gender Awareness Training sessions across Cumbria.

Training, Development and Awareness Sessions
Both Trusts require all staff to compete mandatory e-learning training for Equality and Diversity. In April 2018 we introduced the core skills framework provided by skills for health. With the launch of the Transgender policy, Gender Identity and Awareness Training was made available, 7 sessions took place across the county. With the high uptake on the course has received more sessions will be scheduled for 2019.

Cultural Diversity Awareness Project
We are progressing a Cultural Awareness Project across both Trusts. This project incorporates recommended actions following a recent Cultural Review, which has received widespread support from our local and regional Trades Unions. Some of these areas include delivering diversity awareness training, reviewing faith and spiritual provision, further promotion of Staff Networks and delivery of two cultural orientation/welcome days, linking our current and future workforce with local community groups.

Workforce Equality Standards
In accordance with NHS England's requirements, both Trusts completed the Workforce Race Equality Standard (WRES) for 2018, providing both data and narrative around race equality issues within their 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 our websites.

The Disability Workforce Equality Standard (WDES) comes into effect in 2019 which requires trusts to provide data and narrative around disability equality issues within the workforce. Both Trusts are working with NHS England on what is required. We will be attending the National Disability Summit and the Workforce Disability Equality Standard (WDES) Workshop to prepare for the implementation of the Workforce Disability Equality Standard later this year.

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 and a Digital Patient Information library. As work continues, the emphasis for 2019 is upon system working and sharing best practice.

Culture, Communities and Partnership

EDI Representatives
EDI Representatives are employees and governors within both Trusts who are passionate about promoting equality, diversity and inclusion within their everyday work. The number of representatives is continually increasing and currently stands at over 200, this figure has nearly tripled since last year. We continue to develop our Staff Networks to encourage those with an interest in promoting awareness, raising issues and supporting events around a particular area: Armed Forces, LGBT, Accessibility and Cultural Diversity.

Community Events
We work with a number of different community groups across Cumbria. Over the past 12 months we 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”. We work closely with a local BME organisation AWAZ 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. We 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
We are represented at regional and national EDI events, working together with NHS employers, NHS England and the 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.

Our Trust is also a member of enei (Employers Network for Equality and Inclusion) and joint membership is currently being explored. We are key members of the Cumbria Public Sector Partnership, together with 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.

National BAME Programmes
We are actively promoting national programmes to develop our future leaders from BAME backgrounds. Applications have been submitted for the Leadership Academy’s Ready Now Programme and a member of staff was successful in achieving a place on the national Windrush Programme offered through the Florence Nightingale Foundation.

Volunteer Workforce
We greatly value our volunteer workforce and the support they provide to our patients and staff, however, we are also aware that there are very few volunteers from BAME or diverse backgrounds. Therefore, we are actively engaging with community groups and other Voluntary providers across Cumbria to promote volunteering opportunities and encourage those from diverse and minority backgrounds to join.

Syrian Refugee Families
Together with our other Health Partners across Cumbria we are continuing to work together with Cumbria County Council to support Syrian refugee families as they settle in Cumbria.

Brexit
We are working together with Health and Care Partners to plan and prepare for Brexit and are working to support our staff with EU nationality through the necessary processes.

Awards
In 2018 our Trust was shortlisted for a national Inclusion Award and received commendation for our progressing inclusion work.

Workforce EDI Data

Gender
The NHS workforce is made up of 23% Male and 77% Female. When our 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
Our workforce information shows that we have an ageing workforce with 21% being over the age of 55 and 51% over 45.

Ethnicity
We currently employ in the region of 4200 staff, 96% of which described themselves as White. As the BME rate within the county is low, our figures correspond with the county statistics.

Religion
A large majority of employees have chosen not to disclose their religion, currently 25%, with Christianity ranking highest at 51%. Other religions and cultures are represented within the organisation, however the numbers are very sparse.

Sexual Orientation
Similarly to religion, a large majority of have chosen not to disclose their sexual orientation which is currently at 21%. There are very low indication rates of gay, lesbian and bisexual with the highest disclosing rate being heterosexual at 75%.

Disability – Existing Staff
The ‘not declared’ rate has decreased by 4% from last year to 16% 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.

Patient EDI Data

Ethnicity

The ethnicity profile of patients within CPFT services includes both 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	%
White - British	52.00%
Not stated	37.41%
Any other white background	6.76%
White - Any other White Background	1.45%
White - Irish	0.54%
Other Ethnic Group - Any other ethnic group	0.54%
Mixed - Any other mixed background	0.38%
Mixed - White and Asian	0.23%
Mixed - White and Black Caribbean	0.18%
Mixed - White and Black African	0.14%
Asian/Asian Brit - Bangladeshi	0.13%
Other Ethnic Groups - Chinese	0.11%
Asian/Asian Brit - Indian	0.11%
Asian/Asian Brit - Any other Asian background	0.12%
Asian/Asian Brit - Pakistani	0.09%
Any other ethnic group	0.08%
Black/Blk Brit - African	0.08%
Any other mixed background	0.07%
Chinese	0.06%
Black/Blk Brit - Caribbean	0.06%
Black or Black British - Any other Black background	0.06%
White and Asian	0.05%
Indian	0.02%
Any other Asian background	0.02%
British	0.02%
Caribbean	0.01%
Pakistani	0.01%
African	0.01%
White and Black Caribbean	0.01%
Any other Black background	0.01%
White and Black African	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 in Cumbria this leads to an increase in demand for frailty services. As shown below over 50% of activity was for patients aged 65+.

Age	0-15	16-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Total	5%	5%	6%	6%	8%	11%	15%	22%	21%

Religion

The highest % 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.

Religion	**Total**	**Religion**	**Total**
NULL	65.34%	Baptist	0.03%
Church of England	11.83%	Zen Buddhist	0.03%
Patient Religion Unknown	6.88%	Mormon	0.03%
Roman Catholic	4.08%	Pagan	0.03%
Atheist	3.12%	Presbyterian	0.02%
Christian	2.73%	Christian Humanist	0.02%
Patient Declined	2.25%	Unitarian	0.01%
Methodist	1.56%	Jewish	0.01%
Anglican	0.38%	Pentecostalist	0.01%
Agnostic	0.38%	Church of Ireland	0.01%
Jehovah's Witness	0.32%	Reformed Presbyterian	0.01%
United Reform	0.14%	Buddhist	0.01%
Religion (Other Not Listed)	0.13%	Free Church	0.01%
Not Religious	0.11%	Humanist	0.01%
Church of Scotland	0.08%	Old Catholic	0.00%
Catholic: Not Roman Catholic	0.08%	Hindu	0.00%
Quaker	0.08%	Christadelphian	0.00%
Muslim	0.06%	Evangelical Christian	0.00%
Nonconformist	0.05%	Moravian	0.00%
Spiritualist	0.05%	Greek Orthodox	0.00%
Salvation Army Member	0.03%	Ismaili Muslim	0.00%
Protestant	0.04%		

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. We are working within the act.

QUALITY REPORT 2018/19

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 continued on our journey to system working across North Cumbria, this year, work has included a significant programme of development in terms of joint ways of working across Cumbria Partnership NHS Foundation Trust (CPFT) and North Cumbria University Hospital NHS Trust (NCUH). This work has included the development of joint meetings, policies and procedures. For example we now have in place a joint Being Open and Duty of Candour policy which underpins our thinking around Just Culture and is supported by joint Duty of Candour training.

The further development of joint ways of working across the two organisations, prior to the merger in October 2019 now feed up in to the system governance arrangements which include meetings such as the System Quality Assurance Committee (SQAC).

We continue to work with partner organisations to ensure high quality mental health provision across Cumbria and as such mental health, learning disability and CAMHS services within the South of Cumbria will be transferring to Lancashire Care NHS Foundation Trust (LCFT) and those services in the North to Northumberland, Tyne & Wear NHS Foundation Trust (NTW). Mental health services will transfer to these neighbouring Trusts on 1 October 2019.

As an organisation we have focused on ensuring our preparedness for any regulatory CQC inspections through the monitoring of the completion of the ‘Must Do’ and ‘Should Do’ actions which were highlighted through the CQC inspection which took place in 2017. Progress against these actions is monitored through the Joint Compliance Board (which is emerging into a Quality Improvement Group) and an auditing programme is in place to ensure improvements are sustained. We are hopeful that the CQC recognises the progress that we have made as an organisation at the forthcoming CQC Well Led inspection which is due to take place in June 2019.

In March 2019 we officially launched our brand new set of values shared across Cumbria Partnership NHS Foundation Trust, NHS North Cumbria Clinical Commissioning Group, and North Cumbria University Hospitals NHS Trust, they are:

- Kindness
- Respect
- Ambition
- Collaboration

We are currently focusing on ways in which these values can become more embedded into practice; activities to support this include the review of appraisal documentation to ensure the values are built into discussions with members of staff.

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.

The key highlights as detailed in this quality report for 2018/19 include:

- ✓ Development of a system wide suicide prevention plan with associated multi-agency action plan
- ✓ Skills – based training on risk management and suicide prevention (STORM) training now provided to over 300 staff
- ✓ Consistently achieving significantly better that the national average in terms of harm free care as monitored through the Classic Safety Thermometer
- ✓ Implementation of the Mental Health and Medication Safety Thermometers
- ✓ Further developed a suite of Quality and Safety Dashboard which are used from the ward to the board in terms of the identification and triangulation of key concerns
- ✓ Developed a joint e learning Duty of Candour training for all staff to complete, which includes a focus on Just Culture and Human Factors

Our focus for 2019/20, based on our strategic plans, feedback from our patients, staff and our communities, and from our CQC regulatory inspections will be:

- The development of a system wide 5 year Quality Strategy and associated Plan, which has four key aims:
    1. Focus on culture: journey to Just and improvement culture
    2. Continuously seek out a reduce patient harm
    3. Deliver what matters most to patients, families and carers through positive experiences when accessing our services
    4. Evidence our ongoing improvement journey through getting to ‘Good’ and striving for ‘Outstanding’ in CQC ratings
- Continue to focus and learn from incidents and events to continuously improve the services that we provide
- Strengthening our clinical governance arrangements both as a merged organisation and the system

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

This part describes our priorities for improvement for 2019/20, 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: 23 May 2019
Alison Smith, System Executive Chief Nurse CPFT and NCUH

Signed..... Date: 23 May 2019
Prof. Stephen Eames, Chief Executive for CPFT and NCUH

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

2.1 Priorities for improvement

Progress against 2018/19 priorities for improvement set out in last year's Quality Report:

Current Leadership & Governance Arrangements

- Executive lead is System Executive Chief Nurse for both Trusts 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 aligned Trust Wide Clinical Governance groups.
- Priority area for quality and nursing as set out in the 2017/18 business plan objectives, and agreed by Board of Directors in March 2017.

Quality Priority 2018/2019	**Progress**
Preventing people from dying prematurely as a consequence of suicide	Rationale: • In Cumbria, on average, one person dies each week as a result of suicide accounting for around 50 suicides per year. • Rates of suicide in males are more than three times higher than in females in Cumbria. • Nationally, male and female suicide rates are greater in those aged 45-49 years. • Suicide in England remains one of the leading causes of premature death. • Nationally the target is to reduce suicides by 10% to 2020 **Current Progress:** Continue to complete data collection on suspected suicides for people known to our services and triangulate with other relevant information. This has now been added as an action from the Mortality Review Meeting so that suspected suicides can be added to the reporting process. *Progress update* The agreed process and information sharing to support the process have been an issue with a request by central governance to "put this on hold" for further discussion in the next mortality review meeting. The next mortality review meeting is not yet planned due to this moving from a single organisation meeting to a joint meeting. The process is therefore

not yet working fully as agreed, causing delays in data collection process.
Action – requested date for next mortality review meeting; discussed in joint suicide prevention meeting.

A joint review from across organisational real-time data has been undertaken and is being presented at a multiagency meeting in response to concerns relating to the high number of deaths by suspected suicide and drug related deaths of females in Copeland. This report was completed by 31/03/2019 and presented at the SQAC meeting in April. The report author has noted gaps in the report due to the above issues.

Continue to support implementation of the Integrated Care System (ICS) plan for suicide prevention (CPFT/NCUHT suicide prevention plan is intrinsically linked to this). This will be monitored through the Cumbria Multi-Agency Suicide Prevention Leadership Group.

Progress update
The system wide North East & North Cumbria zero suicide ambition – Every Life Matters plan was signed off in the January 2019 regional steering group.

<u>Summary of the related work streams</u>

Enabler work streams
1. Leadership - To develop a regional and sub-regional framework, linking local activity to national with wide engagement. (Leadership)
2. Communication and engagement - To enable the successful delivery of the plan at all levels across the region. (Leadership)
3. Research - To work in collaboration with university partners to carry out an applied research project linked to the implementation of an agreed aspect of the plan. (Intelligence)

ICS priority work streams – These work streams will bring together good practice across the region:
1. Develop system wide competency. (Prevention)
2. Real time alerts and better use of data. (Intelligence)
3. Learning from deaths and near misses. (Intelligence)
4. Targeting High Risk groups (Prevention/Intervention)
5. Postvention support. (Postvention)

Sub-regional / local priority work streams:
1. Delivering safer services – based on the 10 key elements to improve safety. (Intervention)

2. Developing safer communities. (Prevention)

The Cumbria multiagency plan and updated strategy was signed off in the Cumbria Multiagency suicide prevention leadership group in January 2019 – this strategy, led by Public Health, is currently going for ratification at the Health and Wellbeing Board.

Our plan was reviewed in the November meeting and the zero suicide plan for 2019/20 was agreed at the March 2019 meeting. This plan is based on the national confidential enquiry 20 year review and 10 recommendations for safer services which we have self-assessed against in 2018. The zero suicide plan for MH inpatients has been picked up by the MH care group.

STORM training for 24 CAMHs staff was completed in January 2019 with further training planned.
Monthly STORM program of training for Adult MH continues, with some difficulty releasing staff for training/cancelation by staff causing some training sessions to be cancelled due to poor attendance.
A program of suicide alertness training for non-specialist MH staff continues with good attendance.
A suicide prevention training coordinator is now in post to support the program of training.

Implement National Confidential Inquiry into Suicide and Homicide findings as per plan. The outstanding actions from previous audits have been collated/up dated (January 19) and incorporated into our overarching Suicide Prevention Plan.

Progress update
The 2018 National confidential enquiry audit action plan has been signed off as complete. Following publication of the 2018 inquiry report the 2019 action plan has been developed and was agreed in March. Actions from the audit plan are monitored through the steering group and are based on the 10 recommendations for safer services.

Showcase film from our suicide prevention conference.

Progress – complete. The film has now been received and shared through the SP steering group for wider sharing across teams.

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.

	Progress update Suicide prevention lead will attend a workshop planned for 11 April 2019 developing the model primary care MH and suicide prevention has been included following discussions and presentations relating to the model over the previous quarter. Develop post-vention staff support plan. Engagement for improvement plan. Progress – This project is now complete following multiagency workshops. The proposal is being written up and presented at a CLIC event in May 2019. This is being linked with the ICS work stream to implement post vention support for people affected by suicide, including staff. **Next Steps** • Complete the real time alert report and implement the agreed pathway to support this - ongoing. • To complete, implement and monitor the zero suicide for MH inpatients plan. • To present and implement the staff support engagement for improvement project. • Continue to progress integration of CPFT SP plan across wider system to ensure services are fully engaged with the wider program of priority areas for improvement. • To review the governance framework for suicide prevention reporting to enable appropriate engagement and assurance is in place across services.
Treating and caring for people in a safe environment and protecting them from avoidable harm	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 February 2019 below is a summary of our performance compared with all organisations:

	All Organisations Feb 19 %	CPFT % Feb 2019	CPFT % Jan 19	CPFT % Dec 18
Harm Free Care	93.9	93.3	94	91.8
Harm Free Care (New)	97.8	100	97.8	97.5
Pressure Ulcers (All)	4.6	6.7	5.2	7.5
Pressure Ulcers (New)	1	0	1.4	1.4
All Falls	1.6	2	.9	0.4
Falls with Harm	0.5	0	.5	0
Catheterisation	14.4	14.1	8.6	11.1
Catheter Acquired UTI	0.7	0	0	1.1
VTE	0.5	0	0	0

We have consistently performed above the national average on the majority of the safety indicators to date, however there has been a noticeable deterioration of performance against the national average for the last three months.

From September the process for data entry changed, with each individual team having to input their own data directly onto the national safety thermometer site, with no ability for the senior team, Risk Management or BI to check completeness of submission and intervene if not complete. A Quarter 4 audit has flagged that submission rates from some teams has reduced and this may in part explain the deterioration. Urgent actions have been put in place to rectify this for April 2019. However the care group has seen an increase in low grade pressure ulcer reporting across the system, most noticeably in Workington Care Home sector. The District Nurse team in Workington believe this to be multifaceted, with a new care home manager in one of the largest homes focused on pressure ulcers, training from the TVNs in the Workington area and the React to Red packs being distributed by the CCG across North Cumbria. The Quality and Safety Leads continue to scrutinise each pressure ulcer incident form and are looking for further trends. Community Hospitals are now routinely inputting to the NHS Medication Safety Thermometer, this commenced in January 2019.

- **FALLS**

Work continues to embed all of the development work around the Prevention and Management of Slips, Trips and Falls as outlined in the

Trust Policy POL/001/048. We continue to embed the Falls Risk Assessment and Management Plan (FRAMP) within all of our inpatient units (community, mental health and learning disability units) and in the patient's home, as well as continuing to embed supportive initiatives born out of our SIRI investigations, such as our Call don't Fall prompts.

The Community Care Group has reviewed all of the 147 falls in a Community Hospital between September 2018 and February 2019 inclusive. The majority of these were classified as low harm, demonstrating the month on month improvement we are making to reduce falls with harm. Of the 4 falls that were categorised as moderate or serious harm, all were reviewed and one proceeded to SIRI.
There were no particular common themes from these falls – contributing factors included mental frailty and dementia and underlying pathological factors. The fall that resulted in a SIRI has led to a facilities review of washing and drying of wet floors which has been shared across all care groups from both Trusts.

Plans going forward into the new financial year include:

- CPFT Q&S leads to join the falls steering Group
- Plan for a joint fall policy for both Trusts
- Falls CQUIN target to be considered
- New sensor pads sourced

Success:

- The FRAMP is now well established on the wards and staff are using this well.
- Patients medications are reviewed and where possible medication is discontinued to reduce falls risk.
- Wards consistent with incident reporting for falls and application of DoC

- **Pressure Ulcers**

Work continues to embed all the recent developments around Pressure Ulcer and the CPFT 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.

The 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.

Common learning areas from the 72 hour Themes include:

- Failure to use or delay in use of clinical tools
- Poor communication between practitioners and providers
- Delay in reporting
- A shift of much more complex poorly patients being successfully managed in the community setting resulting in admission avoidance and early discharge

Future plans include:

- Consideration of the required TVN model across the integrated organisation
- Standardisation of training and audit
- Need to share learning, review of policies & products to standardise practice and development of new initiatives
- Continue embedding A.V.O.I.D and support the CCG roll out of the React to Red packs in residential and nursing home settings
- Monitor the trends as more care is delivered in the home environment

Success over the last quarter:

- Some residential homes have remained pressure harm free for over a year
- Community Teams are starting to report green pressure ulcer safety crosses monthly, indicating the progress made in preventing avoidable harms

- **Infection Prevention**

On the back of the Clinical Skills training, the Infection Prevention Team have supported the update from National Early Warning Scores (NEWS) to NEWS2 across all services and the roll out of essential equipment to carry out NEWS2 in the community setting.

Antiseptic Non Touch Technique (ANTT) continues to be embedded across all services and is arguably, coupled with the work to introduce HOUDINI (catheter protocol) and Catheter Passports, responsible for our improved safety and continued low and below national rate of catheter acquired infections within the community setting, as demonstrated in the safety thermometer graph below (red line):

Local outbreaks count of infection such as Norovirus may cause potential harm and possible other health care associated infection when acquired on wards. All incidents are assessed using root cause analysis, findings and subsequent action plans are presented at the Quality and Safety Committee and the Infection Prevention Committee. The implementation of the subsequent actions are managed through individual Care Group Governance mechanisms.

- **Diabetes and Insulin Administration**

The newly developed insulin booklet and administration record have now been embedded by teams across the county and in our inpatient settings.

Progress and incident data continues to be monitored and feed into future evaluation of the work and the new medication dashboard allows us to monitor trends around insulin administration errors more effectively.

There has been a 12 month review of the insulin booklets and insulin incidents completed in March 2019. This report will be ratified via the Community Care Group Governance meeting in April 2019.

The Summary findings include:
Over the last 12 months in North Cumbria there were approx. 246,000 community nursing contacts with patients. The current number of daily insulin visits to administer insulin in North Cumbria Community nursing teams is 235 visits per day.

A total of 68 Insulin incidents were reported between January 2018-January 2019 by the community care group: an incident rate of 0.0008% of all insulin visits. All 68 incidents were individually screened and the key themes were:

- Prescription
- Dispensing
- Administration, (omission or additional, incorrect insulin administration).

Two of the 68 incidents resulted in 72 hr reviews being generated and duty of candour being applied.
None of those 68 insulin incidents proceeded to SIRI investigations.
In this review 60% of the insulin errors were near misses due to staff detecting a risk, raising their concerns and not going ahead with administering the insulin as initially indicated.

	BI Quality and Safety Dashboards We continue to embed the Quality & Safety Dashboards and the ability to measure preventable harm in real time at the click of a button on every desktop. New power BI, quality and safety dashboards which can be accessed by all staff and provide system wide data which can be drilled down from organisational level to care group, service and team are in place across all the community, mental health and children's services. The dashboards provide real-time data across the range of clinical governance topics including: risk, incidents, training, clinical audit, complaints and compliments. Real time data around all incidents with specific focus and individual dashboards for safeguarding, mortality, falls, pressure ulcers and medication incidents provide clinicians and managers with a detailed visual tool to monitor patient safety issues and trends. These dashboards recently provided the community care group with an early warning to a deteriorating position in a district nursing team, enabling the care group to take swift supportive action to prevent further deterioration and patient harm, by rapidly identifying the situation and implementing supportive business continuity measures to protect, patients and staff. **Next Steps** As we move into the new financial year the focus will be on how we combine the learning and best practice from CPFT with the learning and best practice in NCUH and bring all of the patient safety work together in a more co-ordinated way so that learning and actions are system based, cross pathways on the new care group footing rather than on an organisational footprint.
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 continue to focus on in the year ahead.

Current Progress:

- A robust weekly data collection continues to be 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 was completed and submitted to the Quality and Safety Committee in November 2018. A further data update was also submitted to the QSC in February 2019. This provides fuller and more detailed information than can be presented within this report chapter.

