NHS
Pennine Care
NHS Foundation Trust

2017/18

ANNUAL REPORT AND ACCOUNTS

Pennine Care NHS Foundation Trust
Annual Report and Accounts 2017/2018

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

Contents

Welcome from the Chair and Chief Executive

During 2017/18, we have continued to develop as a Trust – both in the local communities that we serve, and further afield across Greater Manchester.

We are proud to be one of the country's leading providers of mental health and community services.

It has been a year of significant change and development. We have seen some major changes in our senior leadership, including appointing to both the position of chief executive and chair. We have also brought together our Mental Health and Specialist Services divisions and are in the process of refreshing the leadership to deliver the best care possible to our service users. You can read more about this in the Directors' Report on page 41.

Externally, we have played a significant role in the recovery of Greater Manchester following the Arena Attack in May 2017. We currently host the Manchester Resilience Hub, set up to coordinate the care and support for children, young people and adults, including those affected in a work-related capacity, whose mental health has been affected by the attack, wherever they may live in the UK.

We have also continued to look at ways we can innovate and improve. In March we launched our partnership with Manchester Metropolitan University. This new Integrated Health and Social Care Partnership will bring together academic and clinical professionals, to apply research to clinical practice and catalyse innovations.

In common with all public sector organisations, we continue to operate in a financially challenging climate. This year, we have a deficit of £2.2m. You can read more about this in the annual accounts.

> **"We would like to take this opportunity to thank our staff, who truly are our greatest asset. We are proud of their dedication and commitment, along with their tenacity in the face of challenges."**

We continue to work closely with a range of partners across our footprint - particularly in relation to developing new Local Care Organisations and have been integral in setting these up in Bury, Oldham and Trafford. These set out a shared ambition for how health and social care will be managed and delivered in the future.

We would like to take this opportunity to thank our staff, who truly are our greatest asset. We are proud of their dedication and commitment, along with their tenacity in the face of challenges.

We are looking forward to the opportunities that lie ahead. There will undoubtedly be challenges, but we are confident we will overcome these and achieve success.

Whatever the next year brings, we remain committed to achieving our vision - to deliver the best care to patients, people and families in our local communities by working effectively with partners to help people to live well.

Evelyn Asante-Mensah OBE
Chair
25 May 2018

Claire Molloy
Chief Executive
25 May 2018

Performance Report Overview

The purpose of this section is to provide sufficient information to enable an understanding of Pennine Care NHS Foundation Trust, including our purpose, key risks to the achievement of our objectives and how we have performed during the year.

Joining the Trust in 2017, I am pleased to see how the Trust is beginning to transform, often in challenging circumstances. We have made significant progress in terms of service innovation, integrating services and developing services to deliver the best care possible.

The Board, having made appropriate enquiries, still have reasonable expectations that the Trust will have access to adequate resources to continue its operational existence for the foreseeable future, being a period of at least 12 months from the date of approval of the financial statements. On this basis, The Trust has adopted the going concern basis for preparing the financial statements. Full information can be found within the financial statements on page 230 of this report.

Claire Molloy
Chief Executive
25 May 2018

Introduction to Pennine Care

Pennine Care NHS Foundation Trust (Pennine Care) was formed in 2002 as a mental health trust. We became the 100th Foundation Trust in 2008 and welcomed community services from the boroughs of Bury, Rochdale and Oldham in 2011. This was followed by a range of Trafford services in 2013.