Initial Health Assessments (IHAs) completed for CLA - there continue to be some challenges getting the IHAs completed in the last quarter. Performance for IHAs continues to be variable and is dependent on the number of available foster placements within Cumbria and the notification and consent received from the County Council. Whilst performance in September and October 2018 was over target the position has deteriorated with 9 of the 15 children in January 2019 placed out of Cumbria. The late notification of children becoming looked after can be a factor in delayed assessments as well as factors such as:

- Delays in receiving the consents from the Social Workers.
- Foster carers or family carers failing to attend the appointment.
- Some young people have refused to attend for assessment.
- Delays in being allocated an IHA appointment for Cumbrian CLA placed in other Local Authorities.

The CLA service continues to be fully integrated into the Strengthening Families team. To help address some of these issues all relevant staff are now trained in undertaking the necessary reviews and meeting health statutory responsibilities. The new allocation of CLA slots in all paediatrician clinics is established and with the exception of the West team there is more than sufficient capacity to meet the demand. Wherever possible the Clinical Director (CD) and Associate Medical Director (AMD) also provide urgent appointments to see children where there has been late notification or repeated cancellation or Did Not

Attend (DNA). Two qualified nurses have also now completed their IHA training and are undertaking their supervised practice, once full competence is achieved this will provide further flexibility for sibling groups and to visit children placed in neighbouring counties.

Performance continues to be managed on a weekly basis by the Clinical Service Manager and Performance Manager with monthly oversight at the Care Group Governance meeting.
There remains a challenge in achieving more integration with Social care which has been escalated to a system level and is fully supported by the Designated nurses from both North and South Clinical Commissioning Groups (CCGs). This also includes addressing issues with Cumbria County Council (CCC) regarding the Egress email account system and an Information Sharing Agreement between CPFT and CCC has been updated accordingly, but still requires CCC sign off. Limited and reduced access to the ICS system for the Strengthening Families (SF) team has now been jointly agreed and will remain limited to the health information only. IHAs completed for October, November, December 2018 (Q3) were at 85.63% overall performance which is an improvement from Q2 which was 64.7%. With the agreed processes in place, continued close monitoring, and the plan for improved receipt of consent information for IHAs it is expected that the IHA performance will improve and remain at a satisfactory level.

In Cumbria we have a joint pathway between Health and Social Care to achieve the early identification of emotional health and wellbeing needs through the use of 'Strengths and Difficulties Questionnaires so early help can be implemented following discussions with Social Worker, Carer and other Professionals working with the child or young person. An SDQ is completed within 3 months of the Child or Young Person becoming Looked After, as early identification and support of any problems helps to improve outcomes. In pre-school children all children in Cumbria are assessed and reviewed using the Ages and Stages Questionnaire: Social and Emotional to identify the emotional health of the young child. The analytical narrative of this is included in the review health assessment and the resulting health care plan. This informs part of the quality assurance process.

- Throughout this financial year steps continue to be in place to ensure CLA are 'fast-tracked' for both initial assessments and for therapy within the Child Adolescent Mental Health Service (CAMHS). This will continue as usual despite the recent changes regarding the CAMHS service now sitting within the Mental Health (MH) Care

Group and no longer within children and families. This will need to be further assessed as the care group is on a trajectory to be aligned with the North Tyne and Wear MH Trust by October 2019.

- The Standard 'routine' CAMHS CHOICE (initial assessment) appointments have an in service target of 35 days, and CLA are still receiving a service within 15 working days with urgent cases being assessed in 24 hours by the CAMHS Crisis, Assessment and Intervention service (CAIS).
- The implementation of a single point of access for Tier 2 and 3 children's mental health services with a standard operating procedure continues to be in place for the County.

There has also been an issue with 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) was written to include the required process and incorporated support from Cumbria County Council to populate and implement. For young people who DNA, follow up is now via the telephone and health information is then sent to a young person over the age of 14, or earlier if the young person has expressed a wish to receive information directly, with details of how to contact the CLA Health Team. The SF practitioner will liaise with Social Workers, carers, birth families, health professionals and key workers to ascertain the young people's health needs. This has led to some examples of good practice where joint visits with social workers for example, are undertaken, which have successfully led to completion of initial and review health assessments.

- All other actions from the last quarterly report were completed.

Additional Information:

- During this year we have introduced an action on the health care plans of all children and young people who have IHAs in Cumbria, following agreement from Cumbrian GPs. The carer will be asked to make an appointment with the GP to discuss the Initial Health Assessment and discuss with the GP any concerns they have about the child or young person's health within 6 weeks of the assessment being completed. This has been of value for carers who have looked after children who have enduring health needs.
- We are also moving towards using a RiO (Trust electronic patient record system) generated Patient Tracker List (PTL) each week to monitor the performance status of each child's IHA, and have divided this data into 3 main areas – **Cumbrian children placed in Cumbria; Cumbrian children placed out of county; and non-Cumbrian children placed into Cumbria.**

Child Sexual Exploitation (CSE)

CSE continues to be a priority for Cumbria Local Safeguarding Children's Board (LSCB):

- A CSE 'chapter' is held on our Safeguarding intranet for access by all our staff and information is also available on the Cumbria LSCB website and CSE is integral in Safeguarding training. Practitioners working with young people also attend the Cumbria LSCB CSE face to face training. There is also a CSE tracker function now available on the electronic patient record RiO.
- 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 incidents and concerns is via Ulysses and this would alert the Safeguarding team and Children and Family care group management team. The practitioner can then be supported and receive supervision support as required.
- The LSCB CSE 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 the designated nurse for safeguarding. The CSE LSCB Working group is attended by the Named Nurse for Safeguarding Children. Support for management and highlighting complex CSE cases are discussed with the safeguarding team and complex cases that need to be 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' and most importantly the lessons learned/changes to practice from complaints is also on the Care Group Governance meeting agenda each month and disseminated to the Integrated team managers meeting for the frontline staff meetings. The Quality & Safety dashboards have also been significantly improved to include compliments as well as complaints. In addition to this there is now an allocated complaints lead within the care group for oversight of any learning and actions completed as the result of

	a complaint so that the care group can be assured that all actions are completed and to give assurance of ongoing service development and quality improvements accordingly. **Next Steps :** • The Strengthening Families team will continue to monitor performance weekly and any drop in performance identified will be highlighted to the Specialist Nurses for further action. • A training needs analysis was undertaken to identify the training needs of the team. • CAMHS and Childrens Learning Disability Services were formally transferred under the management of the mental health care group as of the 1 November 2018 with a plan for this care group to be formally held within the Northumberland, Tyne & Wear NHS Foundation Trust (NTW) on 1 October 2019.
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. • The Trust was not required to set and achieve improvement trajectories for A&E 4hr wait, Referral to Treatment (18wks) or Referral to Diagnostics (6wks), but was expected to maintain the national standards achieved in the previous year (17/18). We achieved this in 2018/19, however it should be noted that the Trust's Type 3 A&E performance has been reported combined with NCUH since September 2017. **Mental Health** • Early Intervention in Psychosis team have to achieve the national standard of 50% for Referral to Treatment in 2 weeks of referral for the 2018/19 year. • CAMHS Urgent access has maintained performance over target throughout the 2018/19 year, in what has been a challenging year for the service due to capacity issues and increasing demand.

- CAMHS are establishing the Eating Disorder pathway and improving data capture to enable more accurate reporting of the CYP-ED RTT targets in the coming year.
- Following the changes to the data capture definitions used by clinicians agreed with commissioners in February 2018, the First Step service has achieved stable performance for 6 week Referral to Treatment above the national 75% target for the full 2018/19 year.

Community/Specialist

- We have achieved performance above the 95% target for A&E 4 hour wait, performing consistently above 98% during 2018/19. It should be noted that the Trust's Type 3 A&E performance has been reported combined with NCUH since September 2017.
- Referral to Treatment (RTT) position for consultant-led services has sustained performance over the 92% threshold over the full 2018/19 year, with the majority of the services reported from the Community & Specialist care group. The new North Cumbria Musculoskeletal service has been included in 2018/19 performance. Achievement of the target by Neurosciences continues to be challenging due to continued resource issues, the service continues to rely on locum consultant workforce. As a result, although the Trust overall has performed over the national standard, performance has deteriorated during 2018/19.

Children and Families

- The Consultant-led Paediatrics service has sustained RTT performance over the 92% threshold, and consistently over 96% in 2018/19.
- Performance for CLA Initial Health Assessments has been challenging in 2018/19, and has struggled to achieve the 85% commissioner set target in most months of 2018/19. This indicator is subject to some factors which are beyond the Trust's control (e.g. timescale for IHA for Cumbrian children placed out of county, large fluctuations in numbers becoming looked after month-to-month etc).
- The Children's Audiology service has continued to achieve the national standard of 99% Referral to Diagnostic, dropping under the target by only 0.1% once in the full 2018/19 year.

Next Steps:

- CAMHS are currently working closely with NTW on a recovery plan, and discussions are starting with Commissioners regarding the relaxing of the current commissioner set Access targets in favour of a focus on Referral to Treatment times for this service.

	• CAMHS Eating Disorder Referral to Treatment data capture continues to be developed with the Service to improve reportable data for commissioners and national statistics. • Services subject to Access targets continue to work closely with the Business Intelligence and Data Quality teams to assure their data for inclusion in performance indicators.
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 was a focused Board story related to least restrictive interventions to raise the profile of both staff and patient experience to the Board. • The Triangle of Care initiative has been approved and signed up too, with current trajectory ahead of target. The MHLD and CAMHS teams have completed the self-assessment and identifying team carer's champions. Quarter 1 in 2019 will see this being rolled out to community services although the CHMART are already undertaking this work which has almost completed. A carer's conference is being considered for 2019. This work is being joined up with the third sector network in Cumbria for a systems approach with Cumbria Volunteer network. • The Participation Strategy is currently on hold as this will now be system wide following the ICS 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. Within MHLD, a second cohort of staff from CAMHS and LD have undertaken the training with good feedback. • There is a significant improvement in compliance with the completion of complaints investigations within the specified timescales and also the quality of reports and letters to the complainant has improved. Changes to the policy of SIRI and complaints has been made following feedback from carers and families which has made it

	simpler when a complaint is received at the same time as a SIRI has been declared. • Within MHLD, the community survey has been completed for 2018 and is on track from 2019, which has given the opportunity for bespoke feedback across the community services. This year, the service has also completed an inpatient survey. • Bespoke networks within MHLD have developed systems and processes to collect experience as opposed to feedback. This has helped shape service priorities. An extended Listening Event schedule was also put in place to support the due diligence process within MHLD. • The PET visit the MHLD wards independently to take specific patient feedback during patient's admission and this has made a significant difference to being able to address patients concerns. Community ward meetings have helped to shape ward improvements. • The summary on a page of complaint and compliment information alongside the FFT has been helpful for teams to review as part of their team and governance meetings within MHLD. • There has been work undertaken by CMHART in relation to the FFT as patients have traditionally engaged with the community survey rather than the FFT. As a result of this work we are seeing an increase in FTT feedback which has been helpful to teams. • There are bespoke pieces of work in relation to how we engage with services users. This has begun in LD services and is planned to start for CAMHS. **Next Steps:** • 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, 2019/20 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. • The second priority is the role out of the Triangle of Care phase 2 which will help to support that we are ensuring involvement of

	families and carers as appropriate when assessing and planning care. During this phase it is planned to complete a carer's conference in partnership with the third sector. • 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 NHS Improvement indicator. A Public Governor, who has a learning disability, takes part in the audit process. 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.

Our focus for 2019/20, based on our strategic plans, feedback from our patients, staff and our communities, and from our CQC regulatory inspections will be:

- The development of a system wide 5 year Quality Strategy and associated 2019/20 Plan, which has four key aims:
    - Focus on culture: journey to Just and improvement culture
    - Continuously seek out a reduce patient harm
    - Deliver what matters most to patients, families and carers through positive experiences when accessing our services
- Evidence our ongoing improvement journey through getting to 'Good' and striving for 'Outstanding' in CQC ratings
- Continue to focus and learn from incidents and events to continuously improve the services that we provide;
- Strengthening our clinical governance arrangements both as a merged organisation and the system;
- Develop and implement Nursing, Midwifery and AHP strategy

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:
https://cdn.cumbriapartnership.nhs.uk/uploads/policy-documents/Being_Open_and_Duty_of_Candour_Policy_POL-CLIN-001.docx_.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.

Freedom to Speak Up Guardian

Freedom to Speak up Guardians have a pivotal role in helping to raise the profile of speaking up and raising concerns in their own organisation, and provide a supportive, confidential advice and support service to staff. The FTSU process is to act as conduit to raise concerns in an appropriate forum and is not there to replace other mechanisms for staff to raise concerns, such as through their line manager, through incident reporting, and through the Raising a Concern or Whistleblowing process.

Following the guidelines of the FTSU report, the FTSU Guardian role is independent of management and able to hold the Trust Board to account. They are supported by the Trust Board to create an open culture which is based on listening and learning and not blaming

In the Trust, there is a dedicated FTSU Guardian, and the role is supported by nominated FTSU Ambassadors.

Lessons continue to be learnt and feedback gathered from those who have used the FTSU Guardian service to raise concerns particularly about patient safety and behaviours.

To raise awareness of the role and to further support staff there is:

- Dedicated e mail address to contact the FTSU Guardian.
- Permanent screensaver reminder of FTSU service
- Corporate presentation available for all staff to use with their teams
- Promotional leaflet
- New promotional posters to be placed around both organisations
- Appointment of ambassadors

Work continues to develop the open and transparent culture that is necessary to encourage staff to raise matters, and for speaking up to be business as usual. The resulting number of formal cases suggests that staff feel comfortable to raise matters and that informal resolution is achieved in most cases. It is important to remain focused on feedback from individuals who have raised, and relevant stakeholders within the process, to ensure the current policy captures the spirit of the Trust's values, and staff feel they can raise concerns or issues without fear of victimisation, blame or reprisal.

Anonymous surveys are conducted where people who have raised concerns can respond to a series of questions, including whether they were subjected to any detrimental behaviour following the concern being raised; whether they felt that by following the process there was a positive outcome; and also if they feel that they would feel confident to raise a concern through this route again.

Rota Gaps

We are currently implementing our People Plan for the developing IHCS for North Cumbria. Development of this strategic delivery plan over 2019 - 2025 will be undertaken through co-production by the whole system, with the first action plan for 2019-20 aligned with the current business planning cycle. This strongly links workforce with service and financial plans, focussed upon the merging Trusts and associated organisations.

We have taken care in the strategy to ensure that we are not simply trying to solve the problems of 2019 or 2020. Instead, the strategy identifies the objectives which need to be achieved to ensure that we have the optimum number of workforce, with the best mix of skills, for the issues that will exist in 2025. The objectives therefore must allow for flexibility in how they will be implemented over the next five years. Engagement has taken place with Care Groups and System Leaders to ensure that transformational Business Cases are balanced with operational pressures affecting service delivery and patient flow, to develop a programme of workforce activity over the short and medium terms.

Our approach to managing bank, agency and locum spend has been nationally recognised as an exemplar leading to a reduction in our temporary workforce and significant cost improvements. This work is now being considered wider into Community and Primary Care, to provide alternative workforce models to support traditional roles and fill workforce gaps. A recent recruitment campaign has also resulted in the successful appointment of a number of International Clinical Fellows who will arrive in June 2019 to help fill our longstanding vacancies and support our existing medical workforce.

With increasing workloads and a workforce seeking flexible working patterns, we need to consider different skill mixes and roles for the workforce of the future in order to meet changes in the complexity of conditions and patient outcomes. Gaps in our workforce lead to over reliance on agency and bank staff, which places further pressure on permanent teams to provide continuity, safety and assurance and at increased cost.

In response to national skills shortages and the local rural/geographical challenges we face, transformation and redesign of our services will be critical to ensure we continue to deliver sustainable, high quality services for our patients with the resources we have. This will be supported by targeted attraction campaigns, an overhaul of our recruitment processes and effective on-boarding, which are all currently being developed.

Mortality Review – Learning from Deaths

There is a dedicated trust wide Mortality Review Steering Group in place and a trust policy in place to support learning from deaths: https://cdn.cumbriapartnership.nhs.uk/uploads/policy-documents/Learning_from_Deaths_Policy_POL-001-078.pdf

Quarterly reporting to the Board of Directors around Mortality continues.

(i) Mortality Statistics for Q1 – Q4, can be found below – each indicator below refers to a quarterly reporting period, during 2018/19:

Ref	Indicator	2018/19	Q1	Q2	Q3	Q4
27.1	Total Number of Deaths*	1127	251	253	299	324
27.2	Total number of deaths that have been subjected to a case record review or investigation) *[Structured Judgment Reviews (SJRs) and SIRI investigations)*	33 investigations 65 SJRs	11 investigations 17 SJRs 0 subject to both.	6 investigations 15 SJRs 0 subject to both.	7 investigations 15 SJRs 0 subject to both.	9 investigations 18 SJRs 0 subject to both.
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.**	1 (0.09%)	0	0	0	1 (0.30%)
27.7	Total Number of SJR's or investigations completed in	23 investigations	6 investigations	5 investigations	5 investigations	7 investigations

	the current reporting quarter, but related to deaths reported in a previous reporting period.					
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.**	2 (0.2%)	0 (0%)	1 (0.4%)	1 (0.3%)	0 (0%)
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	3 (0.26%)	0	1 (0.09%)	1 (0.09%)	1 (0.09%)

	been due to problems in the care provided.**					

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, and a record kept of the scores and rationale. Score 3 or below would be regarded as meeting criteria for 27.3 and 27.8 above:

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:

Key Findings from Structured Judgement Reviews completed (Q1 – Q4 2018/2019):
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.

27.4 Summary of learning and notable practice include:

Community Services Care Group
All of the SJRs highlighted some really good End of Life Care (EoL) care including:

- Rapid and thorough intervention
- Thoughtful and compassionate communication
- Evidence Based MDT care
- Support to family
- Where problems accessing consultant appointments arose, patient and family were supported to resolve issues
- Open visiting in place
- Assessment of capacity in place
- Worked with residential care to reduce physical risks (pressure ulcers, wound care and mobility)
- Good evidence of DNACPR discussions

Specialist Services Care Group
SJRs - all on patients on specialist palliative care unit, reviewed by multiple medical professionals and all with a confirmed palliative diagnosis. Observations – really good communication with families, care is responsive to needs. Some patients have a complex journey with multiple admissions/handovers. We have a number of referral forms/pathways in place. Teams respond to the referrals in a timely manner – within 48 hours in all cases reviewed,

72 hour report / SIRI - The Diabetes team are aware of incidents of young people with Type 1 diabetes in Cumbria who have died of DKA, since 2016. Commonalities in the DKA deaths include them being looked after children, evidence of self-neglect, potential abuse, very low BMI. The third case was at a transition point from leaving home to independent living and had learning difficulties and other physical health needs.
Mental Health Teams have identified that referral processes into their services can be complicated and will re share referral pathways regarding primary point of access.

Mental Health Care Group
Communication with families and the GP was good and in one example very proactive care from the CHMART who continued to have contact whilst in the acute settings.

27.5 Actions taken during the reporting period, and those actions proposed going forwards, from what has been learned from SJR's and Investigations undertaken:

Community

- As well as the SJRs we have completed 72 hour review's on a number of deaths
- The quality of incident reporting has been monitored and has been noted to be improving
- Teams supported thorough the quality and safety leads with reporting and reviewing of deaths
- To share widely through care group governance meetings

Specialist

To review rebooking system processes in Physical Health Psychology to ensure appointments are offered within accepted timescales. Our Acquired Brain Injury and Physical Health Psychology Service utilise differing risk assessment which could be beneficial to other services.

A recommendation regarding the development of a pathway regarding the management of people with persistent pain and long term mental health conditions and acknowledges the potential risk of suicide at all stages was made, discussions are underway across services to progress this.

Mental Health

Reminding about care plans need to include physical care. This is already included in the care planning training that is being rolled out within the care group.

27.6 Assessment of the impact of actions taken:

Community Services

An improving picture of both reporting and the quality of the incident reports

Specialist Services

Following SIRI recommendation, Diabetes Team now have access to RIO patient data system to enable better communication and sharing of information with Mental Health Services.

Mental Health

Positive action taken by the care group in relation to physical health care monitoring.

Next Steps - To develop a joint reporting and monitoring process between the Trust and North Cumbria University Hospitals Trust.

2.2 Statements of assurance from the Board of Directors

Statement of coverage

During 2018/19 the 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 6 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 - 17
Mental Health Community – 8
Children and Families – 12
Specialist - 8

We have reviewed all the data available to us on the quality of care in all of these relevant health services.

As of April 2018, transfer of all south Cumbria based community health and palliative care services to University Hospitals Morecambe Bay Trust took place, which reduced the number of sites the services operated from, as reflected in the information above.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Cumbria Partnership NHS Foundation Trust for 2018/19.

Participation in clinical audits and national confidential inquiries
During 2018/19, 9 national clinical audits and 2 national confidential enquiries covered relevant health services that we provide. During that period, we participated in 64% 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 we were eligible to participate in during 2018/19.

Eligible to Participate In	Participated
Learning Disabilities Mortality Review (LeDeR) Programme	Yes
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 Care at the End of Life (NACEL)	Yes
National Audit of Intermediate Care	No
National Clinical Audit of Anxiety and Depression (NCAAD)	Yes
National Clinical Audit of Anxiety and Depression (NCAAD) Spotlight on Psychological Therapies	Yes
National Clinical Audit of Psychosis (NCAP) Spotlight on Early Intervention in Psychosis (EIP)	Yes
National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness	Yes (NCE)
National Diabetes Foot Care Audit (NDFA)	Yes
National Diabetes In Patient Audit (NaDIA)	No
National Diabetes in Pregnancy Audit (NPID)	Yes
Prescribing Observatory for Mental Health (POMH-UK) Topic 16b: Rapid tranquillisation	Yes
Prescribing Observatory for Mental Health (POMH-UK) Topic 18a: Prescribing clozapine	Yes
Prescribing Observatory for Mental Health (POMH-UK) Topic 6d: Assessment of the side effects of depot antipsychotics	No
Prescribing Observatory for Mental Health (POMH-UK) Topic 7f: Monitoring of patients prescribed lithium	No
Sentinel Stroke National Audit programme (SSNAP)	No

The following table shows the national clinical audits and national confidential enquiries in 2018/19 that we 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	9 of 9 (100%) North CCG Reviews: 3 of 3 (100%) South CCG Reviews: 6 of 6 (100%)

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% No cases were relevant to the Trust.
National Audit of Care at the End of Life (NACEL)	Yes	71 of 71 – 100%
National Audit of Intermediate Care (NAIC)	No	The Community health Triumvirate regard this national clinical audit as labour intensive and past participation has not added value due to the diversity of the integrated services provided by the Trust. Available resources are being channelled into supporting exciting and challenging developments in Cumbria, including establishing the Integrated Care Communities (ICCs) and the Community Hospital Re-development Programme.
National Clinical Audit of Anxiety and Depression (NCAAD)	Yes	20 of 78 - 26%
National Clinical Audit of Anxiety and Depression (NCAAD) Spotlight on Psychological Therapies	Yes	25 of 25 - 100%
National Clinical Audit of Psychosis (NCAP) Spotlight on Early Intervention in Psychosis (EIP)	Yes	96 of 96 forms - 100%
National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness	Yes	5 of 5 (100%) suicide questionnaires returned 0 of 0 (100%) homicide questionnaires returned 0 of 0 (100%) Sudden Unexpected Deaths (SUDs) questionnaires returned
National Diabetes Footcare Audit (NDFA): Fourth Round	Yes	171 of 171 (100%)

National Diabetes in Pregnancy Audit (NPID)	Yes	8 of 8 (100%) Submission tied into Morecambe Bay.
National Diabetes Inpatient Audit (NaDIA)	No	Around the time this audit commencing there was a depleted staffing resource available, which has now been addressed, but prevented the Specialist Services Care Group from taking part. Despite this the audit remains in the Trust systems to ensure learning and potential actions take place once published nationally.
Prescribing Observatory for Mental Health (POMH-UK) Topic 16b: Rapid tranquillisation	Yes	59 of 59 (100%)
Prescribing Observatory for Mental Health (POMH-UK) Topic 18a: Prescribing clozapine	Yes	195 of 195 (100%)
Prescribing Observatory for Mental Health (POMH-UK) Topic 6d: Assessment of the side effects of depot antipsychotics	No	This was not participated in this cycle as the trust did well in the previous round of the audit. Also funding has been identified to increase Pharmacy support to the community mental health teams, which will include monitoring of depot medications, including medicines reconciliation and identifying patients prescribed high dose antipsychotics.
Prescribing Observatory for Mental Health (POMH-UK) Topic 7f: Monitoring of patients prescribed lithium	No	The Trust did not participate in this audit due to pressures on medical staff time and clinical work needed to be prioritised.
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 13 national clinical audits were reviewed by us in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided:

National Clinical Audit of Psychosis (NCAP)
This audit collected data about the care provided to a large, random sample of patients from all the main provider organisations in England and Wales. The national findings show improvements in aspects of physical healthcare for these patients and in prescribing practice. The provision of information about medication to patients remains poor nationally, and the availability of psychological therapies remains low. More needs to be done to assist patients into employment. In response to this national audit report the trust is raising awareness of the key findings through a staff newsletter and presentation and feedback to clinicians in the Clinical Governance Group. We have secured funding for further specialist cognitive behavioural therapy – psychosis training (CBT-P), and this is accompanied by the roll out of additional in house training focusing on psychosis. We have identified a lead to develop employment services and is part of a joint bid across the sustainability and transformation partnership with two other NHS trusts to gain funding for specialist employment workers for secondary care mental health services, these are already in place within Early Intervention services. Also we are delivering training to raise greater awareness of the importance of working with families and carers and clarifying the system for offering and documenting carers' assessments.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Chronic Neurodisability, focusing on cerebral palsy study: "Chronic Neurodisability: Each and Every Need"
This audit largely related to Acute Trusts rather than our Trust. However, four forms were completed covering the Trust geographical area and some learning was gained from the relevant national report elements. The actions included a number of improvement proposals to the electronic patient record system, the development of patient passports to ensure readily accessible information, the development of a patient-held emergency health care plan and ensuring that weight and nutritional status are recorded at every healthcare encounter.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
Following a benchmarking exercise carried out in summer 2018 as an action from the last round of NCISH, and based on this new report, it has been agreed that the focus of this year's (2019/20) action plan will link to the "10 ways to improve safety". None of the areas in the benchmarking exercise were red. The ones that were amber were used to identify areas for development which are reflected in the Suicide Prevention Action Plan.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH): the management and risk of patients with personality disorder prior to suicide and homicide

In response to this national report we have audited the prescribing of antipsychotics to people with personality disorder diagnoses, has introduced staff supervision/reflection groups, and developed standard operating procedures within the Personality Disorder Pathway.

National Diabetes Foot Care Audit: Third Round (NDFA)
This report covered eligible people with diabetes who were seen by a foot care service with a new ulceration. We scored better than the national average for bacterial infection rates, time to assessment, twelve week outcome recording, ulcer free by twelve weeks and low hospital admission rates. Actions put into place included increasing the participation from the community podiatry team, checking the coding of diabetic foot disease patients, sharing the findings with the Lead Vascular Consultant to raise awareness of low revascularisation rates and consideration of setting up a follow up diabetic clinic.

National Confidential Inquiry into Suicide and Homicide (NCISH): The assessment of risk and safety in mental health services
The 'Assessment of clinical risk in mental health service – An NCISH report' was published in October 2018. We took part in this national audit by providing details of the clinical risk assessment tool that is used. We use the Grist clinical risk assessment tool in the Mental Health services care group.
The national audit set out to describe the range of clinical assessment tools that are used across the UK, to compare these to best practice and to seek the views of clinicians, service users and carers on the tools and possible improvements. We were one of the 85 mental health providers to respond to the audit (representing all NHS Mental health providers across the UK). The national report does not provide individual trust or tool data so it cannot be used as a benchmarking report. The report does highlight some problems with risk assessment tools in general and also presents some recommendations for improvements. This local report compares our use of the Grist with the national report's identified problems and areas for improvement.
This comparison shows that the practice within the Mental Health care group is good when compared to the 6 clinical messages highlighted in the report. The areas in need of further improvement that the report highlights are the greater inclusion of family and carers in the risk assessment, formulation and management process and regular clinical supervision of working with risk. Both of these areas are already known to be in need of improvement and work was already underway to improve.

National Parkinson's Audit
This UK-wide audit took a multi-professional approach. We took part in the physiotherapy, occupational therapy and speech and language elements of the audit. The audit engages services to measure the quality of their practice, within their model of care provision and trigger service improvement plans. An organisational audit tool and a patient data tool was completed for each profession. Questionnaires were distributed to patients to collect data for the Patient Reported Experience Measure (PREM).

In comparison with national return rates our services were around average. No local reports were received due to the small numbers of patients seen during the data collection period, Occupational therapy saw 3 eligible patients, physiotherapy saw 5 and Speech and language therapy saw 2.
General findings from all services show there have been improvements in many areas since 2015 but there are areas identified that require improvement, including specialised multidisciplinary working. A new 8 week course will be developed and introduced for newly diagnosed patients and funding has been secured for staff to attend a PD warrior course.

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary Rehabilitation Audit

The National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme's Pulmonary Rehabilitation (PR) clinical audit 2017 ran from 3 January 2017 to 31 July 2017, for patients who attended their initial PR assessment (or if not assessed, began PR) between 3 January 2017 and 31 March 2017. Local reports were received for 5 areas, Solway, West (Allerdale & Copeland), Carlisle, Furness and South Lakes. The reports for Furness and South lakes have been passed to Morecambe Bay University Hospitals NHS Foundation Trust as the staff transferred earlier this year. The data below compares the service level results with the national results from the 2017 audit.
Audit data pertaining to 7,476 patients was received from 184 services nationally (out of the 195 identified - 79% of all eligible patients). All our teams were above this national average with West 90%, Solway 100% and Carlisle 100% of eligible patients. Muscle strength was recorded for 27% of patients nationally this was a large improvement from the 2015 audit results of 15%. The second national priority set by the audit is to use practice walks for all patients, we fully comply with this. Actions arising from this audit include increasing consistency across North and West teams by introducing practice tests for the Carlisle patients and raising awareness of recording data for West teams.

Physiotherapy Hip Fracture Sprint Audit

The Royal College of Physicians commissioned this audit as part of the Falls and Fragility Fracture Audit Programme (FFFAP). Each physiotherapist treating hip fracture patients completed a national hip fracture database (NHFD) audit form. The national main findings showed a large proportion of patients who have hip fractures do not get referred onto further rehabilitation in the community when they leave hospital. To improve services for these patients we have started an 'engaging for improvement' project.

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

In response to this national report we are going to present the findings at a teaching session for clinicians from Psychiatry, Learning Disabilities, Neurology and Pharmacy to ensure that all clinicians are aware of the "Valproate checklist for women of childbearing age" on the electronic patient system; 'RiO', and make printed copies of information sheets available to clinicians for clinic appointments.

POMH-UK Quality Improvement Programme. Topic 16b: re-audit. Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour.
A total of 59 cases were submitted for this national audit. We performed better than the national average in the treatment target (oral medication should be offered before intramuscular or intravenous) – for 61% of cases only oral medication was used (compared with 43% of the national cases). We achieved 100% in Standard 1a, which is about having a prompt debrief following rapid tranquillization, and scored better than the national average in Standards 1b and 1c, which cover updating the care plan, and Standard 3a, which is about monitoring the person at least every hour following rapid tranquillization. In response to this national report the following actions have been taken: the findings were presented at a clinical teaching session; the rapid tranquillisation policy was reviewed, updated and expanded; and a national joint treatment algorithm was adopted and launched for use in the Trust.

POMH-UK Quality Improvement Programme. Baseline Topic 18a: The use of clozapine.
A total of 195 cases were submitted for this national audit. Variations in practice were found in physical health checks and annual reviews. The actions that have been or will be taken by us as a result of this audit include: presentation of the findings by the lead pharmacist for mental health to the community health team leads, presentation to the trust's Quality and Safety Leads, and a further audit using a sub-set of the questions with the aim of reviewing the implementation of clozapine care plans on RiO.

Prescribing Observatory for Mental Health (POMH-UK) Topic 17a: The Use of Depot / Long Acting Injectable (LA) Antipsychotic Medication for Relapse Prevention
In this audit of people on continuing depot/long-acting injectable (LAI) antipsychotic medications, relevant clinical findings included: the most common rationale for initiation of the depot/LAI was to improve medication adherence; all the local cases had a Care Plan; only around a third had a clinical plan documented to address default from treatment. Actions are being taken to alert staff to the key findings through a staff newsletter, through caseload supervision, and a leadership team meeting.

Local clinical audits
The reports of 99 local clinical audits were reviewed by us in 2018/19, and we intend to take the following actions to improve the quality of healthcare provided.

Children and Families Care Group

Records Audit of Safeguarding Supervision
Following the introduction of a new safeguarding supervision process within the Children and Families Care Group, an electronic staff survey was created to ensure that the policy is embedded and evidence of Supervision is taking place. 120 staff practitioners completed the survey. The results were mixed, showing that 90% of staff had received

Management Supervision in the past 2 months and 100% of staff knew who to contact should they need Safeguarding support and advice. However, recording of Safeguarding Supervision on the electronic system was low at 66%. Actions taken in response included the electronic system to be updated to include a supervision document and staff guidance on recording, on genograms and significant events.

Child Looked-After Records Audit to /identify and Remove Duplicate Records Incorrectly Created due to Change of Demographic Details.

An issue was identified around duplicate records for clients who are 'Child Looked-After' (CLA) within the Trust. 128 adopted clients were identified to be audited and 36 records were identified requiring immediate actions that were initiated and monitored internally by the CLA administration team. This meant that the audit identified that 28% of the adopted client records in the Electronic Patient Record either had or had the potential for a duplicate record being created. Actions taken in response included a new service Standard Operating Procedure to be in place, CLA admin team now receive monthly data on clients known to be adopted by Cumbria County Council, a new health summary sheet to be ratified by Governance Senior Leadership Team and alerts have now been added to the electronic systems.

Audit of Autism Diagnosis Pathway

The audit commenced following the introduction of a new Autism Assessment Pathway in June 2017 and was needed to evaluate the effectiveness of the Multi-Agency Assessment Pathway and coherence with NICE guidelines CG128. The results showed that 30% less autism assessments concluded in 2018. Positive outcomes of the audit were the development of an autism assessment tracker. In West Cumbria time from referral to assessment decision improved and most families receive a face to face feedback with a standardised report. Actions included to clarify the process for initiating autism assessments, standardising the use of the autism pathway and autism assessment tracking by all community paediatricians, a booking systemic overhaul, improving the draft letter storage process and further understanding of reasons for low pre-school diagnosis rates in the South of the county.

Community Health Care Group

Self-Administration of Medicines on Community Inpatient Wards

Each community ward was visited by a member of the pharmacy team. The nurse in charge of the ward was interviewed and the medication charts reviewed to identify prescribing of items potentially suitable for self-administration. For those items identified, pharmacy staff found the item, ascertained if it is correctly labelled and searched the electronic record (EMIS) for information on consent and recording of self-administration. The audit identified that on all the wards, the nurse in charge was aware of the self-administration of medicines policy and could locate it, but although all the wards had trained some staff members on the policy, none of them had trained all of their staff. Only three wards (Copeland, Workington and Cockermouth) have medicines storage which is

suitable for self-administration (i.e. individual patient bedside lockers). 48 items from the limited list of medications (Creams, inhalers, eye drops, Nicotine replacement therapy (NRT), nasal sprays (GTN) items were prescribed at the time of the visit. Of these 15 were being self-administered by patients, 6 could not be found and 22 were inaccurately labelled. None of the patients self-administering had a completed consent form in the notes or pharmacy record of self-administration in the notes. All of the above is now being addressed. The self-administration of medicines policy has been updated and the pharmacy team have improved recording of self-administration during the medication reconciliation process and review patient's use of self-administered items during inpatient stays.

National Early Warning Score (NEWS) and Observations

Following incidents within the Community Health Care Group, opportunities to record observations had been missed. The audit captures where we are with staff understanding and compliance of taking observations and general awareness of NEWS (national early warning system). This audit is to be used as a benchmark of information. 284 staff in community nursing and community rehabilitation teams, working in Allerdale, Copeland Eden and Carlisle were invited to complete a questionnaire. There were 132 (46%) responses to the survey. The majority of staff responding to the survey completed observations as part of their role and have been supplied with equipment to undertake the observations. Staff correctly identified when NEWS should be used and when the NEWS should be repeated. The number of staff who reported they had never had training in NEWS was 55 (41%) this is currently being addressed by providing access to training for all staff.

Diabetic Booklet Audit

The audit was devised to understand the use of the diabetic booklet. The audit tool was sent to each Community Nursing Team in Allerdale, Copeland, Carlisle and Eden. The audit showed that the diabetic blue booklet is in use for the majority of patients (89%) whose notes were audited. 11% (6) of patients did not have the diabetic blue booklet in use. There were three sections on the front page of the diabetic booklet that were not always competed; allergies (28%), type of diabetes (32%) and blood glucose aim range (43%). These sections should be completed by the GP when prescribing the insulin. For 96% of patients audited the blood glucose reading was recorded at each visit. For 83% of patients the site of injection was not rotated on a weekly basis. In the majority of cases it was stated that the site was rotated more frequently than weekly; often left and right repeatedly. It is recommended that the audit should be repeated in 12 months' time to ensure that the diabetic booklet is fully embedded in all teams and a thematic review of incidents should also be considered.

Mental Health Care Group

Audit of prescription of antipsychotics within personality disorder diagnoses (CMHART)

Antipsychotic prescribing to people with diagnoses of Emotionally Unstable Personality Disorder (EUPD) / Borderline Personality Disorder, Antisocial Personality Disorder, and Mixed EUPD with Antisocial Personality Disorder was audited across Cumbria. The frequency of antipsychotic prescription (55%) was slightly lower than the national average (65%). However, the requirements set out by the NICE guidelines were not completely followed. For example, in 32% of cases, where antipsychotics were recommended specifically for personality disorder the rationale was not noted. The recommendation of not using antipsychotics for more than 4 weeks in Borderline Personality disorder was only 13.5% (national average 5%). Actions taken or planned include: a doctors' teaching session has been held where the findings were presented and discussed, a web link to information for service users has been added to the team SharePoint, information on the NICE guidance has been circulated in the CMHART newsletter.

Re-audit of Safeguarding Audit in First Step
Most of the 197 cases reviewed in this audit were self-referrals, which continues to be the predominant route into the service. In only 14 cases was there any information provided by the GP about safeguarding. 95% of assessments had the safeguarding section completed, although the amount documented within the section varied. Planned actions include: sharing the findings widely within and outside First Step, ensure staff record dates of birth of children rather than ages, validation of safeguarding information received by contacting relevant other professionals, and focussing re-audit on patients who have parental responsibility.

Re-audit of Suicide Risk Assessment in the Memory & Later Life Services
This re-audit looked at 61 care records. The findings showed improvement in the routine assessment and documentation of patients' risk of self-harm or suicide at initial assessment compared to the previous audit. 94% of cases had a GRiST completed for the current treatment episode, although only 78% were completed within the recommended time frame of 48 hours. The frequency (50%) and quality of formulations show that staff would benefit from further guidance/practice regarding the completion of risk formulations within the 5 Ps framework. Actions taken include:

- The continued roll out of Memory and Later Life specific risk training across the network
- Feedback of overall findings to team leaders in a network governance meeting
- An offer of individual feedback to team leaders regarding their own team's performance in the audit.

Specialist Services Care Group

Audit of internal referrals (from the Clinical Nurse Specialists (CNS) to the Medical Staff) within the Specialist Care Team (West)
An audit was designed as there had been a perception of, at times, high and unpredictable medical workload from the hospital support (liaison) part of the medical role in West

Cumberland Hospital. This was causing a strain on scarce medical time, particularly with a longstanding medical vacancy. Workload data across the whole service in Cumbria highlighted excess numbers of both direct and indirect West medical consultations, compared to South and East Cumbria. Reasons for the high and unpredictable workload in West were felt to be multifactorial but otherwise poorly understood. CQC had recognised the responsiveness of the service but asked about how the team dealt with fluctuations in workload and what the capacity was per day for the hospital team referrals. There was no data at the time to answer these questions. The audit was therefore designed to capture qualitative and quantitative data around referrals to give a greater understanding and identify areas for improvement.
Initially data was analysed about the number of referrals at West Cumberland Hospital. The medical workload for outreach consultations varied between a minimum of 3 and maximum of 12 per week over the 13 week period analysed, mean number 7.6. There were a total of 101 outreach consultations in the 13 week period. Individual days varied between 0 and a maximum of 5 consultations. Thursday was the busiest day with 29 consultations and the lowest number was on a Wednesday 11. Next busiest was Tuesday 23. Monday and Friday both had 19.
A referral form was designed to give more information regarding reason for referral and more qualitative information such as complexity. This was expanded to be used for all referrals to the medical team which included the community CNS. There was a difference in reason for referral between hospital and community CNS. For hospital CNS main reason for referral was assessment for Loweswater admission (Specialist Palliative Care beds at West Cumberland Hospital), followed by medical complexity e.g. multiple comorbidities. Gaps in CNS cover at West Cumberland Hospital were identified. In terms of complexity of referral, the majority were of medium complexity with a smaller number highly complex- demonstrating appropriate requesting of support from the medical team with complex patients.

The audit therefore gave a unique insight into referral dynamics of the team with qualitative and quantitative data around referrals. As a result of this audit a weekly Community Review Meeting with the Consultant and Community CNS team (later expanded to include the hospital CNS) was set up to provide additional support/ education within the team. A more robust plan was developed to cover hospital CNS gaps. Greater clarity on the Hospital Palliative Care outreach service at West Cumberland Hospital with a memorandum of understanding (MOU) to clarify response times and cover arrangements. Teaching on medical complexity was identified as a priority for the team and the first education session took place on 30/10/2018 jointly with the diabetes team.

Audit of Community Learning Disability Mental Health Pharmacological Interventions

The audit was in response to the recent NICE guidance being published regarding mental health problems in people with learning disabilities (NG54). The audit looked at ensuring that the community teams are working in accordance to best practice outlined in the guidance.

The key findings were mainly positive regarding psychiatric clinic letters with high adherence levels to identified best practice. However, it was noted that improvement, now being addressed, was required for reducing or discontinuing pharmacological interventions and establishing the most effective lowest dosages.

The Prescribing and Monitoring of Emergency Rescue Medication (Buccal Midazolam or Rectal Diazepam) for People with Prolonged or Recurring Seizures – Are Guidelines Being Followed?

Due to some concerns being raised about the safe prescribing and monitoring of Emergency Rescue Medication (Buccal Midazolam or Rectal Diazepam) for people with prolonged or recurring seizures amongst Cumbrian patients, an audit of a selection of Emergency Rescue Medication plans was conducted to investigate if guidelines are being followed.

Emergency Rescue Medication Plans were collected from staff members from within the Cumbria Neurology Service and the Cumbria Community Learning Disability Teams. In total 28 plans were audited. The findings were largely positive with the majority of plans being completed according to guidelines. Once analysed the main findings led to actions being recommended around the development and updating of the Emergency Rescue Medication plan template.

Central Support Services

Audit of a Sample of Patient Safety Incidents Which Resulted in Moderate or Greater Harm to Identify Good Practice, Issues or Gaps with Compliance with the Duty of Candour

This Trust-wide audit aimed to determine the baseline compliance position against the Care Quality Commission Regulation 20 for Duty of Candour. This regulation requires that when a notifiable patient safety incident occurs and results in moderate or greater harm that certain actions are triggered. A sample of 40 incidents were critically reviewed and all were correctly identified as requiring Duty of Candour or not. Where Duty of Candour did apply there was evidence that the appropriate letter has been prepared and provided to the patient or relative. However, a high percentage of the letters were not attached to the internal monitoring system, Ulysses. This finding was reflected within our new joint Duty of Candour Policy and supportive approaches introduced to ensure staff are aware and able to meet the requirement.

NICE Guidance

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. 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.

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. 91 guideline assessments have been ratified and an additional 379 NICE Technology Appraisals on medicines have been reviewed through Medicines Management Committees to date.

Participation in clinical research

The number of patients receiving relevant health services, provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics Committee was 722. A total of 35 different studies were recruited to.

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. Two papers, recently published in the journals *Public Health* and *Journal of Evaluation in Clinical Practice*, by members of our research team have shown that clinical research activity may have numerous indirect positive effects on the functioning of a hospital. 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.

Our Research and Innovation Strategy 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 both Trusts together as a single department. Professor Dave Dagnan has been 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 15 May 2019, our recruitment figure stands at 722 participants into 35 different portfolio studies. This is a decrease from this time last year which has largely been caused by a lack of portfolio studies in areas which we cover. However, there has been a significant shift in terms of the type of research undertaken. In the past it focused primarily on observational research, whereas this year the share of interventional research has increased. 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	1049	27
2017-18	924	35
2018-19	722	35

Footnote: recruitment to studies takes place from 1 April – 31 March each year. As there can be a slight delay between the actual recruitment of people to studies and recording on the national performance management system, this may result in some changes to the figures in the table above for previous year.

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. We currently have 4 commercial studies open to recruitment, with 57 recruits to date, an increase on this time last year. 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). We currently have 16 observational portfolio studies and 8 interventional portfolio studies open to recruitment. A higher proportion of our recruits now come from interventional studies which carry a greater weighting in terms of recruitment figures. We have 1 CTIMP currently open.

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 2018-2019

Study Name	Managing Specialty	Participants
Exploring the cause and prevalence of memory problems in mental health	Mental Health	146
STRINGS - Storage, Transport & Incubation for N. Gonorrhoea Samples	Infection	71
Recovering Quality of Life (ReQoL)	Mental Health	65
Lifestyle Health and Wellbeing Survey	Mental Health	57
HAWS - Haemoglobin Application to Wounds Study	Diabetes	53
WIDE study: Wound Infection Detection Evaluation study	Diabetes	52
PrEP Impact Trial	Infection	47
PARAGON; patient reported outcomes after GON block	Neurological Disorders	42
FICUS - faecal incontinence cost utilisation study	Gastroenterology	41
BrainCool-Migraine study	Dementias and Neurodegeneration	26
Safetxt: a randomised controlled trial of a safer sex intervention	Infection	21
ActiveCHILD Physical activity in under5s	Children	8
Free-Cog	Dementias and Neurodegeneration	8
Trajectories of Outcome in Neurological Conditions Phase 3 Consent and questionnaire	Dementias and Neurodegeneration	7
Trajectories of Outcome in Neurological Conditions Phase 2 Demographics and Clinical Info	Dementias and Neurodegeneration	7
Treatment of adolescent anxiety disorders : the views of clinicians	Mental Health	7
MODEM	Dementias and Neurodegeneration	6

ThrIVe-B programme for Bipolar Mood Instability: A feasibility study	Mental Health	6
NCISH	Mental Health	5
The contribution of the social work role in CMHTs	Mental Health	5
TriMaster v1	Diabetes	5
Vision in Parkinson's Disease	Dementias and Neurodegeneration	5
Teri-QoL	Neurological Disorders	5
EMHeP: Efficiency, cost and quality of mental healthcare provision	Mental Health	5
HCP Training in Assistive Technology	Health Services Research	4
DRUID	Diabetes	3
Managing Unusual Sensory Experiences (MUSE) in At Risk Mental States	Mental Health	3
BECOME	Neurological Disorders	2
Improving utilisation of pulmonary rehabilitation v1	Primary Care	2
AD GENETICS	Dementias and Neurodegeneration	2
Focus on early eating, drinking and swallowing	Children	1
Improving healthcare for probationers: mapping the landscape	Primary Care	1
The psychosocial impact of diabetes & severe mental illness: DAWN-SMI	Mental Health	1
RCT of COPe-support online resource for carers	Mental Health	1
Alleviating Specific Phobias Experienced by Children Trial (ASPECT)	Mental Health	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 2018 we have approved 22 studies - an increase on this time last year. These include 4 Investigator Initiated Trials (IITs) which we have developed ourselves and which contribute to Strategic Aim 4. All four of these studies are included on the national NIHR portfolio.

We are 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 for the second year running to have 100% of the information recorded in LPMS (the Local Portfolio Management System) complete and accurate. We 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. This year's conference was held on the 11 May 2018. It was well attended and received very positive feedback. This was the first conference for the combined CPFT/NCUH R&D department.

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.

Achievements and impact

We have also managed a very successful project to increase research activity within primary care in the region. We have taken an innovative approach to this whereby our research department employs a GP who is then able to facilitate the introduction of research within interested GP practices across the region. We are now a significant contributor to primary care research within the NECRN region.

We have significantly increased research engagement within the Memory Services over the course of the last year. There is now a research champion within each of the 6

memory matters teams and research now form part of the dementia pathway. This means that everyone who is assessed by the memory services is now asked about whether or not they are interested in taking part in research, which increases opportunities for patients and facilitates recruitment to studies in this area.
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.

One study which had an immediate impact for patients was the 'Improving Hospital Discharge Arrangements for People who are Homeless'. An outcome of this study was the introduction of mental health ward staff to the homeless prevention worker within the council. Prior to this there had been no clear pathway for discharging patients with housing issues. This study immediately meant that the process for discharging people with housing or homelessness issues was improved.

Another study with the potential to quickly have an impact on patient outcomes is the PARAGON study. Primary headache disorders, including migraine, cluster headache, and occipital neuralgia, are some of the most debilitating conditions that impact negatively on patients themselves and the wider economy. A subset of patients does not respond to currently available prophylaxis and rescue medication. Nerve block medication treatment is offered to these treatment-resistant patients. Greater occipital nerve block (GON block) is an established nerve block procedure that has a favourable safety profile and is cost-effective – the active ingredients used are a mix of local anaesthetic agent and steroid. The exact effectiveness and the optimal method for delivering GON block is not clear due to a relative lack of evidence from gold-standard randomised controlled trials and variety in the applied GON block procedure. Initial pilot data on GON block patients, and related evidence from use of anaesthetics in dentistry, suggests that lying a patient down for ten minutes after the procedure enhances the effectiveness of the GON block and thereby leads to an increase in the achieved headache-free period. This present study (an IIT led by Dr Jitka Vanderpol, Consultant Neurologist, CPFT in collaboration with the developers of an application that will be used for data collection) seeks to use a prospective, randomised, multi-centre approach to determine whether the patient's position straight after injection of the GON block medicine influences the patient-reported outcomes regarding headache symptoms afterwards.

Commissioning for Quality and Innovation (CQUIN)
A proportion of Cumbria Partnership NHS Foundation Trusts income in 2018/19 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.

Further details of the agreed goals for 2018/19 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 2017/18 the amount of CCG CQUIN income available was £3.4m. The negotiated settlement for 2017/18 was £2.9m which represents 85% of the available total. The value of NHSE CQUIN available was £70k 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 2 (2018/19) will not be confirmed until the end of Quarter 1 2019/20.

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 currently registered with the CQC to provide the following regulated activities.

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

- Alston Hospital
- Brampton Hospital
- Cockermouth Hospital
- Copeland Unit
- Haverigg Prison
- Keswick Hospital
- Penrith Hospital
- Wigton Hospital
- Workington Hospital
- Maryport Hospital
- Voreda House

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

Surgical procedures – we can only carry out these activities via Trust Headquarters, Voreda House.

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

- Alston Hospital
- Brampton Hospital
- Cockermouth Hospital
- Carleton Clinic, Carlisle
- Copeland Unit
- Dova Unit, Barrow
- Haverigg Prison
- Kentmere Ward, Westmorland General Hospital
- Keswick 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 the Trust during 2018/2019.

Care Quality Commission registration

During 2018/19 we 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 our services 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 our Quality, Safety and Safeguarding Team to embed required improvements following CQC inspections which highlight any issues and concerns.
- Introduction of a joint Trust (CPFT & NCUH) assurance process for CQC standards, which includes a relaunch of 15 Steps Assessments, across CPFT, with rollout taking place as of February 2019.
- Continued embedding of a Joint Compliance Board, which has oversight of CQC regulatory activity, actions and improvement planning.
- Re-introduced monthly engagement meetings between CPFT, NCUH and CQC inspectors to share any learning, development and improvement and any issues arising.

Regulatory inspections

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. Copies of any published inspection reports are available for review on the CQC website www.cqc.org.uk.

Findings and actions from the 2017 inspection are being progressed, with 19 of the 22 Must Do actions being completed. All actions are monitored through the Joint Compliance Board, and there is regular reporting of progress to meetings of the Quality & Safety Committee and Board of Directors.

Each of our care groups have in place a Quality Improvement Plan (QIP) to capture all improvement work that is underway or planned, and these include the findings and actions from the CQC inspections. The plans are monitored through monthly meetings with the care groups, chaired by the System Executive Chief Nurse and System Executive Chief Operations Officer, and exception provided to the Joint Compliance Board.

The Trust current CQC ratings

Our overview ratings for the Trust and our services can be found on our website. The matrix below shows the overall trust wide ratings:

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

CQC Inspection Notification

On the 29 January 2019 we received notification that the CQC were beginning to plan the next inspection. The initial provider information request (PIR) was submitted in February, and we have received the dates for the provider level Well Led inspection from the CQC, due to take place on 24 and 25 June 2019. Unannounced inspections to core services are due to pre-ceed the Well Led inspection. A preparation plan has been developed in readiness for the upcoming inspection activity, which is monitored through the Joint Compliance Board.

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 place from the 12 – 16 February 2018.

The final report following this review, which was 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, 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 took place on the 21st May 2018, and a completed action plan to address the recommendations was submitted. Findings and actions are not specific to the Trust, however the action plan progress is being monitored through the Cumbria Health and Wellbeing Board.

Joint CQC / Ofsted inspections - SEND

On the 11 March 2019 we received one week's notice of the inspection of SEND (Special Educational Needs and Disabilities), which is a joint inspection by Ofsted and the CQC, for children and young people from 0-25 years. This was an inspection of the local area, so involved education and health commissioning and providers. The inspection lasted for a week, and started on 18 March 2019. Two CQC inspectors were part of the overall inspection team who interviewed staff, held focus groups, visited early years settings and reviewed case notes (through sampling). During the high level feedback on the 22 March examples of notable practice were highlighted, along with some recommendations for improvements to be made. The report is due to follow around May 2019, with planned re-inspection of these areas in around 18 months' time.

Ofsted inspections

The Trust did not receive any direct external inspections from Ofsted during 2018/19.

Hospital Episodes Statistics data

The Trust submitted records during April 2018 to February 2019 (data from March – April 2018 not yet published) 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 (National 99.4%);
    - 99.7% for outpatient care (National 99.6%); and
    - 94.7% for accident and emergency care (National 97.6%)
- which included the patient's valid General Medical Practice Code was:
    - 99.9% for admitted patient care (National 99.9%);
    - 99.7% for outpatient care (National 99.8%); and
    - 99.9% for accident and emergency care (National 99.3%)

Information Governance (IG)

Information Governance is to do with the way we process and handle information. It covers personal information (relating to patients/service users and employees) and also corporate information (for example financial and accounting records). By embedding Information Governance in the culture of the Trust, we can provide assurance to the public and our regulators that we comply with relevant legislation and central guidance; that information is handled appropriately, lawfully and securely. The Information Governance vision is that we "*Enable high quality care by facilitating the ethical, legal, effective & appropriate use of accurate & reliable information that maintains confidentiality, integrity & availability*".

This has been a busy year as there has been numerous changes in the standards that we need to adhere to in order to help us comply with the data laws. These include:

- **The Data Security and Protection (DSP) Toolkit** - From April 2018, the new Data Security Protection Toolkit (DSP Toolkit) replaced the Information Governance Toolkit. It forms 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. Final publication assessment scores reported by organisations are used by the Care Quality Commission for use as part of the Well Led inspection. The new Toolkit includes compliance with GDPR.
- **The General Data Protection Regulation (GDPR)** was implemented on the 25 May 2018. Alongside this Regulation is the Data Protection Bill (published in September 2017) which introduced a number of changes to the GDPR requirements which are extensive. There is a raft of other legislative requirements to following (i.e. NIS Directive). 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 -** organisations need to be compliant by 31 March 2020. The Trust is leading the way as one of the pilot sites working with NHS Digital in preparation. The Trust has added the national data opt-out to their record of processing activities (ROPA) as part of their GDPR work and provided valuable feedback on NHS Digital's Compliance Implementation Guide which will be available to all organisations nationally soon.

We submitted as compliant against all mandatory assertions contained within the Data Security and Protection Toolkit. Improvement plans are in place to further enhance compliance in 2019 – 2020. This was independently verified by Audit One auditors.

Information Governance and Cyber Security incidents

We take our responsibilities for the protection of patient and staff information seriously. Breaches of confidentiality or loss of personal data are reported and investigated through our Incident Reporting procedure and assurance processes. During the reporting period, the Information Governance Team has recorded 973 IG incidents between 1 April 2018 and 31 March 2019. We use the national Incident Reporting Tool within the Data Security and Protection Toolkit. Incidents are coded in line with the SIRI guide "Guide to the Notification of data security and protection incidents – reporting incidents post the adoption of the General Data Protection Regulations (25 May 2018) and the NIS Directive (10 May 2018). Any incident must be graded according to the significance of the breach and the likelihood of those serious consequences occurring. The incident must be graded according to the impact on the individual or groups of individuals and not the organisation.

We reported the following incidents via the Data Security and Protection Toolkit to its Regulators:

Date of Incident	Reference number	Summary of Incident	Outcome	Status
07/06/2018	196	An individual called the Communications Helpdesk on 1 June 2018 (17:00) to make a complaint about a video which included her talking about pressure ulcers, her full name, her place of work, and her job title being published online and shared on social...	Not required to report Not required n/a	Closed
08/06/2019	219	A relative of a deceased individual complained to the Trust via the formal complaints procedure. This was subsequently investigated but the complaints team missed within the reams of correspondence received the request to be provided with copies of her...	Not required to report Not required n/a	Closed
22/06/2019	1466	15 boxes were sent to Fastness by Millom Hospital under a legacy contract (PCT22). The Data Controller for these is CPFT as legacy information. On 1 April 2018, these services transferred to University Hospitals of Morecambe Bay. A transfer agreement...	Not required to report Not required n/a	Closed
20/07/2018	1885	The Trust had received a number of emails from a data subject via our Patient Experience Team alleging that the Trust had been intercepting his emails to North Cumbria University Hospitals (NCUH) and Cumbria Medical Services (CMS). The data subject...	Not required to report Not required n/a	Closed

10/08/2018	3163	Communications department have been approached by the Daily Telegraph to ask for a statement in reaction to a number of staff email and passwords being published. This breach occurred and published in 2016. The Trust was not aware of the breach. Following...	Not required to report Not required n/a	Closed
24/08/2018	3336	• Mental health initial assessment of patient A was sent to Patient B – a member of staff attached Patient As assessment to Patient B's cover letter	ICO (24/08/2018)	Closed
14/09/2018	4590	Patients mum called the Child and Adolescent Mental Health Service to complain as her daughter's clinical letter has been sent to the wrong address and another family have opened the letter they received and have shared the contents of this letter with…	ICO (14/09/2018)	Closed
02/11/2018	6153	The Trust has been made aware that a third party has disclosed sensitive and privileged information in the form of meeting minutes in relation to a joint multi agency risk evaluation meeting. This information was disclosed directly to the patient without...	Not required to report Not required n/a	Closed
30/01/2019	8099	Complaint raised via our Patient Experience Team that a patient's daughter had found a Do Not Resuscitate (DNR) alert with the patient demographics of another patient on her Mum's District	Not required to report Not required n/a	Closed

		Nursing Notes in her home. Daughter upset regarding the DNR as...		

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.

CAUSE 1	Count	%
Misfiled Documentation	171	29.53%
Breach Of Confidentiality - Electronic	69	11.92%
Missing Records/Documentation	67	11.57%
Breach Of Confidentiality - Written	47	8.12%
Lost Or Stolen Smart Card	46	7.94%
Failure To Follow IG Code On Conduct/Trust Policy	38	6.56%
Documentation Error	28	4.84%
Data Quality RIO Issue	26	4.49%
Data Quality EMIS Issue	15	2.59%
Inappropriate Access To Systems/data	12	2.07%
Smartcard Security Issues	8	1.38%
Missing/unavailable Records (Corporate)	7	1.21%
Breach Of Confidentiality - Verbal	6	1.04%
Clinical Coding Issue	6	1.04%
Data Quality SOEL Issue	6	1.04%
Incorrect Destruction Of Health Records	5	0.86%
Uploaded To Internet / Intranet In Error	5	0.86%
Damaged Or Broken Smart Card	3	0.52%
Data Quality ADASTRA Issue	3	0.52%
Insecure Disposal Of Data	3	0.52%
Data Sent To Incorrect Recipient	2	0.35%
IG Suppliers / Contractor Issues	2	0.35%
Incorrect Destruction Of Records (Corporate)	1	0.17%
Unauthorised Access To Information Systems	1	0.17%
Unavailable Records	1	0.17%
Verbal Disclosure	1	0.17%
Total:	579	

The IG compliance programme against the Data Security and Protection Toolkit standards is closely monitored by the Joint IG Board that meets on a quarterly basis. The meeting is chaired by the joint Executive Director of Finance & Estates (our Senior Information Risk

Owner) and is attended by our Caldicott Guardian (for CPFT and NCUH). Other regular attendees are representatives from the care groups, providing 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 2018-19 include:

General Data Protection Regulations came into force on 25 May 2019. To support compliance we have:

- Developed awareness programme for all staff with the Board trained by NHS Digital with IG staff achieving Certification or GDPR Practitioner status
- New Individual Rights process developed
- Single Subject Access request process in place with plans to integrate further in 2019 – 2020
- Record of Processing activities mapping tool developed and in pilot stage
- Contractor documentation package developed for use by Procurement Team
- Single coding process of IG incidents in line with national guidance
- Single Data Protection Impact Assessment process in place
- Appointment of Data Protection Officer for both Trusts

Integration:

- Appointment of Senior Joint IG roles
- Joint Trust policies in place
- Alignment of staff under single management arrangements pending future re-structure in 2019
- Working with Integrated Care Communities to support new ways of working

Data Security and Protection Toolkit:

- Successful completion of the inaugural year of Data Security and Protection Toolkit
- All mandatory requirements met with improvement plans in place for areas such as security due to NCUH infrastructure and procurement contracting process.
- Mandatory IG training – CPFT (95%)
- Independently audited by Audit One with all recommendations recommended being completed by the end of the financial year

Information Rights

- With changes in GDPR the response rate to respond to subject access requests is now 30 days and FOI to be responded in 20 days the % of cases hitting this compliance level is detailed below. National target set by Information Commissioner is that 85% as a minimum of all requests are dealt on time.
    - 91% - % SAR responded in 30 days
    - 98% - % FOI responded in 20 days

- 11% increase in FOI cases received this year – complied within existing resources – requests with increased complexities
- Future plans to align processes further in 2019/20

Registration Authority

- Our Registration Authority Service continues to excel and provides a first class service not only to the Trust but the CCG, GP's, Pharmacies and other Independent Organisations
- Continue working collaboratively with external partners (GP's & Pharmacies) to streamline RA Services to reduce travel, time and costs for the Trust and our partners.
- Appointment of NVQ Level 3 RA Apprentice
- Progressing Integration working arrangements between CPFT & NCUH RA Services.
- Ahead of target with GP/Pharmacy 3 year rolling programme of reviews. Increase from 1% to 44%
- Rollout of smartcard self-service unlock to CPFT to streamline processes

Health Records

- 3452 records (11.57%) processed for disposal since start in February 2018. This represents only the destruction of deceased community health records due to Goddard Enquiry and our inability to destroy all those identified for disposal.
- 16.11% of uncatalogued records, catalogued and archived
- All requests for records dealt with within 24 hours
- Working on projects such as implementing EPR to Community Hospital wards, roll out of ICE, Agile working, projects to clear out children's records and mental health records from large storage areas across the Trust.
- Providing training and advice across the Trust
- 89 teams audited against health records keeping standards 71 passes at 80% or higher
- 32 teams have been audited against the scanning procedure
- 95% of patient records marked as deceased within 4 working days

General

- Whole IG Team trained at either Certificate or Practitioner level in GDPR
- 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 that are being reviewed jointly
- For eighth year in a row all staff have been trained in information governance (hitting over 95% compliance)

Payment by Results
The Trust was not subject to the Payment by Results clinical coding audit during 1 April 2018 – 31 March 2019.

Data Quality Statement
The Trust will be taking the following actions to improve data quality, the review and continued implementation of our Data Quality Strategy; continued cycle of internally performed audit of performance indicators for assurance in the validity of reported performance; acting upon the advice and recommendations made by external auditors. 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 relevant acute indicators

Indicator – Care Programme Approach (CPA) follow up: proportion of discharges from hospital followed up within seven days (target 95%)

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 continuing the provision of daily performance position to the relevant services, facilitating and encouraging regular validation of the records included in this indicator. The Trust will also continue to conduct regular audits of the processes used and its paper records to verify that this indicator is accurate. Where performance is impacted by capacity and service related issues, these will be escalated via the appropriate Care Group governance route and discussed with Commissioners where required.

Period	Level Description	Number of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (QA)	Total number of patients on CPA discharged from psychiatric inpatient care (QA)	**Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (QA)**
Q1 2017/18	England	15,824	16,372	**96.7%**
	CPFT	211	222	**95.0%**
Q2 2017/18	England	15,814	16,347	**96.7%**
	CPFT	188	193	**97.4%**
Q3 2017/18	England	16,017	16,790	**95.4%**
	CPFT	175	184	**95.1%**
Q4 2017/18	England	16,040	16,795	**95.5%**
	CPFT	159	166	**95.8%**
Q1 2018/19	England	16,594	17,329	**95.8%**
	CPFT	159	166	**95.8%**
	Lowest	292	398	**73.4%**
	Highest	205	205	**100.0%**
Q2 2018/19	England	16,350	17,080	**95.7%**
	CPFT	156	163	**95.7%**
	Lowest	303	365	**83.0%**
	Highest	135	135	**100.0%**
Q3 2018/19	England	16,104	16,860	**95.5%**
	CPFT	169	179	**94.4%**
	Lowest	266	326	**81.6%**
	Highest	189	189	**100.0%**
Q4 2018/19	England	15,470	16,150	**95.8%**
	CPFT	157	162	**96.9%**
	Lowest	213	255	**83.5%**
	Highest	216	216	**100.0%**

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.

Period	Level Description	Number of admissions to acute wards that were gate kept by the CRHT teams (QA)	Total number of admissions to acute wards (QA)	**Proportion of admissions to acute wards that were gate kept by the CRHT teams (QA)**
Q1 2017/18	England	16,543	16,763	**98.7%**
	CPFT	161	163	**98.8%**
Q2 2017/18	England	16,506	16,734	**98.6%**
	CPFT	150	152	**98.7%**
Q3 2017/18	England	15,992	16,231	**98.5%**
	CPFT	143	147	**97.3%**
Q4 2017/18	England	15,769	15,973	**98.7%**
	CPFT	125	125	**100.0%**
Q1 2018/19	England	16,392	16,707	**98.1%**
	CPFT	125	125	**100.0%**
	Lowest	57	67	**85.1%**
	Highest	618	618	**100.0%**
Q2 2018/19	England	16,307	16,565	**98.4%**
	CPFT	126	131	**96.2%**
	Lowest	180	221	**81.4%**
	Highest	586	586	**100.0%**
Q3 2018/19	England	15,586	15,935	**97.8%**
	CPFT	120	120	**100.0%**
	Lowest	535	679	**78.8%**
	Highest	516	516	**100.0%**
Q4 2018/19	England	15,642	15,943	**98.1%**
	CPFT	103	104	**99.0%**
	Lowest	500	567	**88.2%**
	Highest	989	989	**100.0%**

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

re-admitted 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.

Experimental statistics have been published by NHS Digital, providing the data below, note that CPFT data will include Mental Health and Community Hospital admissions:

0 to 15 years old:

Year	Period of coverage	Level description	Indicator value	Numerator	Denominator
2016/17	01/04/2016 to 31/03/2017	England	11.6	109,255	939,615
2016/17	01/04/2016 to 31/03/2017	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	4.1	*	85
2016/17	01/04/2016 to 31/03/2017	Highest	68.4	*	*
2016/17	01/04/2016 to 31/03/2017	Lowest	1.6	*	140

*Only 1 year of data nationally published for CPFT

16 and over:

Year	Period of coverage	Level description	Indicator value	Numerator	Denominator
2013/14	01/04/2013 to 31/03/2014	England	12.6	659,135	5,232,925
2013/14	01/04/2013 to 31/03/2014	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	14.7	315	2,030
2014/15	01/04/2014 to 31/03/2015	England	13.0	690,590	5,309,670
2014/15	01/04/2014 to 31/03/2015	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	13.6	265	1,825
2015/16	01/04/2015 to 31/03/2016	England	13.4	708,545	5,278,810
2015/16	01/04/2015 to 31/03/2016	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	12.1	205	1,720
2016/17	01/04/2016 to 31/03/2017	England	13.6	720,450	5,315,000
2016/17	01/04/2016 to 31/03/2017	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	14.3	195	1,370
2017/18	01/04/2017 to 31/03/2018	England	14.1	758,510	5,397,560
2017/18	01/04/2017 to 31/03/2018	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	17.4	275	1,700
2017/18	01/04/2017 to 31/03/2018	Highest	46.4	*	*
2017/18	01/04/2017 to 31/03/2018	Lowest	1.8	*	285

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 continuing to conduct regular audits of the processes used and its paper records to verify that this indicator is accurate. Where performance is impacted by capacity and service related issues, these will be escalated via the appropriate Care Group governance route and discussed with Commissioners where required.

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

Community Mental Health Teams Overall Patient Experience Scores 2018/19

	Trust Scores		Performance	
Domain	2018/19	2017/18 (comparable scores only)	80th percentile for 2018/19	Performance in top 20% for 2018/19
Access and waiting	79.5	Not comparable	85.9	No
Safe, high quality, coordinated care	66.0	Not comparable	73.0	No
Better information, more choice	69.3	Not comparable	71.4	No
Building closer relationships	74.0	79.6	77.1	No
Clean, comfortable, friendly place to be	Domain not used	Domain not used	Domain not used	Domain not used
Overall	72.2	No data	76.2	No

The Trust considers that this data is as described for the following reasons. The NHS Digital Quality Accounts resource for this indicator has not been updated since 2013, NHS England statistics have been used to provide the following data (https://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info/)

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, validate and challenge Service access and waiting time performance across the care group with a view to minimising waiting times wherever possible.

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 2017-2018	1500	504	33.6%	914	60.9%	73	4.9%	5	0.3%	4	0.3%
MH Av. Q3-Q4			64.9%		28.8%		5.1%		0.3%		0.8%

2017-2018*											
CPFT Q1-Q2 2018-2019	1293	467	36.1%	760	58.8%	62	4.8%	3	0.2%	1	0.1%
MH Av. Q1-Q2 2018-2019*			65.9%		18.0%		5.0%		0.3%		0.8%

*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 2018 to 30 September 2018 being published in March 2019. 2018/19 Q3 and Q4 information will be published in September 2019.
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.
We have 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:

- We are committed to supporting and embedding a positive reporting culture to enable us 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) we were 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 NHS FT.
- At a support service level there has been continued work completed by the Incident and Risk Management Team to support our staff 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, Care Group Associate Directors of Nursing, the Medical Director and the Learning Lessons Facilitator(s).
- Collectively key staff 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 8517 patients, service users and carers during 2018/19. All survey findings and recommendations are reported monthly to the relevant care groups, Executive Team and Board of Directors; and quarterly to the Quality & 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 19 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 2018/19

Team	Care Group	Quantity
Inpatient Wards	Mental Health	397
Inpatient Wards	Community	619
Community Services	Community	1548
Here for you visits	Community	389
Here for you visits	Mental Health	231
Parent	Children & Families	298
Children	Children & Families	1754
Community Services	Specialist Services	743
Friends and Family SAE Card	Trust	2399
Friends and Family SAE Card	Memory Matters and Later Life Services	417

Examples of findings from surveys and patient feedback for 2018/19:

- 99.07% of people who used the Physiotherapy Service said they were treated with dignity and respect by the staff
- 95.59% of children using the Immunisation Nurses Service said that they felt safe
- 99.49% of people using the Specialist Palliative Care Service said that they were treated with kindness and compassion by the staff looking after them
- 98.96% of parents who's child was using the Health Visiting Service said that their child was treated with dignity and respect
- 98.96% 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
- 100% of people using the Specialist and Special Care Dental Services said that their treatment completed in an efficient, timely and pain free manner
- 94.55% of people using the Memory and Later Life Service said that their diagnosis was disclosed in a sensitive and compassionate way
- 93.38% of people who had an inpatient stay in a Community Hospital said that they felt safe whilst in hospital
- 92.08% of people who had an inpatient stay in a mental health inpatient unit felt that they were treated with dignity, respect and compassion by the staff looking after 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.

We have received 5819 completed FFT questions, of which contained 5004 free text comments to support their answer.

Examples of findings from the FFT question are as follows:

- 88.65% of people are extremely likely or likely to recommend the Mental Health inpatient ward to friends and family
- 94.16% of patients are extremely likely or likely to recommend the Community inpatient ward to friends and family
- 97.23% of people are extremely likely or likely to recommend the First Step Service to friends and family
- 99.05% of people are extremely likely or likely to recommend the Health Visiting Service to friends and family
- 95.45% of people are extremely likely or likely to recommend the Children's Speech and Language Therapy Service to friends and family
- 97.62% of people are extremely likely or likely to recommend the Minor Injury Unit to friends and family
- 99.53% of people are extremely likely or likely to recommend the Community Pulmonary Rehabilitation Service to friends and family
- 100% of people are extremely likely or likely to recommend the Specialist Palliative Care Service to friends and family
- 99.46% of people are extremely likely or likely to recommend the Dental Service to friends and family.

Mandated National Mental Health Survey 2018
The Mental Health Community Survey 2018 is part of a series of annual surveys required by the CQC for all NHS Mental Health Trusts in England. We commissioned Quality Health to undertake the Mental Health Community Survey 2018. The survey is based on a sample of all service users who were seen between 1 September 2017 and 30 November 2017.A total of our 850 patients were sent a questionnaire. 820 were eligible for the survey, of which 229 returned a completed questionnaire, giving a response rate of 27.93%. This survey has highlighted many positive aspects of the service user experience.

Key facts about the 229 service users who responded to the survey:

- 73.45% of respondents have been told who is in charge of organising their care and services

- 25.46% of respondents had been in contact with NHS mental health services for less than 1 year,
- 72.96% 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
- 62.81% of respondents knew who to contact out of office hours if they had a crisis
- 73.66% stated that they always felt that in the last 12 months that they were treated with respect and dignity by NHS mental health services and 21.43% said yes, sometimes
- 39.30% of respondents were male and 60.70% were female.
- 10.04% were under 35, 13.54% were aged 36-50, 23.14% were aged 51-65 and 53.28% were aged 65 and over.

Any other public and patient involvement activities

We have in place arrangements for service user and carer involvement through the Patient Experience Involvement Group (PEIG) which is made up of both mental health and community service users and carers.

In 2018/19 our service users and carers (PEIG) have been involved in the following:

- Sitting on 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 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 monthly ward visits facilitated by the Patient Experience Team.
- Development of leaflets: service users and carers provide constructive feedback on new or updated 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 volunteer requests. 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 a feature on quarterly public meetings during 2018/19, although some were not heard due to late cancellation by the patients involved. A patient, service user or carer has been invited to attend 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

These people have accessed the following services:

- Memory Matters & Later Life Services – Ruskin Unit - Through the voice of the Ward Manager, the wife of an older person with highly complex needs shared the experience of the seeing her husband receive care which at times was managed by the use of restrictive interventions. A specialist Psychiatric Intensive Care Unit (PICU) was not available but the Multi-Disciplinary Team (MDT) worked with the patient and his family to provide care which has resulted in significant improvement. His wife's words were read and photos of the man behind the illness were shown.

  The staff example was shared by a Nurse who was asked to attend PICU a part of a response to an emergency BLICK being activated on the Carleton Clinic Site. The Police were called to attend and offered to take the patient into custody to provide a safe environment. The Board heard what informed the Nurse to put the patient's needs first and to decide to manage his care needs by nursing him on the unit.

- Dental Services, Carlisle – a parent shared her experience of her son's delay in receiving dental treatment in Furness, the young boy, 6 years old had toothache and required teeth extractions. The waiting list in Furness was lengthy therefore the parent was offered an appointment in Carlisle, which she accepted. Her son's teeth were removed and it was a good experience for both apart from the son waking up from the anaesthetic without his mother present and he became upset.

Our staff experience

Our core objective is to embed the right culture and make the organisation a great place to work. Staff engagement is essential because we know that when staff are happy and fully engaged they provide the best possible care for our patients. 'This is Us' is the Trust's approach to staff engagement. Staff have the opportunity to meet with the CEO each quarter, in a variety of locations, to hear about the Trusts plans, raise any concerns and ask questions. The annual business plan and priorities are shared at the start of the financial year and cascaded to individuals through 'This is me', values based appraisal. Staff are also kept informed through a weekly CEO Blog, a newly developed staff intranet portal, email and 'Trust Talk' printed magazine.

NHS Staff Survey

The NHS Staff Survey is the largest survey of staff opinion in the UK; it is carried out annually to gather the views on staff experience at work in ten key indicators. The survey is administered electronically and completely anonymous. Indicators are measured on a scale of 10 and we are benchmarked against the average score of other similar trusts.

The response rate for the 2018 NHS staff survey was high, 49% compared to a national average of 41%. The scores for each indicator, together with comparison against the average for combined mental health / Learning disability and community trusts are presented in the table below:

Indicators	2018/19		2017/18		2016/17	
	Trust	Average	Trust	Average	Trust	Average
Equality, diversity and inclusion	9.2	9.2	9.4	9.2	9.3	9.2
Health and wellbeing	5.9	6.1	6.1	6.1	5.9	6.2
Immediate managers	7.1	7.2	7.2	7.1	6.9	7.1
Morale	6.2	6.2	x	x	x	x
Quality of appraisals	5.5	5.5	5.7	5.4	5.3	5.4
Quality of care	7.2	7.4	7.5	7.4	7.4	7.5
Safe environment – bullying and harassment	8.2	8.2	8.3	8.3	7.7	8.2
Safe environment – violence	9.6	9.5	9.5	9.5	9.4	9.5
Safety culture	6.7	6.8	6.7	6.7	6.5	6.7
Staff engagement	7.0	7.0	7.1	7.0	7.1	7.0

*There is no comparable data for 2017/18 and 2016/17 for the Morale indicator, as this was a new indicator for the 2018/19 survey.

The results from the Staff Survey show that staff engagement is the same as similar Trusts (7.0); staff recommendation of the Trust as a place to receive treatment is slightly higher than average and recommendation as a place to work is lower than average. Results for all scores are lower than in 2017 when staff engagement was reported as 7.1.

Indicator	2017/18	2018/19
Staff recommendation of the Trust as a place to receive treatment	72.6%	66.4%
Staff recommendation as a place to work	61.7%	57.9%

Indicators for safe environment from violence and bullying and harassment, staff morale, equality and diversity and quality of appraisal are average or above average when compared to similar trusts. The survey shows that staff feel safe to speak out and do not feel discriminated against at work. They receive more training than similar trusts and report high rates of annual appraisal with quality of appraisal similar to other trusts. We benchmarked below average in the health and wellbeing, immediate management, quality of care and safety culture indicators. Staff have particularly highlighted their lack of involvement in decision making and inability to undertake improvements in their area of work. They also express uncertainty in who the senior managers are and lack of communication. They do not feel the organisation takes positive action on health and wellbeing.

Since the last NHS staff survey we have achieved the bronze Health and Wellbeing at Work award which recognises the achievements of managers and health advocates in promoting health and supporting staff wellbeing. 23 staff health advocates delivered a twelve month campaign of health promotional activities based on the results of a staff health needs assessment, including awareness of enhancing sleep and reducing alcohol consumption. We changed our occupational health service provider and now all staff and their families have access to an employee assist programme.

Closer working and integration with NCUH over the past 12 months has brought about change and aligned governance arrangements. Local pulse surveys, which monitor staff engagement throughout the year, indicate that clarity and work relationships have potential to impact on staff engagement.

Future Priorities and Targets

The results of the NHS Staff survey are reviewed in light of feedback from pulse surveys and exit interviews and themes from issues raised with the Freedom to Speak Up Guardians. These themes inform our organisational development plan and initiatives.
In 2019/20 we will continue to support staff health and wellbeing and continue to work towards achieving the silver Health and Wellbeing at work award. Our other priorities include:

- Enhancing opportunities for more flexible working.

Whilst survey results show that opportunities for flexible working are improving, they are still below average when compared to other trusts. An Engaging for Improvement project will see HR and staff working together to explore options for flexible working and better work life balance.

Opportunities for flexible working – NHS staff survey 2018				
	2015	2016	2017	2018
CPFT	50.8%	52.8%	55.8%	56.5%
Average	56.5%	58.2%	58.1%	60.4%

- Improve relationships and positive behaviours at work.

Staff have been involved in the development of a new set of organisational values. These values and a supporting behaviours framework was launched in April 2019 and forms the basis of a new appraisal process.

Personal experience of harassment, bullying or abuse at work from managers– NHS staff survey 2018				
	2015	2016	2017	2018
CPFT	8.1%	14.2%	10.0%	11.9%
Average	11.0%	11.0%	10.5%	10.8%

- Maintain a focus on communication

This will be particularly important through 2019/20 as we progress towards a merged organisation with NCUH. We will build on the ‘This is Us’ engagement programme and development of the staff intranet portal.

Staff feedback will continue to be monitored through quarterly pulse checks and progress reported to the Quality & Safety Committee, a Board Committee..

Complaints Handling

There have been a total of 497 of the above recorded by the Patient Experience Team of which:

- 145 PALS
- 196 Service Complaints
- 156 Formal Complaints

Of those:

- 7 were closed due to the terms of reference not being agreed with the complainant
- 16 were closed due to consent from the patient not being received
- 9 complaints were withdrawn
- 5 were recorded as a PALS and redirected to correct organisation
- 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 2018/19, is 156, an increase of 30% from 120 complaints in 2017/18. Of the 141 processed, 15 of those did not meet criteria to progress to entirety:

- Terms of reference for investigation not agreed - 5
- Consent not received - 5
- Complaint withdrawn - 2
- Identified as a SIRI - 2

The number of complaints recorded as 5 day service complaints received in 2018/19 is 196 compared to 218 in 2017/18, a decrease of 10.09%.
The total number of all complaints received in 2018/19 is 258, compared to 338 in 2017/18, a decrease of 23.67%.
The number of Patient Advice & Liaison enquiries received in 2018/19 is 196 compared to 228 in 2017/18, a decrease of 14.04%.

Time Taken to Respond to Formal Complaints

We currently have a target of 35 working days for response time for resolved formal complaints. For 2018/19 we achieved 55 % compared to 34% in 2017/18.

Number of Days taken to respond to Complaints	**Formal complaints**	**% of complaints responded to in 2018/2019**
≤35	68	55%
≤45	37	30%
≤55	9	1%
>55	10	1%
Total	124	88%
complaints remaining open on 15/04/2019	17	12%
Total	141	

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 being quality assured and signed off 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, accessing the service for treatment within CAMHS.

Community Health care group - Patients complained about the care and treatment provided. Complaints received about staff member's attitude towards them.

Specialist Services care group - Patients complained about their experience of Dental Services, and the treatment that was provided. Patients complaints about the Neurology Services, and the treatment that they have been provided with.

Examples of improvements following a complaint:

- CAMHS Consultants to ensure that all appointments are inputted on the RiO electronic system and this was addressed by the Medical Director.
- School Immunisation Service has identified that the triaging of the forms needs to be thorough and the teams are now highlighting the consent response Yes with green highlighter to ensure that no nasal flu vaccines are given when consent hasn't been provided.
- Community Inpatient Wards now ensure that discharge checklists are fully completed.
- The North Cumbria MSK Service reviewed their Policy to include the process of sending a discharge letter to patients and they now consider if patients should be discharged after one missed appointment.
- More rubber dam clamps were made available to clinicians in the Dental Service following an incident of a young person having their tooth chipped during treatment.
- Ramsey Unit have implemented a process where the Named Nurse arranges to meet with family members within 5 days of admission to share information regarding their loved one.

Parliamentary and Health Service Ombudsman (PHSO)

For the period of 2018/19 – 8 cases were under review by the PHSO, these are from years 2014/15, and 2017/18. The number and details of these cases are as follows:

- 5 Cases - remain ongoing.
- 3 Cases - have been fully investigated and are now closed, the outcome being 2 not upheld and 1 partially upheld.

Future priorities

From the feedback received in 2018/19 the following priorities have been identified for 2019/2020 to further improve our complaints process:

- To continue to embed the learning lesson's process and the learning from complaint investigations.

- 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.
- To develop a joint Complaints Handling Policy with NCUH.

Compliments

We received and recorded 1236 compliments in 2018/19. This is a decrease from 2017/18 when 2432 were received. During 2018/19 we received 7102 free text comments through the Friends and Family Test and other comment fields on the questionnaires.

Health, safety and security

We recognise and accept our 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. We place 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.

The Health and Safety, Security Departments were part of the first wave of shared services in preparation for the developing changes of healthcare provision in Cumbria. Both departments have been brought under the common headship of the Corporate Resilience and Safety portfolio represented at the Board by the System Executive Director of Finance & Estates.

The Workforce and Organisational Development directorate cover the staff wellbeing element of health and safety including stress.

The joint Corporate Health and Safety, Security Committee meets on a monthly 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	41	56	18	1	0	11	127
Manual Handling	2	24	8	0	0	21	55
Security	57	3	0	0	0	1	61
Violence/ Aggression	709	332	76	3	0	13	1133

* 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 trustwide 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 2018/19.

- Specialist reviews/ environmental assessments/ specialist advice – 51
- New estates projects (specialist health, safety and security advice) - 2
- Policy/Strategy reviews – 6

A new Joint Health and Safety Policy was agreed and ratified in August 2018. The framework of the policy is based upon the Health and Safety Management Framework described in Health and Safety Guidance (HSG) 65 Plan, Do, Check, Act. The policy was launched through the Continuous Service Improvement 9th wave in November 2018. This is to address the Health & Safety Risk EST1718-01 on the Corporate Risk Register to ensure robust health and safety management process.

A program of developing joint policies for all the existing H & S, Security policies across both Trusts has been agreed with Corporate Governance. To launch the joint policies, a programme was submitted to the Continuous Service Improvement Team. This has been accepted in November 2018 as part of the Engaging for Improvement Wave 9 scheme.

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.

Violence and Aggression

As part of a national program of focussed inspections, our Mental Health services were inspected on 27 November 2018 by the HSE. Inspectors visited Dane Garth at Furness General Hospital and Carlton Clinic Carlisle. The outcome is that the services inspected were compliant. The inspectors commended staff on the innovative approach in reducing the risk of violence and aggression. They noted training had been well received by staff. They made comment on the use of the “live” dashboard to monitor and improve outcomes.

Musculo-Skeletal Disorders

As part of a national program of focussed inspections by the HSE our Mental Health services were inspected on 28 November 2018. Inspectors visited Carlton Clinic Carlisle. The outcome is that the services inspected were compliant. They made comment that there was evidence that the staff training given was been practiced at ward level.

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

The following tables provide information against a range of performance indicators. The indicators have been included as they reflect the Trusts national, statutory and local reporting requirements. Quality and Safety are a key focus within our performance measures.

Operational performance (Single Oversight Framework metrics)												
Indicator	Period	Target	Actual month and volume			Year to Date			Latest month national comparison		Trend points (% from target)
AE 4 hour waits (Type 3)	Mar-19	99.2%	●	**99.93%**	1,432	●	99.76%		●	98.9%	
RTT % incomplete <18 weeks (CPFT)	Mar-19	92.0%	●	**96.3%**	3,145	●	96.3%		●	86.7%	
Diagnostics: % waiting <6 wks (CPFT)	Mar-19	99.0%	●	**100.0%**	131	●	100.0%		●	97.7%	
1st episode of psychosis seen <2 weeks (CPFT)	Mar-19	53.0%	●	**69.2%**	13	●	69.2%		●	74.5%	
IAPT Recovery Rate (CPFT) (qrtly)	Mar-19	50.0%	●	**54.4%**	1603	●	51.5%		●	52.3%	
IAPT referrals treated <6 weeks (CPFT)	Mar-19	75.0%	●	**99.7%**	602	●	99.7%		●	89.5%	
IAPT referrals treated <18 weeks (CPFT)	Mar-19	95%	●	**100%**	602	●	100%		●	99.1%	
Inappropriate OAP MH bed days (CPFT) (rolling 3 months)	Feb-19	18	●	**915**		●	1408		●	57930	
Data Quality Maturity Index (DQMI) (CPFT)	Sep-18	95%	●	**98.7%**		●	N/ap		●	N/ap	

Quality of care (Single Oversight Framework metrics)

Safe

Indicator	Period	Target	Actual	Year to Date	Latest national comparison	Trend
Never events - rolling 6 months (CPFT)	Mar-19	0	**0**	0	237	
Patient Safety Alerts not completed (CPFT)	Mar-19	0	**0**	0	64	
Potential under-reporting of patient safety incidents rate (rolling 6 months) (CPFT)	Sep-18		**53.6**	N/ap	55.57	
<16 yr old admissions to adult MH wards (bed days) (CPFT)	Mar-19	0	**0**	0	4	

Effective

Indicator	Period	Target	Actual	Year to Date	Latest national comparison	Trend
CPA 7 day follow ups (CPFT)	Mar-19	95%	**92.5%**	94.7%	95.5%	
% clients in settled accommodation (CPFT)	Dec-18		4.0%	4.0%	58.8%	
% clients in employment (CPFT)	Dec-18		1.0%	1.0%	8.7%	

Caring

Indicator	Period	Target	Actual	Year to Date	Latest national comparison	Trend
FFT Staff % recommend care (CPFT) (qtrly - no Q3 survey)	Sep-18	70%	**75.6%**		81%	
Mixed-sex accommodation breaches (CPFT)	Mar-19	0	**0**	0	1722	
FFT Mental Health % positive (CPFT)	Mar-19	95%	**95.2%**	94.6%	90%	
FFT Community % positive (CPFT)	Mar-19	95%	**98.3%**	97.5%	96%	

Organisational Health (Single Oversight Framework metrics)

Indicator	Period	Target	Actual	Year to Date	Latest national comparison	Trend
Staff sickness (CPFT)	Mar-19	4%	**4.8%**	4.6%	4.7%	
Staff turnover (CPFT)	Mar-19	0.9%	**1.0%**	1.0%		
Staff recommend trust as a place to work (CPFT)	2018	61%	**62%**	N/ap		
Proportion of temporary staff (CPFT)	Mar-19	5%	**5.0%**	4.2%		
CQC Community Mental Health survey: Overall experience (CPFT) (annual)	2018		**6.74**	N/ap		

Performance during 2018/19

Key Highlights

We have achieved the 4 hour wait target 95% for A&E; the 6 week referral to diagnostic 99% standard in paediatric audiology; Referral to Treatment 18 week 92% standard; the EIP 50% standard; and both 6 week and 18 week IAPT standards this financial year (April 2018 to March 2019).

Areas for improvement

1. Inappropriate Out of Area Placement (OAP) bed days - Out of Area Placements has been challenging in 2018/19 due to bed pressures, compounded by an increasing level of Delayed Transfers of Care for the Mental Health care group. OAPs are closely managed in a joint arrangement with the Clinical Commissioning Group (CCG). Each placement is discussed and agreed with the CCG prior to placing the patient.

2. Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge - The Mental Health care group monitor the completion of 7 Day Follow Ups closely, with daily performance validation processes in place with the Business Intelligence and Data Quality teams. The main theme for under performance so far this financial year has been patient engagement (i.e. refusal of appointments, disengagement with service etc). Focus in 2019/20 is on reducing down to 72 hours as per CQUIN targets.

3. MHSDS Data Quality Maturity Index (DQMI) - The Mental Health care group are closely monitoring performance against the new and additional experimental data quality indicators for the Mental Health Minimum Dataset in the DQMI. Performance is expected to dip as the new indicators are added in to the overall score and the Business Intelligence team are engaged with NHS Digital as developments are made and metadata shared with trusts. Internally reporting is already underway to locally monitor the indicators, which will be improved if NHS Digital are able to release their script and logic behind each indicator.

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 continue to provide further depth and assurance around the information captured within the self-assessment, the bi-annual audit programme changed in April 2018 to a quarterly review programme. The programme to all care groups is well received and an increase in

frequency provides greater service coverage and visibility. The review programme is supported by a service user representative who takes an active role in the completion of these reviews.

Findings of the reviews are fed and monitored through the care group and aligned trustwide 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 trustwide level governance structures.
- Provides the Trust with a greater level of assurance around access and support for people with a learning disability.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny Committees

NHS Morecambe Bay Clinical Commissioning Grou
p Moor Lane Mills, Moor Lane Lancaster, Lancashire, LA1 1QD

tel. 01524 519369
email. info@morecambebayccg.nhs.uk
web. www.morecambebayccg.nhs.uk

NHS North Cumbria Clinical Commissioning Grou
p 4 Wavell Drive, Rosehill Carlisle, Cumbria, CA1 2SE

tel. 01768 245486
email. enquiries@northcumbriaccg.nhs.uk
web. www.northcumbriaccg.nhs.uk

03 May 2019

Corroborative Statement from North Cumbria & Morecambe Bay Clinical Commissioning Group (CCG) on *Cumbria Partnership NHS Trust's Quality Account 2018/19*

North Cumbria CCG (NCCCG) and Morecambe Bay CCG (MBCCG) welcome the opportunity to review and comment on the Quality Account 2018/19 for Cumbria Partnership Trust (CPFT).

As commissioners, both NCCCG and MBCCG are committed to commissioning high quality services from CPFT and take seriously their responsibility to the general public to ensure that patient's 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 Quality Review process has changed this year as the Integrated Health and Care System has developed; incorporating the Acute, Mental Health and Community Trusts. A monthly Integrated Healthcare Partnership Quality Assurance Committee was established to provide Senior Staff in both organisations, with NHSE, NHSI, CQC and other partners, the forum to seek assurance about quality. This has developed through the year and has become a System Quality Assurance Committee, providing the opportunity to monitor, review and discuss quality issues. This Committee provides oversight for the quality agenda in both North Cumbria University Hospitals and Cumbria Partnership Foundation Trust, as staff have been starting to work together on continuous improvement across the services. In addition to this, NCCCG in collaboration with MBCCG as appropriate, carried out commissioner-led unannounced assurance visits to

monitor the quality of the services provided and to encourage continuous quality improvement.

The CCGs would like to commend the hard work, commitment and resilience of CPFT staff, and the efforts that have led to the Care Quality Commission's finding that in the 'Caring domain' 12 of the 14 core services were good, with 2 core services rated as outstanding. The CCGs note that the overall Trust rating remains 'Requires Improvement'.

The Quality Account provides an open account of the achievements made in the past year and describes the priorities for 2019/20 and is an important contribution to public accountability in relation to quality. The CCGs appreciate the amount of work involved in producing this report and commends the openness within it.

We note the quality improvement priorities in 2018/19 and going forward into 2019/20, in preventing people dying prematurely and the development of the 'real time' alert system of unexpected deaths. This has already led to early work taking place following the system recognising a cohort of similar suicides in one of the localities. We note the work on harm-free care and the development of a Quality & Safety Dashboard, giving staff the ability to measure preventable harm in 'real time'.

We note the progress on meeting the timely access targets, that the CAMHS Service is working with Northumberland Tyne & Wear Trust on a recovery plan and that the CAMHS Eating Disorder Service will improve data capture and reporting.

The report provides detail on people having a positive experience of care, noting there are 'Patient Stories' at each Trust Board Meeting and the change in emphasis to using patients feedback as part of service improvements.

The report provides detail on the results from the Mortality Review process and the results of the audit reports and programmes Trust staff were involved within the year.
We note the Trust's Key areas for improvement during 2019/20:

- To reduce the number of people being sent out of Cumbria County for their care and reinforcing the management of the joint arrangement for improving this.
- To improve the follow up of patients discharged from Mental Health Services within 7 days.

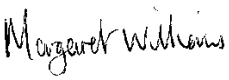
MBCCG recognised the collaboration undertaken between University Hospitals of Morecambe Bay NHS Foundation Trust and Cumbria Partnership NHS Foundation Trust in safely integrating hospital and community services across South Cumbria from April 1 2018.
MBCCG now acknowledges the Board approval to integrate Mental Health Services within Morecambe Bay. This integration aims to bring the Health and Care System together in line with the Better Care Together 2 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.
MBCCG note the work already started to improve the quality of Mental Health and Learning Disability Services.

Overall the report is well written and presented and is reflective of quality activity across the organisation. As required under the Quality Report Regulations, staff within the CCG have checked the accuracy of data relevant to the contract. In so far as we have been able to check the factual details, the CCG's view is that the report is materially accurate. It is clearly presented in the format required by NHS England and the information it contains accurately represents the Trust's quality profile.
North Cumbria CCG looks forward to continuing to work with CPFT as the Integrated Health and Care Service becomes established and the involvement of Northumberland Tyne and Wear gets on to a more formal footing, to support and assure the improvements of the quality of services commissioned in 2019/20.

North Cumbria 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 2019/20.

Yours sincerely

Anna Stabler
Director of Nursing & Quality
North Cumbria Clinical Commissioning Group



Margaret Williams
Chief Executive Nurse
Morecambe Bay Clinical Commissioning Group

Cumbria Health Scrutiny Committee

Cumbria Partnership Foundation Trust

Quality Accounts Feedback 2019

The Cumbria Health Scrutiny Committee welcomes the opportunity to comment on the Cumbria Partnership Trust's Draft Quality Accounts for 2018/19.

Members understand the format and layout of the document is set for the Trust but still felt that the document is challenging for the wider public including as it does a great deal of technical language.

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 Committee welcomed the improvements in staff satisfaction this is no small achievement given some of the changes taking place such as the proposed merger with the North Cumbria University Hospitals Trust and the transfer of Mental Health Services.
The Committee has been working closely with the Trust on its review of Mental Health Services and will continue to monitor and scrutinise the transfer of Mental Health Services later this year
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
9th May 2019

Healthwatch Cumbria
Best Life Building
4-8 Oxford Street
Workington
Cumbria CA14 2AH

Tel 01900 607208
www.healthwatchcumbria.co.uk

Cumbria Partnership NHS Foundation Trust
Maglona House
68 Kingstown Broadway
Carlisle
CA3 0HA

Healthwatch Cumbria
Response to Cumbria Partnership NHS Foundation Trust Quality Accounts Report for 2018-19

30th April 2019

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 2018-19.

Part 1: Statement on quality from the Chief Executive

Commencing with a succinct description of the organisational changes the Statement sets a clear vision of the Trust values and culture and the aspiration to have a positive and open culture both within the Trust and with communities and partners, this we recognise, welcome and continue to support.

The tone of the whole document is summarised within the remainder of the Statement, namely the commitment to deliver high quality care and to improve and transform services with partners and the clear aspiration to improve the Care Quality Commission (CQC) rating across all services.

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

Progress against 2017/18 priorities for improvement

The detailed and clear narrative in respect of the Quality Priorities 2018/2019 describing the rationale, progress, actions, learning and next steps is exceptionally good and very informative. Responding to the 2017/18 Quality Accounts Healthwatch Cumbria referred

to tangible improvements and the cycle of learning and improvement, we are pleased to see this theme continuing through 2018/19.

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.

We note that additional consideration (2) of the NHS Improvement letter 17th December 2018 Quality accounts: reporting arrangements 2019/19, ahead of legislation requested Trusts to provide details of ways that staff can speak up (including whistle-blowers) and how they ensure such staff do not suffer detriment as a result has been addressed with measures including the role of the Freedom to Speak Up Guardians and the Raising a Concern process.

In accordance with the current NHS reporting requirements, mandatory quality indicators requiring inclusion in the Quality Account we believe the Trust has fulfilled this requirement.

Information received by Healthwatch Cumbria (HWC) from service users and their families and carers regarding services provided by Cumbria Partnership Foundation Trust (CPFT) is consistent with the data, statements and comments contained in the Quality Account.

Healthwatch Cumbria is aware that the Trust is actively collaborating with other organisations and listening to public opinion, plus utilising co-production methodology to help public services and communities to develop alternative service models, actions we fully support.

Overall, we would say that this is a well balanced document in that it acknowledges areas of improvement needed and the remedial measures being taken to address these. The emphasis on culture change, increased involvement of the public, staff and partner organisations to develop continuous improvement is integral to the document. We welcome, and would like to find ways of supporting this in practice.

Sue Stevenson
Chief Operating Officer
Healthwatch Cumbria

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.

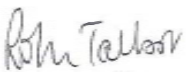
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to 24 May 2019
  - papers relating to quality reported to the board over the period April 2017 to 24 May 2018
  - feedback from commissioners dated 03/05/2019
  - feedback from governors dated 07/05/2019
  - feedback from local Healthwatch organisations dated 30/04/2019
  - feedback from Overview and Scrutiny Committee dated 09/05/2019
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – not available
  - the national patient survey dated 04/07/2018
  - the national staff survey, published 03/2019
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 22/05/2019
- 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



Prof. Robin Talbot, Chair 23 May 2019

Prof. Stephen Eames, Chief Executive 23 May 2019

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 2019 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways 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 Requirements for External Assurance for Quality Reports 2018/19; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Detailed Requirements 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 become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2018 to April 2019;
- Papers relating to quality reported to the Board over the period April 2018 to April 2019;
- Feedback from Commissioners, dated 3 May 2019;
- Feedback from governors, dated May 2019;
- Feedback from local Healthwatch organisations, dated 30 April 2019;
- Feedback from Overview and Scrutiny Committee, dated 9 May 2019;
- The Trust's latest complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The latest national patient survey dated 9 July 2018;
- The latest national NHS staff survey;
- Care Quality Commission inspection, dated 26 January 2018;
- The Head of Internal Audit's annual opinion over the trust's control environment, dated 22 May 2019; and
- Any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Cumbria Partnership NHS Foundation Trust as a body, 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 2019, 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;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can 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 qualified conclusion

We identified errors in our detailed testing. 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 included in the Quality Report for the year ended 31 March 2019 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 qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance for Quality Reports 2018/19; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Signed:

Karen Murray

Director, for and on behalf of Mazars LLP

Date: 24 May 2019

Chartered Accountants and Statutory Auditor
One St Peter's Square

Manchester

M2 3DE

Annex 1

CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST

Annual accounts for the year ended 31 March 2019

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.

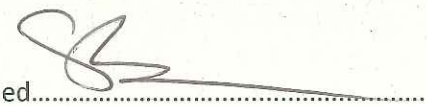
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Cumbria Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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 23 May 2019.

Prof. 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 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk and risk management arrangements

The Chief Executive has overall accountability for risk management and discharges that duty through the Executive Team and their respective portfolios.

During 2018/19 we have worked increasingly collaboratively with North Cumbria University Hospitals NHS Trust (NCUH) and together we have introduced shared governance and leadership structures across all of our services. Senior clinical leaders are in place throughout each of our care groups. They are responsible for driving improvements to quality and safety, and actively support 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. During the year we have integrated most of our support service teams with those in NCUH and have aligned our systems and processes so that, collectively, our Corporate and Support Service teams provide support across both Trusts.

A 'best of both' principle was adopted in the work to refresh and align our quality governance, clinical risk management and leadership frameworks to ensure good practice in both Trusts formed the basis of our aligned arrangements to identify, manage, escalate and report risks, as appropriate to the scale and nature of the risk. The Board of Directors (the Board) 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.

Risk management is part of our 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 on our intranet site.

We benefit 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 System Executive Chief Nurse. 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.

The Risk and Control Framework

Board Membership

There were a number of changes to Board membership during the year. Substantive appointments were made to the System Executive Chief Nurse, Executive Director of Workforce & Organisational Development, Executive Chief Operating Officer, Executive Medical Director and Executive Director of Strategy. All Executive Directors have the remit across both Trusts. An Interim Executive Director of Mental Health, Learning Disabilities and CAMHS (non-voting Director) was also appointed during the year to manage the transition of mental health, learning disabilities and CAMHS services to alternative providers. Two Non-Executive Directors were appointed into vacant posts and have roles across both Trusts bringing the total number of Non-Executive Directors appointed to both Trusts to three. In February 2019, the Governors Council, agreed the appointment of Prof. Robin Talbot as Chair of both Trusts for a two-year term, to take effect on 1 April 2019 following the retirement of NCUH Chair. These changes reflect and demonstrate our commitment in moving toward an integrated health and care system, but do not diminish our responsibilities and accountabilities as a NHS Foundation Trust.

As at 23 April 2019 we have:

- Seven Non-Executive Directors (the Chair plus six other Non-Executive Directors, three of whom also have NED roles within NCUH)
- Seven Executive Directors, six of whom have voting rights
- No Executive Director or Non-Executive Director vacancies

The balance between Executive and Non-Executive Directors on the Board remains in line with the Code of Governance for NHS Foundation Trusts and our Constitution and 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 2017/18 a review was undertaken of the corporate governance structures that support Board Committee effectiveness in order to prepare for and implement aligned board-level governance arrangements across both trusts which took effect in April 2018. During Quarters 1 and 2 activity focussed on the alignment of clinical and corporate governance meetings structures to support the aligned board level arrangements. These took full effect from October 2018.

At the time of writing, following agreement from the Governors Council in November 2018 and approval of the Strategic Case by NHS Improvement (NHSI) in February 2019, activity is underway to prepare for both Trusts to merge to become a single organisation. The aim is that the new Trust will 'go-live' in October 2019 following approval of the Full Business Case by the Board in June 2019, and subject to successful progress through the Transactions process with NHSI. As this transaction is technically an acquisition of NCUH by CPFT the merged Trust (name not yet confirmed at time of writing) will be a Foundation Trust.

A programme management approach has been adopted to prepare for and manage the merger transaction. Work streams led by Executive Directors deliver the required activity and report progress into the Programme Board which is chaired by the Chief Executive. The Governors Council are engaged in the process and have been involved in the review and development of the Constitution for the new Trust.

At the time of writing a further review is ongoing to explore opportunities to enhance the effectiveness of the Trusts' governance framework, taking into consideration feedback received in March 2019 from NHS Improvement as part of their supportive 'Moving to Good' programme, as well as for integrating aspects of corporate governance with the North Cumbria Clinical Commissioning Group as part of moves toward an integrated health and care system. These reviews are likely to result in some changes to the governance framework and associated meetings structures which will be implemented during 2019/20 having due regard to impacts on, and from, merger and CCG integration activities.

Meetings that have been in place during 2018/19, and any changes or adjustments to their arrangements within the year, are set out below.

Board and Board level Committee

The Board is supported by a governance structure as follows, which deals with various components of corporate governance and risk. With the exception of the Audit and Risk Committee and Charitable Funds Committee all meetings described below happen in an aligned manner with NCUH (meeting at the same place, at the same time). These aligned arrangements recognise the statutory duties of both Trusts as separate legal entities whilst also enabling efficiencies through avoiding duplication of senior managers' attendance at meetings.

- Quality and Safety Committee (Q&S) – the designated Board Committee 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 Committee 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 Committee which oversees the management of Charitable Funds held by the Trust.
- Audit & Risk Committee (A&R) – an independent Committee and senior Board Committee, 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.
- Remuneration Committee – wholly NED membership.
- Mental Health Legislation Committee – membership is Mental Health Act Managers, and is chaired by a Non-Executive Director. In December 2018 the Board of directors agreed to introduce this meeting as a formal Board level sub-Committee. At the time of writing transition arrangements are underway for the first meeting of this Committee to take place led by the Executive Director of Mental Health.
- 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 Committee effectiveness

- Clinical Management Group (CMG) (formerly Trust Management Board (TMB)) - the senior operational management group led by the Chief Executive and attended by Executive Directors, senior operational and clinical leaders within care groups and Heads of Support Services. CMG monitors risks to operational, clinical and financial performance and escalates issues and risks to Board level Committees as appropriate.
- Trust Wide Clinical Governance Group (TWCGG) – the senior forum for clinical governance, led by the Deputy Director of Nursing and Quality (April 2018 - September 2018) and System Executive Chief Nurse (October 2018 - April 2019). This group 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 following the substantive appointment of the System Executive Chief Nurse. In April 2019 this meeting was 'stood down' with alternative arrangements taking effect from May 2019 as part of changes to the governance framework.

- Joint Leadership Development Group – 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 our strategy. During the year membership of this group expanded to also include senior managers from the North Cumbria Clinical Commissioning Group.
- Compliance Board - led by the Executive Chief Operating Officer and including Executive Directors and senior managerial and clinical leaders, with a specific focus on CQC compliance.

During 2018/19 the effectiveness of our Board and Committees was evaluated through a survey involving Board members and members of each Board 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 although identified the need to review the future format of board effectiveness surveys.

Risk Management Strategy

The annual review of our Risk Management Strategy was undertaken with the Board agreeing the updated Risk Management Strategy in November 2018. The Risk Management Strategy will be reviewed again during the first half of 2019/20 as part of further alignment activity with NCUH and the move toward an integrated health and care system.

The strategy 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

Central to our integrated approach to risk governance is risk appetite. In June 2018 we agreed a joint risk appetite statement, joint strategic objectives and joint strategic risks. In setting out our appetite for risk, we use a risk appetite framework based upon that promoted by the Good Governance Institute but which has been expanded to include wider range of risk domains that reflect complex sustainability challenges currently facing the NHS. Board members' individual risk appetites inform a collective debate on the organisational risk appetite which is then agreed by the Board.

The System Executive Chief Nurse is accountable for ensuring appropriate systems and processes are in place to enable the implementation of our 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 through our 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 our governance frameworks. Training on the Risk Management Policy was delivered to team leads during the year as part of our risk management training programme. The Board Development programme during the year has also incorporated risk management training for board members through activity to review and update strategic risks that underpin the Board Assurance Framework (BAF), review and development of the risk appetite statement, and most recently in March 2019, a review of the risk and assurance escalation flows to inform the development governance framework.

During 2018/19 elements of our risk management processes started to become aligned with those of NCUH, with the aim that during 2019/20 they will become fully aligned. This includes the bringing together of both Trusts' risk management policies into a single joint policy.

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 and the use of dashboards within governance forums is becoming embedded.

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.

During the year, our Integrated Governance Manual was refreshed to recognise how we have aligned our governance and performance management frameworks with NCUH, and also sets out our joint arrangements for priority setting, business planning and our aligned Board Assurance Framework.

Quality governance

Quality governance is a key activity of the Board 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 we have undertaken an annual self-assessment against NHSI's Well Led Framework which informs our evaluation of our quality governance arrangements. Our self-assessment against the Well Led framework, conducted during Quarter 4 of 2017/18, took into consideration the findings and recommendations from the CQC's inspection and our progress with improvement actions identified in our 2016/17 self-assessment.

In Quarter 3 of 2018/19 we commissioned a peer-review against NHSI's Well Led framework, led by Northumberland Tyne and Wear, and which was undertaken between October 2018 and February 2019. Delivery of improvement actions has been monitored through relevant governance forums and with Board level oversight. Our 2018/19 annual self-assessment against the Well Led framework commenced in March 2019, with the outcome of that assessment due to be formally considered by the Board in June 2019. The self-assessment takes into consideration feedback from the external peer review. Areas identified for improvement included strengthening arrangements for workforce planning, strengthening our arrangements for corporate risk management, and strengthening our quality impact assessment (EQIA) arrangements to understand whether impacts identified within EQIAs materialised as expected.

Our last formal Well Led external review was undertaken by Deloitte in 2015. The timeframe for our next formal external review is likely to be during 2019/20.

We last underwent a formal Well Led inspection by the CQC in November 2017 and will be inspected again in June 2019. The CQC inspection report assessed us as 'requires improvement' overall with 22 'must do' actions requiring immediate attention. Details of how we have responded to their recommendations can be found in the Quality Report.

Risks logged within our risk registers continue to be managed and regularly monitored through our governance frameworks. Scrutiny of the corporate risk register is undertaken monthly by the Clinical Management Group (CMG). Monthly monitoring is also undertaken to ensure risks within risk registers are reviewed and updated in a timely manner. As at 23 April 2019 10.2% of 'open' risks within our risks registers were overdue for review, compared with 4.31% on 31 March 2018. This aspect of risk register management is now incorporated into our performance management framework and is a regular aspect of quality governance within care groups and support services.

During the year we have continued to strengthen our operational and strategic risk management processes through the inclusion within our BAF reports, of a visual representation of how risks within the corporate risk register impact upon, or are impacted by, strategic risks within the BAF. This, together with developments to our quality and safety dashboards and reporting on risk management to aid understanding and thematic analysis of how risks within risk registers have changed over time, enable a better understanding of our risk profile. The BAF continues to be shared with our care group and support service leadership teams after each quarterly update to enable cascading throughout the Trust of how the most significant risks to our objectives are being managed.

Longer term actions which collectively will strengthen the quality of our risk management arrangements during 2019/20 include building on work commenced in 2018/19 to refresh 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.

As part of our integration with NCUH, some changes were made during the year to care group structures. Some of our care groups now incorporate services from both Trusts, an example of this is the Children and Family Care Group. Activity to align quality governance arrangements has also taken place during the year through alignment of policies and meetings structures. Further integration and alignment work will be undertaken during 2019/20 to refocus clinical governance arrangements within our integrated structures and to embed quality improvement as the driving principle of our governance frameworks. Staff surveys and staff engagement activities give us rich information that we are 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 integrated performance management framework.

To comply with the governance conditions of the Provider Licence, we are required to provide a Corporate Governance Statement to NHSI. The Corporate Governance Statement relating to 2018/19 was presented to the Board for formal acceptance in May 2019. 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 our 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 CMG.

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. No exception reports have been required during 2018/19.

We expect to comply with all of the Provider Licence conditions in 2019/20. 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 our 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 our policies and procedures. We continue 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.

We encourage the reporting of incidents or concerns and use as a tool to learn and improve. We have 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.

Our approved Raising Concerns (Whistleblowing) policy is published on our website. The Audit & Risk Committee oversees our Raising Concerns process and our Freedom to Speak Up Guardian provides regular updates to the Board.

Risk reporting

Risk management is fundamental to how we operate. Our 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 our risk management information system (Ulysses). Those risks recorded within Ulysses collectively form our risk register. The risks recorded on our 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 our risk register. Individual responsibilities include ensuring appropriate arrangements are in place for effective risk management and mitigation.

During Quarter 1 the Boards of both Trusts agreed joint strategic objectives, joint strategic risks and an aligned approach to the Board Assurance Framework (BAF). The first 'joint' BAF was agreed in July 2018 and is reviewed on a quarterly basis.

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 CMG 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.

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 in 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

We have recognised for some time that data quality is an underpinning issue in most things that we and this has been highlighted by both our Internal and External Auditors over recent years. In July 2016, the A&R Committee endorsed a three-year Data Quality Strategy to systematically improve data quality across all of our information systems. The A&R Committee received updates on progress against the strategy throughout 2018/19 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 partners in the IHCS 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 future provision of mental health services across Cumbria which we are working with our commissioners and regional partners to progress, and partnership working with GP practices to enable a more sustainable model for primary care across north Cumbria.

In June 2018, in collaboration with the Board of NCUH, our Board reviewed the top strategic risks and major operational and clinical risks facing the organisations, and agreed the following top strategic risks which form the basis of our aligned Board Assurance Framework. In January 2019 the Board agreed the inclusion of an additional risk (Risk 10) within the BAF relating to the impacts on support services from transferring mental health services to alternative providers in line with Commissioner Intentions.

Risk 1	Leadership and workforce is not sufficient to deliver the scale and pace of transformative change
Risk 2	Cultural change to improve quality and empower people is not sustained
Risk 3	Engagement with the public and partners is not effective in achieving positive change that improves or transforms services
Risk 4	Quality of services (experience, safety, outcomes) are not improved because programmes to transform, integrate and save have adverse quality impacts
Risk 5	Financial sustainability is not achieved as the effectiveness of cost reduction plans and implementation of new service models does not deliver the anticipated financial benefits set out in our long term plans
Risk 6	Health and Health Service improvement plans are impeded by dependency on key partners who are not sufficiently ready / able to support our plans
Risk 7	Vulnerable services become too unstable to continue during the implementation of wider transformation programmes across Cumbria and North East
Risk 8	Infrastructure developments are not sufficiently enabling of transformation
Risk 9	Fragility within primary care impacts our ability to effectively manage patient flow
Risk 10	Support services are insufficiently resilient to effectively support the Trust following transfer of mental health services to an alternative provider

The Board Assurance Framework is reviewed on a quarterly basis, with the framing of top strategic risks being reviewed on at least an annual basis, usually during Quarter 3.

Significant operational and clinical risks

Risks are identified, managed and monitored through our governance frameworks, in accordance with the Risk Management Policy and the aligned performance framework. 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 us include:

- 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
- short and medium term disruption to the resilience of support services associated with the transfer of mental health, learning disabilities and children & adolescent mental health services (CAMHS) to alternative providers.
- delays in patients accessing specialist dental services due to lack of availability in specialists to support the delivery of care during treatments
- 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

As part of our increasingly integrated working with NCUH, both Trusts are working together to implement aligned processes for policy management. Initial work commenced during Quarter 4 of 2017/18 and has continued throughout 2018/19. The aim is for fully integrated arrangements by the end of Quarter 1 of 2019/20. Activity has taken place throughout 2018/19 to align policies with NCUH, and where appropriate to have joint policies spanning both Trusts. This work continues into 2019/20 and may result in adjustments and extension to review timeframes for some policies.

During 2018/19 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 1 April 2019 was 27. This compares to 36 as at 31 March 2018. Policy management performance is monitored by Trust Wide Clinical Governance Group (TWCGG) and the Compliance Board, 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.

Quality Impact Assessments

As part of our collaborative working with NCUH, an aligned approach to undertaking quality impact assessments was agreed by the Q&S Committee in April 2018 and has been applied throughout the year. The approach to undertaking quality impact assessments takes a holistic approach to assessing the impacts of major change schemes, including those proposed within our efficiency programme. The impact assessment approach enables decisions to be made based upon a balance of risks to quality, equality and the clinical and financial sustainability of services. The process is jointly led by the System Executive Chief Nurse and Executive Medical Director and overseen by the Q&S Committee. It is also integrated into our business planning process, which evolved during the year to integrate and incorporate the trust's approach to workforce planning. Board level assurance on the timely undertaking of impact assessments is provided through the Q&S Committee who also have a role in the EQIA approvals process. During 2019/20 the EQIA process will be strengthened further through undertaking evaluations of post-change impacts compared with anticipated impacts.

Workforce strategies

The Q&S Committee receive routine 'hard truths' nurse staffing reports throughout the year, including fill rates and care hours per patient day (CHPPD).

The People Plan for the North Cumbria Integrated Health and Care System, approved by the Board in March 2019, sets out the strategic delivery approach to ensure a sustainable workforce. It also states the annual delivery plan priorities for 2019/20. Priorities for 2019/20 include developing an attraction plan and improving recruitment processes, also designing an effective, inclusive and engaged workforce through local plans that meet the needs of the population built on multi professional working and new roles. Delivery of the People Plan will be overseen through the Q&S Committee.

We use the population centric model for workforce planning and have a draft workforce plan. The model hospital approach is being used to identify opportunities for workforce efficiencies, although this is at an early stage of development and will be incorporated into our workforce planning approach during 2019/20.

A workforce planning group is in place, chaired by the Executive Director of Workforce & OD and has representation from primary care, nursing and Allied Health Professions. Our lead officer for workforce planning is a member of the workforce planning group. A workforce planning summit is planned to take place during 2019 and will involve a wide range of stakeholders.

In summary, we have staffing governance processes in place although these are currently immature and will be strengthened to become embedded over 2019/20.

Business conduct / conflicts of interest

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS guidance: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/.

Our Standards of Business Conduct policy was updated in 2018 to reflect changes to legislative requirements and to become a joint policy with NCUH. Policy requirements are being implemented on a phased approach during 2018/19 and 2019/20. This commenced with an update of Board members' and the Lead and Deputy Lead Governors' declarations in Quarter 3 of 2018/19, medical and senior clinical and non-clinical decision makers in Quarter 4 of 2018/19, with declarations for the remainder of individuals and groups stated within our policy being updated during 2019/20. Information on our 'declarations of interest' internet page will be updated on a progressive basis during the phased implementation period. Delivery of the phased implementation plan is being overseen by the A&R Committee.

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 foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Further details can be found in the Performance Report.

Emergency preparedness

Our emergency planning and business continuity consider organisational resilience and our 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 our contingency planning, or wider health or multi-agency planning to which we contribute. We work collaboratively and share information appropriately with responder organisations in furtherance of multi-agency co-operation and co-ordination.

We seek 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, we 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.

We comply with NHS England's requirements by providing an EPRR structure and implementing a business continuity management system through which we 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

We closely monitor budgetary control and expenditure through the Financial Delivery Group, Clinical Management Group and, at Board level, through the FIP Committee. A dedicated programme management team support the identification and delivery of schemes which improve efficiency and positively impact our overall financial efficiency efforts.

The Executive Director of Finance, Digital & Estates presents finance reports to both the FIP Committee and the Board. Through our Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation the Board 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 our operations.

The Board receives both performance and financial reports at each of its public meetings in addition to reports from the Chairs of its Committees, 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, whilst our adjusted year-end financial out-turn was under achievement against our financial control total, through our risk sharing agreements the north Cumbria system will receive, with bonuses, approximately £21.2m from the Provider Sustainability Fund for 2018/19.

We acted within an agreed risk sharing arrangement within the year. Until month 11, the Trust was forecasting delivery against the agreed position. However, in month 12 the Trust reported a year end deficit of £7.632m. After adjusting for items excluded in the control total calculation (such as impairments, donations, transfers by absorption) the Trust therefore reported that its deficit position was £5m. This is £2.9m higher than the agreed control total. As a result the Trust did not receive the full allocation of Provider Support Fund. The lost income was £1.4m. The increased deficit position arose because of the Trust agreeing to a lower than planned contract income with the local Clinical Commissioning Group. This decision was based on the 2018/19 Operational Plan which provided for a system wide risk share agreement. This decision by the Trust allowed the Cumbria system to achieve greater benefits than the £1.4m PSF funding that the Trust could have earned. The risk sharing is agreed formally by the Board through our annual planning process and reviewed through the year by the System Leadership Board of which we are a participant.

The financial plan for 2019/20 has been developed in conjunction with NCUH and North Cumbria Clinical Commissioning Group and was agreed by both Boards in March 2019. There are significant

risks to the delivery of the financial plan and many of the caveats notified to NHSI for the 2018/19 financial plan remain relevant into 2019/20.

We were rated as being placed in Segment 2 under NHSI's SOF at 22 April 2019. You can find further details about ratings in the NHS Improvements Single Oversight Framework Report.

We have continued to reduce reliance on agency staff during the year 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

We reported two incidents via the Data Security and Protection Toolkit to the Regulator during 2018/19. One incident related to a clinical letter sent to the wrong address, the other related to health assessment information sent to the wrong patient. Both incidents were investigated and investigation reports sent to the Information Commissioners Office with recommendations completed for improvement. We are committed to learning from all incidents with a view to preventing recurrence in the future. 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*.

We have 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 System Executive Chief Nurse during 2018/19.

We recognise 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, we have 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 our performance and governance

frameworks. This includes monthly review by the Board 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.

We currently use 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 NCUH. The Clinical Policies sub group continued to meet in 2018/19 to ensure clinical policies were reviewed in a timely manner. During Quarter 2 its remit was widened to include the ratification of all policies (not just clinical policies) and is now referred to as the Policy Management Group (PMG). The work to review policies is ongoing and is overseen by the A&R Committee. Our governance 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 we measure and monitor our 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, which continue to evolve, also provide the basis for assuring the Board on the quality, accuracy and completeness of data and enable triangulation of safety data.

In Quarter 2, as part of the alignment of governance arrangements with NCUH, the aligned Performance & Delivery Group was formed to identify, monitor and manage risks to performance. The Group which is a sub group of Clinical Management Group, met intermittently throughout 2018/19, as much of its business was undertaken in practice through care groups' 6-weekly performance review meetings. The ongoing role and function of the Performance & Delivery Group will be considered as part of the governance framework review being undertaken during Quarter 1 of 2019/20.

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.

We achieved a number of quality improvements during the year, including further development and roll out of quality and safety dashboards within integrated care groups to improve quality governance, and improvements introduced through research and development, such as improving

hospital discharge arrangements for people who are homeless. 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 System Executive Chief Nurse 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, FIP, A&R and Charitable Funds Committees each have activity schedules framed around enabling the Board to have line of sight to any significant risks to internal control. An annual evaluation of Committee effectiveness is undertaken for each of these Committees. This is a self-assessment by Committee members and regular attendees, the outcome of which is considered by the A&R Committee.

We 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 Committee of the Board. The focus of the internal and external audit programme is set to both support and complement our objectives and provide an assessment for the Board on areas of specific risk. The internal audit programme is developed having due regard to the risks and risk controls set out in the BAF 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 CMG.

Our internal auditors awarded substantial, good or reasonable assurance on all audits they undertook during the year, with the exception of our arrangements for business continuity which were awarded limited assurance during the year. We are actively working to review our care groups' and services business continuity arrangements and updating business continuity plans is ongoing. 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 arrangements for business continuity 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: 23 May 2019

Prof. Stephen Eames Chief Executive

Independent auditor's report to the Council of Governors of Cumbria Partnership NHS Foundation Trust

Opinion on the financial statements

We have audited the financial statements of Cumbria Partnership NHS Foundation Trust ('the Trust') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including 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 interpreted and adapted by the Government Financial Reporting Manual 2018/19 as contained in the Department of Health and Social Care Group Accounting Manual 2018/19, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006 ("the Accounts Direction").

In our opinion, the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

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.

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 year-end receivables to ensure revenue is recognised in the correct financial year; • reviewing intra-NHS reconciliations and data matches received from the Department of Health & Social Care, and sample testing the mismatches to obtain assurance that the amounts recognised by the Trust as income were correct; • reviewing management oversight of material accounting estimates and changes to accounting policies, including in respect of first time adoption of IFRS 15; and • testing adjustment journals selected using specific risk characteristics relevant to revenue recognition Our work has provided us with the assurance sought in relation to this key audit matter
Property Valuations Land and buildings are the Trust's highest value assets. Management engage Cushman & Wakefield, as an expert, to assist in determining the current 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.	Our approach involved a range of substantive procedures including: • 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 Cushman & Wakefield, information on the methodology and their procedures to ensure objectivity and compliance with professional standards and consider the reasonableness of their approach; • selected a sample of in year valuation movements to gain assurance 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. In 2018/19 RICS issued updated guidance which impacted upon the assessment of the useful economic lives (UEL) of assets for accounting purposes. We

	assessed the impact of this guidance on the trust's approach to estimating the UELs of assets. We challenged the Trust's use of a 10-year smoothing factor in certain elements of the valuation of PPE and determined that it did not affect the material accuracy of the PPE valuation. Our work provided the assurance we sought in respect of this key audit matter.

Our application of materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures on the individual financial statement line items and disclosures, and in evaluating the effect of misstatements, both individually and on the financial statements as a whole. Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Trust
Overall materiality	£3.314m
Basis for determining materiality	2% of operating expenses.
Rationale for benchmark applied	Operating expenses was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements.
Performance materiality	£2.320m
Reporting threshold	£0.099m

An overview of the scope of our audit

As part of designing our audit, we determined materiality and assessed the risk of material misstatement in the financial statements. In particular, we looked at where the Accounting Officer made subjective judgements such as making assumptions on significant accounting estimates.

We gained an understanding of the legal and regulatory framework applicable to the Trust and the sector in which it operates. We considered the risk of acts by the Trust which were contrary to the applicable laws and regulations including fraud. We designed our audit procedures to respond to those identified risks, including non-compliance with laws and regulations (irregularities) that are material to the financial statements.

We focused on laws and regulations that could give rise to a material misstatement in the financial statements, including, but not limited to, the National Health Service Act 2006.

We tailored the scope of our audit to ensure that we performed sufficient work to be able to give an opinion on the financial statements as a whole. We used the outputs of our risk assessment, our understanding of the Trust's accounting processes and controls and its environment and considered

qualitative factors in order to ensure that we obtained sufficient coverage across all financial statement line items.

Our tests included, but were not limited to:

- 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 irregularities including fraud or error;
- review of minutes of board meetings in the year; and
- enquiries of management.

As a result of our procedures, we did not identify any Key Audit Matters relating to irregularities, including fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed under 'Key audit matters' within this 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 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 and Risk Committee which we consider should have been disclosed.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of the Chief Executive's Responsibilities, 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.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

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 2018/19; 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 2018/19; 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.

The Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception
Qualified conclusion – Except for

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, with the exception of the matters described in the 'Basis for qualified conclusion' paragraph below, we are satisfied that, in all significant respects, Cumbria Partnership NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

Cumbria Partnership NHS Foundation Trust's 2018/19 agreed financial plan included a planned deficit control total of £2.1m. As reported in the financial statements the Trust's deficit is £7.632m. Making adjustments for items not included in the control total calculation, the Trust is reporting a year end deficit of £6m. This is £3.9m higher than the agreed control total position. As a result, the Trust was not eligible to receive its final quarter installment of Provider Support Funding. This amounts to £1.4m of lost income for the Trust. This is evidence of a weakness arrangements against the sustainable resource deployment sub criteria.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is 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 for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1)(d) 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, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General 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 Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

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.

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.

Certificate

We certify that we have completed the audit 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.

Karen Murray

Karen Murray

For and on behalf of Mazars LLP

One St Peter's Square
Manchester
M2 3DE
24 May 2019

Foreword to the Accounts

Cumbria Partnership NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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 23 May 2019
Prof. Stephen Eames
Chief Executive

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

	NOTE	Year ended 31 March 2019 £000	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	Year ended 31 March 2018 £000
Operating income from patient care activities	3		**147,620**		165,568
Other operating income	4.1		**12,829**		14,589
Total operating income			**160,449**		180,157
Operating expenses	5.1		**(165,682)**		(179,635)
Operating deficit			**(5,233)**		522
Finance costs:					
Finance income		**266**		26	
Finance expense – financial liabilities		**(565)**		(582)	
Finance expense - unwinding of discount on provisions		**(4)**		(2)	
PDC Dividends payable		**(1,507)**		(1,582)	
Net finance costs			**(1,810)**		(2,140)
Gain/ (losses) on disposal of assets	10.3		**(4)**		(12)
Gain/ (losses) from transfer by absorption	10.1		**(585)**		-
DEFICIT FOR THE YEAR			**(7,632)**		(1,630)
Other comprehensive income					
Impairments on property plant and equipment	10.1		**137**		1,552
Revaluation gains on property, plant and equipment	10.1		**-**		2,300
TOTAL COMPREHENSIVE INCOME/ (EXPENSE) FOR THE YEAR			**(7,495)**		2,222

The values presented in the Trust's accounts have been rounded.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

	NOTE	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Property, plant and equipment	10.1	**67,611**	66,771
Intangible assets	11	**2,817**	3,178
Investment in associates and joint ventures		**35**	35
Total non-current assets		**70,463**	69,984
Current assets			
Trade and other receivables	14.1	**11,864**	6,998
Cash and cash equivalents	15.1	**7,239**	8,119
Total current assets		**19,103**	15,117
Current liabilities			
Trade and other payables	16.1	**(25,244)**	(17,910)
Borrowings	16.2	**(1,687)**	(352)
Provisions	17	**(852)**	(786)
Other liabilities	16.6	**(1,005)**	(661)
Total current liabilities		**(28,788)**	(19,709)
Total assets less current liabilities		**60,778**	65,392
Non-current liabilities			
Borrowings	16.2	**(7,916)**	(7,218)
Provisions	17	**(1,443)**	(1,525)
Total non-current liabilities		**(9,359)**	(8,743)
Total assets employed		**51,419**	56,649
Financed by taxpayers' equity:			
Public dividend capital		**37,023**	34,758
Income and expenditure reserve		**4,996**	12,596
Revaluation reserve		**9,400**	9,295
Total taxpayers' equity		**51,419**	56,649

Signed: .....Prof. Stephen Eames, Chief Executive Date: 23 May 2019

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

Changes in Taxpayers' Equity for the year ended 31 March 2019

	Taxpayers' Equity			
	Public Dividend Capital	**Income and Expenditure Reserve**	**Revaluation Reserve**	**Total**
	£000	**£000**	**£000**	**£000**
Balance at 1 April 2018	**34,758**	**12,596**	**9,295**	**56,649**
Other transfers between reserves	-	32	(32)	**-**
Total Comprehensive Income for the year:				
Retained deficit for the year	-	(7,632)	-	**(7,632)**
Revaluation gains on property, plant and equipment	-	-	137	**137**
Public Dividend Capital Received	2,265	-	-	**2,265**
Balance at 31 March 2019	**37,023**	**4,996**	**9,400**	**51,419**

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

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 2019

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**(5,233)**	**522**
Non-cash income and expense		
Depreciation and amortisation	**3,542**	**3,551**
Impairments and (reversal of) impairments	**2,530**	**(178)**
Income from Capital donations- cash	**(473)**	**-**
Decrease/ (increase) in receivables and other assets	**(4,801)**	**2,171**
(Decrease)/ increase in payables and other liabilities	**7,421**	**(899)**
Decrease in provisions	**(20)**	**(370)**
Net cash generated/ (absorbed) by operations	**2,966**	**4,797**
Cash flows from investing activities		
Interest received	**266**	**26**
Purchase of intangible assets	**(270)**	**(693)**
Purchase of property, plant and equipment	**(6,476)**	**(3,955)**
Sale of Property, plant, equipment	**1**	**3,316**
Receipt of cash donations to purchase capital assets	**473**	**-**
Net cash outflow from investing activities	**(6,006)**	**(1,306)**
Cash flows from financing activities		
PDC received	**2,265**	**844**
Movement in loans from Department of Health and Social Care	**2,383**	**448**
Capital element of PFI payments	**(274)**	**(249)**
Capital element of finance lease	**(79)**	**(77)**
Interest paid on finance lease liabilities	**(14)**	**(14)**
Interest on PFI borrowings	**(523)**	**(544)**
Interest on Department of Health and Social Care Loan	**(26)**	**(24)**
PDC dividends paid	**(1,572)**	**(1,405)**
Net cash outflow from financing	**2,160**	**(1,021)**
Increase/ (decrease) in cash and cash equivalents	**(880)**	**2,470**
Cash and cash equivalents at 1 April 2018	**8,119**	**5,649**
Cash and cash equivalents at 31 March 2019	**7,239**	**8,119**

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 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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 2019/20 plan includes receipts of Department of Health and Social Care revenue support loans of £4.8m, the Trust also has £1.3m of revenue support loans due for repayment during 2019/20. The Directors consider it reasonable to expect cash support to be available and for the Trust to continue to be able to meet its liabilities as they fall due.

The Directors recognise the significant level of risk within the 2019/20 plan, in particular, the level of internal and system CIP's needed to achieve the control total. . The Trust is working to merge with North Cumbria University Hospitals NHS Trust and is also going to divest its mental health services to Lancashire Care NHS Foundation Trust and Northumberland, Tyne and Wear NHS Foundation Trust. The Trust is working with North Cumbria CCG, key local partners, 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

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.

1.4.1 Revenue from contracts with customers

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

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

Revenue from NHS contracts

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income. Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

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

1.4.2 Revenue grants and other contributions to expenditure

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

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

1.4.3 Other income

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

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.

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 for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

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

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 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 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.

Current value in existing use 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.

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

Subsequent expenditure

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'Held for Sale' cease to be depreciated upon the reclassification. Assets in the course of construction 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)

The Trust will apply the new RICS guidance on asset lives from period starting 1st April 2019.

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 abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged 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 useful 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.

1.8 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 lives in a manner consistent with the consumption of economic or service delivery benefits:

	Years
Intangible assets	
Software	7

1.9 Inventories

The cost of all consumable goods is charged to operating expenses at the date of purchase. Any stock holdings are not material in value either individually or in aggregate.

1.10 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.11 Financial assets and financial liabilities

Recognition

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

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

Classification and Measurement

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

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

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

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

De-recognition

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

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

1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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

Operating leases

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

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

Leases of land

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.

1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant the estimated risk adjusted cash flows are discounted using 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 0.29% (2017/18: 0.1%) in real terms.

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 17 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any

'excesses' payable in respect of particular claims, are charged to operating expenses when the liability arises**.**

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 18 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 18, 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.

1.15 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS 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.

1.16 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Corporation tax

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.

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 20 in accordance with the requirements of HM Treasury's FReM

1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had 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.

1.20 Transfers of functions to and from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.21 Critical accounting judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of 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 16.4.

The Trust will apply the new RICS guidance on asset lives from period starting 1st April 2019.

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 Trust has exercised judgement based on guidance within the Annual Reporting Manual not to consolidate its Charitable Funds based on grounds of materiality.

1.22 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.
- Following the publication of new guidance from the Royal Institution of Chartered Surveyors the asset lives of the Trust's Buildings and dwellings will be amended, the Trust estimates this impact to be approximately £378k in 2019/20.
- 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, in addition to the asset recognised in 2018/19, a contingent asset is recognised in line with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.
-

1.23 Early adoption of standards, amendments and interpretations

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

1.24 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 Trust is in the process of assessing the impact on the financial statements from the adoption of IFRS 16.

- IFRS 14 'Regulatory Deferral Accounts' (Not yet EU endorsed*)
- IFRS 16 'Leases' (Application required for accounting periods beginning on or after 1 January 2019 but not yet adopted by the FREM)
- IFRS17 'Insurance Contracts' (Application required for accounting periods beginning on or after 1 January 2021)
- IFRIC23 'Uncertainty over Income Tax Treatments' (Application required for accounting periods beginning on or after 1 January 2019)

**The European Financial Reporting Advisory Group recommended in October 2015 that the Standard should not be endorsed as it is unlikely to be adopted by many EU countries.*

2. Segmental Analysis

Operating Segments

	Year ended 31 March 2019 £000	Year ended 31 March 2018 * £000
Non-segment operating Income	**145,341**	166,480
Net segment expenditure:		
Integrated Acute Specialist Med Care Group	**(992)**	(884)
Integrated Community Care Group	**(54,350)**	(51,256)
South Community Services	**-**	(16,253)
Integrated Families Care Group	**(11,683)**	(11,827)
Integrated Mental Health Care Group	**(51,076)**	(47,245)
Operations and Clinical Management	**(912)**	(1,044)
Director of Quality and Nursing	**(2,226)**	(2,754)
Corporate Costs	**(23,734)**	(31,323)
(Surplus)/deficit before finance costs, depreciation, impairments and movements in fair value of investments	**368**	3,894
Finance income	**265**	26
Finance expense – financial liabilities	**(565)**	(582)
Finance expense – unwinding of discount on provisions	**(4)**	(2)
PDC Dividends payable	**(1,507)**	(1,582)
Donated assets income receipts	**473**	-
Net impairments on revaluation of property, plant and equipment	**(2,530)**	178
Gain / (Loss) on disposal of asset	**(4)**	(12)
Depreciation and amortisation	**(3,543)**	(3,551)
Transfer by absorption	**(585)**	-
NET DEFICIT FOR THE YEAR	**(7,632)**	(1,631)

*Comparative figures have been restated

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.

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 2019 £000	Year ended Restated* 31 March 2018 £000
High cost drugs	**3,446**	2,522
Mental Health Services	**68,542**	65,163
Community Services	**73,877**	97,883
Other Services**	**1,755**	-
Income from activities	**147,620**	165,568
Analysis by type of organisation		
NHS Trusts	**336**	337
NHS Foundation Trusts	**1,753**	178
NHS England and Clinical Commissioning Groups	**135,805**	156,972
NHS Other	**5**	7
Local Authorities	**7,283**	7,290
Other Non NHS	**683**	784
Department of Health and Social Care	**1,755**	-
Income from activities	**147,620**	165,568

*Income from Activities from 2017/18 has been restated in line with regulatory reporting.
**Agenda for change pay award.

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.

4.1 Other Operating Income

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Education and training	**2,767**	2,551
Research and development	**348**	375
Non-patient care services to other bodies	**5,097**	6,651
Rental revenue from operating leases	**1,007**	1,189
Provider Sustainability Funding (PSF)	**1,804**	2,997
Cash Donation to purchase capital assets	**473**	-
Other income	**1,333**	826
Total	**12,829**	14,589

The NHS Provider Licence sets out the education and training that the Trust is required to provide.

4.2 Revenue from contract with customers recognised in the period

The Trust recognised £474k of revenue in the reporting period which was included within contract liabilities (i.e. deferred IFRS 15 income) at the previous year end.

5.1 Operating Expenses

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Purchase of healthcare from non NHS bodies	**588**	589
Non-executive Directors' costs	**109**	113
Staff costs	**126,147**	137,271
Drug costs	**5,634**	4,914
Supplies and services - clinical (excluding drug costs)	**5,074**	6,536
Supplies and services - general	**3,757**	5,119
Establishment	**1,634**	1,568
Transport	**2,671**	2,822
Transport including Patient Travel	**96**	78
Premises	**8,952**	12,660
Movement in credit loss allowance: contract receivables / contract assets	**(211)**	-
Movement in credit loss allowance: all other receivables and investments	**-**	83
Depreciation and amortisation	**3,542**	3,551
Net Impairments of property, plant and equipment*	**2,530**	(178)
Audit fees - statutory audit	**40**	40
Other non audit services provided by external auditors	**8**	8
Internal audit	**126**	128
Clinical negligence	**462**	447
Legal fees	**522**	373
Consultancy	**938**	332
Training courses and conferences	**736**	655
Restructuring	**193**	239
Change in Discount Rate	**(4)**	2
Car Parking and security	**8**	6
Insurance	**20**	29
Losses, ex- gratia and special payments	**29**	6
Other**	**2,081**	2,244
	165,682	179,635

*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 2019 was an additional £8k remuneration for work on the Quality accounts (£8k 2017/18).

6. Operating Leases

6.1 Operating lease revenue:

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Minimum lease receipts	**1,007**	1,189

6.2 Operating lease expense:

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Minimum lease payments	**3,219**	4,178

6.3 Future minimum lease payments due:

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
On Buildings Leases		
Not later than one year	**2,367**	2,195
Between one and five years	**2,182**	1,510
Later than five years	**7,734**	6,914
	12,283	10,619
On Other Leases:		
Not later than one year	**603**	709
Between one and five years	**432**	582
Later than five years	**-**	-
	1,035	1,291
Total	**13,318**	11,910

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 2019 there were 8 early retirements from the Trust agreed on the grounds of ill-health (in the year ended 31 March 2018 there were nil early retirements). The estimated additional pension liabilities of these ill-health retirements will be £293k, (in the year ended 31 March 2018 the estimated additional liability was nil). The cost of these ill-health retirements prior to 2018/19 will be borne by the NHS Business Services Authority - Pensions Division.

9 Employee costs and numbers

9.1 Employee costs

	Year ended 31 March 2019	Year ended 31 March 2018
	Total	Total
	£000	£000
Salaries and wages	**100,385**	108,071
Social security costs	**9,361**	9,999
Apprenticeship Levy	**481**	519
Employer's contributions to NHS pensions schemes	**12,733**	14,064
Agency/contract staff	**5,237**	5,482
Termination benefits	**193**	239
Total gross staff costs	**128,390**	138,374
Recoveries in respect of seconded staff	**(1,318)**	(728)
Total staff costs	**127,072**	137,646
Of which:		
Costs capitalised as part of assets	732	136

10 Tangible Fixed Assets

10.1 Property, plant and equipment as at 31 March 2019 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 2018	6,009	52,484	253	821	6,399	254	11,410	1,894	79,524
Additions	-	1,826	-	1,662	269	21	2,658	298	6,734
Disposals/ derecognition (Note a)	-	-	-	-	(17)	(22)	(42)	(237)	(318)
Revaluations (Note b)	(857)	(2,623)	(6)						(3,486)
Impairments (Note c)	(103)	(449)	-	-	-	-	-	-	(552)
Reversal of impairments (Note c)	680	8	1	-	-	-	-	-	689
Reclassifications		2,483	-	(2,483)	-	-	-	-	-
Transfers by absorption (Note e)	(60)	(412)	-	-	(106)	-	(194)	-	(772)
Cost or valuation at 31 March 2019	**5,669**	**53,317**	**248**	**0**	**6,545**	**253**	**13,832**	**1,955**	**81,819**
Accumulated depreciation at 1 April 2018	**-**	**1,236**	**-**	**-**	**3,103**	**164**	**6,649**	**1,601**	**12,753**
Charged during the year	-	1,074	6	-	536	17	1,171	107	2,911
Disposals (Note a)	-	-	-	-	(12)	(22)	(42)	(237)	(313)
Revaluations (Note b)	(857)	(2,623)	(6)	-	-	-	-	-	(3,486)
Impairments (Note c)	857	1,796	-	-	-	-	-	-	2,653
Reversal of Impairments (Note c)	-	(123)	-	-	-	-	-	-	(123)
Transfers by absorption (Note e)	-	(30)	-	-	(55)	-	(102)	-	(187)
Accumulated depreciation at 31 March 2019	**0**	**1,330**	**0**	**0**	**3,572**	**159**	**7,676**	**1,471**	**14,208**
Net book value									
Owned	5,669	35,792	248	-	2,973	94	6,000	484	51,259
Finance leased	-	6,749	-	-	-	-	157	-	6,906
PFI	-	8,882	-	-	-	-	-	-	8,882
Donated	-	564	-	-	-	-	-	-	564
Total at 31 March 2019	**5,669**	**51,987**	**248**	**0**	**2,973**	**94**	**6,157**	**484**	**67,611**

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 Tangible Fixed Assets (cont'd)

a) Disposals: During 2018/19 the Trust wrote off assets with a cost of £318k (2017/18 £327k) and accumulated depreciation of £315k (2017/18 £nil) that were no longer in use.

b) Revaluations: This line has been used to write out accumulated depreciation following the revaluation.

c) Impairments: The Trust revalued its Land, Buildings and Dwellings at 31 March 2019 and 31 March 2018. 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 2018/19 valuation resulted in an overall net decrease in value of £2,393k (2017/18: £2,011k). This was made up of a net increase of £137k (2017/18: increase of £1,552k) in value which was credited to other comprehensive income and a net increase of £2,530k (2017/18: decrease £459k) impairment charged to operating expenses.

d) In 2017/18 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 there was also a small gain on sale of £15k for medical equipment with £nil net book value.

e) As a part of the transfer of south community services to University Hospital Morecambe Bay NHS Foundation Trust, the Trust transferred assets with a NBV of £585k to the organisation.

The Trust held £6,750k of assets under finance leases at the balance sheet date (£6,837k at 31 March 2018). Depreciation in respect of finance lease assets for the year ended 31 March 2019 was £106k (2017/18: £93k).

10.2 Non-current assets held for sale and assets in disposal groups

	31 March 2019 PPE - Land £000	31 March 2018 PPE - Land £000
NBV at 1 April	**-**	0
Assets classified as available for sale in the year	**-**	3,000
Assets sold in year **	**-**	(3,000)
NBV at 31 March	**0**	0

** 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.

10.3 Asset disposal in year

	Total £000	Plant and Machinery £000	Transport equipment £000
Net book value of asset disposed	**5**	5	0
Sale proceeds	**(1)**	-	(1)
Expenditure associated with sale	**-**	-	-
Gain/ (loss) on sale	**(4)**	(5)	1

11. Intangible Fixed Assets

	31 March 2019 Software Licences £000	31 March 2018 Software Licences £000
Cost at 1 April	**4,240**	3,797
Additions	**270**	443
Reclassifications from PPE	**-**	-
Cost at 31 March	**4,510**	4,240
Amortisation at 1 April	**1,062**	575
Charged during the period	**631**	487
Amortisation at 31 March	**1,693**	1,062
Net book value		
Purchased at 1 April	**3,178**	3,222
Total at 1 April	**3,178**	3,222
Purchased at 31 March	**2,817**	3,178
Total at 31 March	**2,817**	3,178

12.1 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 Trust has a capital commitment of £0.3m at 31 March 2019 and had a capital commitment of £0.5m under capital expenditure contracts at 31 March 2018.

12.2 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 2019 £000	31 March 2018 £000
not later than 1 year	**1,280**	1,287
after 1 year not later than 5 years	**1,412**	2,191
Total	**2,692**	3,478

13. Inventories

The Trust had no material inventories at 31 March 2019 or at 31 March 2018.

14. Trade and other receivables

14.1 Trade and other receivables – current

	31 March 2019 £000	31 March 2018 £000
Contract Receivables *	**10,758**	-
Trade receivables	**-**	4,627
Other receivables	**413**	333
Prepayments	**1,167**	1,620
Accrued Income		1,104
Provision for the impairment of receivables	**-**	(686)
Allowance for impaired contract receivables/assets	**(474)**	
Total	**11,864**	6,998

There were no prepaid pension contributions at 31 March 2019 or 31 March 2018.

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

14.2 Allowances for credit losses- 2018/19

	Contract receivables and assets £000	All other receivables £000
Balance at 1 April brought forward		
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	**686**	(686)
Arising during year	**-**	-
Utilisation of allowances	**(1)**	-
Reversal of allowances	**(211)**	-
Balance at 31 March	**474**	(686)

14.3 Allowances for credit losses- 2017/18

	All receivables £000
Allowances as at 1 April 2017- as previously stated	**603**
Prior period adjustments	**-**
Allowances as at 1 April 2017- restated	**603**
Increase in provision	**241**
Unused amounts reversed	**(158)**
Total	**686**

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

15. Analysis of cash movements

15.1 Reconciliation of net cash flow to movement in net funds

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Net funds at 1 April	**8,119**	5,649
Net change in year	**(880)**	2,470
Net funds at 31 March	**7,239**	8,119
Broken down into:		
Cash with Government Banking Service	**7,225**	8,105
Cash with commercial banks and in hand	**14**	14
Net funds at 31 March	**7,239**	8,119

16. Liabilities

16.1 Trade and other payables at the balance sheet date are made up of:

	31 March 2019 £000	31 March 2018 £000
Amounts falling due within one year:		
Tax payable	**2,332**	2,863
NHS payables	**12,135**	4,413
Capital payables	**427**	169
Other payables	**5,069**	6,025
Accrued interest on loans*	**-**	1
Accruals	**5,281**	4,439
Total	**25,244**	17,910

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

Other payables include £1,776k outstanding pension contributions at 31 March 2019 (£1,956k at 31 March 2018).

16.2 (a) Borrowings

	31 March 2019	31 March 2018
	£000	£000
Current		
Obligations under finance leases (note 16.3)	**77**	78
Obligations under PFI contracts (note 16.4)	**298**	274
DHSC	**1,312**	-
Total	**1,687**	352
Non-current		
Obligations under finance leases (note 18.3)	**59**	137
Obligations under PFI contracts (note 18.4)	**5,026**	5,324
DHSC	**2,831**	1,757
	7,916	7,218

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

16.2 (b) Liabilities arising from financing activities

	Loans from DHSC	**Other loans**	**Finance leases**	**PFI and LIFT schemes**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Carrying value at 1 April 2018	**1,757**	**-**	**215**	**5,598**	**7,570**
Cash movements:					
Financing cash flows - payments and receipts of principal	2,383	-	(79)	(274)	**2,030**
Financing cash flows - payments of interest	(26)	-	(14)	(523)	**(563)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	1	-	-	-	**1**
Application of effective interest rate	28	-	14	523	**565**
Carrying value at 31 March 2019	**4,143**	**-**	**136**	**5,324**	**9,603**

16.3 Finance lease commitments

	31 March 2019	31 March 2018
	£000	£000
Gross finance lease liabilities which are due:		
Within 1 year	**92**	92
Between one and five years	**69**	201
Finance charges	**(25)**	(78)
Total	**136**	215

	31 March 2019 £000	31 March 2018 £000
Net finance lease liabilities which are due:		
Within 1 year	**77**	78
Between one and five years	**59**	137
Total	**136**	215

16.4 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.

16.4(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 2019 £000	31 March 2018 £000
Gross PFI liabilities	**8,731**	9,525
Of which liabilities are due:		
Within 1 year	**794**	794
Between one and five years	**3,175**	3,175
More than five years	**4,762**	5,556
	8,731	9,525
Finance charges allocated to future periods	**(3,407)**	(3,927)
Net PFI liabilities	**5,324**	5,598
Of which liabilities are due:		
Within 1 year	**298**	274
Between one and five years	**1,498**	1,370
More than five years	**3,528**	3,954
Total	**5,324**	5,598

16.4(b) Total on-SoFP PFI service concession arrangement commitments

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI service concession arrangements, including the operating cost, the contingent rent and life cycle cost	**14,534**	15,687
Of which liabilities are due:		
Within 1 year	**1,272**	1,259
Between one and five years	**5,179**	5,112
More than five years	**8,083**	9,316
Total	**14,534**	15,687

16.4(c) Analysis of amounts payable to service concession operator

	31 March 2019	31 March 2018
	£000	£000
Unitary payment payable to service concession operator	**(792)**	928
Consisting of:		
Interest charge	**523**	544
Repayment of finance lease liability	**273**	250
Service element – current year (see note 18)	**-**	134
Service element – prior years (see note 18)	**(1,588)**	-
Other	**-**	-
Total amount paid to service concession operator	**(792)**	928

16.5 Department of Health and Social Care Loan

The Trust has a total of £4.1m of revenue support loans, of which £1.3m is due for repayment in 2019/20.

16.6 Other liabilities

Other liabilities as disclosed in the Statement of Financial Position comprise deferred income.

	31 March 2019	31 March 2018
	£000	£000
Current	**1,005**	661
Total	**1,005**	661

17. Provisions

	Total	**Pensions Injury Benefit**	**Pensions early departure**	**Restructuring**	**Other**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2018	2,311	1,356	255	162	538
Change in the discount rate	-	-	-	-	-
Arising during the year	308	1	11	125	171
Used during the year	(206)	(62)	(25)	(119)	-
Reversed unused	(113)	-	-	(43)	(70)
Unwinding of discount	(5)	(4)	(1)	-	-
At 31 March 2019	**2,295**	**1,291**	**240**	**125**	**639**

	Total	Pensions Injury Benefit*	Pensions early departure	Restructuring	Other
	£000	£000	£000	£000	£000
Expected timing of cash flows:					
Within 1 year	**851**	62	25	125	639
Between one and five years	**349**	248	101	-	-
After 5 years	**1,095**	981	114	-	-
	2,295	**1,291**	**240**	**125**	**639**

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

The pension provision is in respect of staff who have taken early retirement or retirement prior to 2018/19 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.

£285k is included in the provisions of NHS Resolution as at 31 March 2019 (£717k at 31 March 2018) in respect of clinical negligence liabilities of the Trust.

18. Contingencies

The Trust is in dispute with its Private Finance Initiative (PFI) provider and has claimed penalties and deductions relating to fire defects and other issues at Workington Hospital. The fire dispute is subject to a legal process which is ongoing but is expected to be concluded during 2019/20. Following the outcome of the first stage of the dispute process the Trust has recognised an asset but this will require adjustment following the conclusion of the dispute process. The above disclosure has been reduced due to its commercially sensitive nature.

There is a contingent liability of £43k at 31 March 2019 (£54k at March 2018) 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.

19. Financial Instruments

19.1 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 19.3, was £17,758k (£13,491k at 31 March 2018) being the total of the carrying amount of financial assets.

19.2 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.

19.3 Financial assets by category

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

	31 March 2019 £000	31 March 2018 £000
NHS and DH Bodies receivables	**7,286**	3,882
Other receivables and accrued income	**3,233**	1,490
Cash at bank and in hand	**7,239**	8,119
Total	**17,758**	13,491

19.4 Financial liabilities by category

	31 March 2019 £000	31 March 2018 £000
Trade Payables within the DHSC group	**12,135**	4,413
Trade Payables outside the DHSC group	**8,482**	10,636
Accruals		
Provisions	**2,295**	2,311
PFI borrowings	**5,324**	5,598
Finance lease borrowings	**136**	215
DHSC Loan	**4,143**	1,757
Total	**32,515**	24,930

19.5 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 2019.

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 2019.

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 2019.

19.6 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.

90% of the Trust's income is derived under block contracts with its Commissioners, which run until at least 31 March 2020, 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 2019, £852k is payable within one year, £349k between one and five years. Trade and other payables are due within 1 year.

20. Third Party Assets

The Trust held £398k cash at bank and in hand at 31 March 2019 (£1,945k at 31 March 2018) which comprises £73k monies held by the Trust on behalf of patients (£73k at 31 March 2018), and £325k held on behalf of The West, North and East Cumbria Sustainability and Transformation Partnership (£1,872k at 31 March 2018). These amounts have been excluded from the cash at bank and in hand figure reported in the accounts.

21. 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 have 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:

	2018/19 Income £000	2018/19 Expenditure £000	2018/19 Receivables	2018/19 Payables
NHS England	13,138	15	1,458	8
North Cumbria Clinical Commissioning Group	98,008	15	1,933	9,436
Morecambe Bay Clinical Commissioning Group	27,031	17	1,070	17
North Cumbria University Hospitals NHS Trust	2,865	3,271	1,018	485
University Hospitals of Morecambe Bay NHS Foundation Trust	2,136	3,892	205	969
Health Education England	3,317	7	1,107	55
Department of Health and Social Care	1,775	-	-	-

All income, expenditure, payables and receivables 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. During 2018/19 the Trust received £375k from its Charitable Fund for the redevelopment of Millom Community Hospital.

22. Losses and Special Payments

	31 March 2019		31 March 2018	
	Number of cases	**Value of cases**	Number of cases	Value of cases
		£000		£000
Stores losses and damage to property	**-**	**-**	1	4
Ex gratia payments	**9**	**29**	7	2
Compensation payments	**-**	**-**	-	-
Total	**9**	**29**	8	6

The above are reported on an accruals basis and there were no cases of loss in excess of £300k in 2018/19 or 2017/18.

24. Transfer of South Community Services

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.