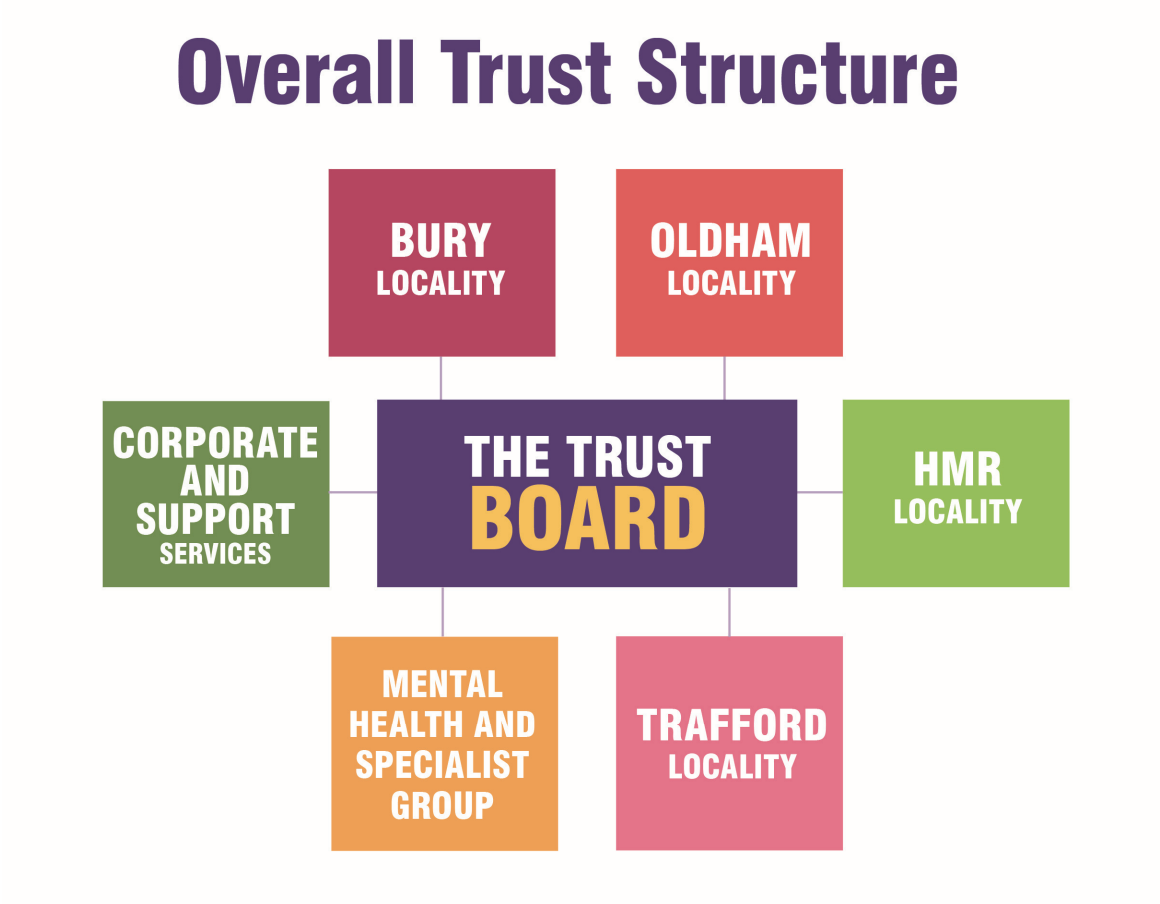
Since its formation, we have grown to become a leading provider of community and mental health services.

We are responsible for providing community and mental health services across several boroughs of Greater Manchester. Our purpose is to help communities to live healthy lives, acting with integrity and upholding our values.

Our 5,500 staff provides care to around 1.3 million people across six boroughs of Greater Manchester as follows:

- **Bury** - community and mental health services for children and adults; intermediate care for adults; urgent care services for children and adults
- **Rochdale** - community and mental health services for children and adults
- **Oldham** - community and mental health services for children and adults; intermediate care for adults
- **Tameside and Glossop** - mental health services for children and adults; health improvement for adults; intermediate care for adults
- **Stockport** - mental health services for children and adults
- **Trafford** – community services for children and adults; child and adolescent mental health services (CAMHS)

We also provide mental health services for military veterans across the whole of Greater Manchester, working in partnership with other trusts which cover Lancashire, Cheshire and Merseyside.



Our services are delivered by six divisional localities. These are:

- Community Services Bury
- Heywood, Middleton and Rochdale (HMR) Community Services
- Oldham Community Services
- Trafford Community Services
- Mental Health and Specialist Services Group

Our Corporate Services Group underpins these divisions, supporting effective functioning and the delivery of services.

Our services

The breadth of our service portfolio means we are uniquely positioned to provide whole-person care; addressing people's physical and mental health in an integrated way.

The majority of our services are based in health centres, clinics, GP practice and community centres. Where appropriate, we also provide care and support in people's usual place of residency - this could be their own home or a nursing or residential home. Some of our services are hospital-based.

Our staff work closely with a range of partners including commissioners, other NHS trusts, GPs and social care staff, along with colleagues from the voluntary, charity and private sectors.

Mental health services and specialist services

We provide a range of care and treatment for people with mild to moderate conditions such as depression, anxiety or dementia; along with more serious mental health illnesses such as schizophrenia, bi-polar disorder and more.

- Primary care mental health services, including Increasing Access to Psychological Therapies (IAPT)
- Working age adult inpatient and community services, including access and crisis, home treatment, assertive outreach and early intervention
- Older people's inpatient and community services
- A Military Veterans Service for ex service personnel
- The Manchester Resilience Hub for those affected by the Manchester Arena attack
- Child and adolescent mental health services (CAMHS) including community, inpatient and in-reach/out-reach services
- Low secure and step-down rehabilitation services – providing longer term care for people with more complex mental health issues, such as schizophrenia
- A Psychiatric Intensive Care Unit (PICU) – for men who need a short-term period of intensive mental health care and support
- Community-based alcohol and drug services
- Services to support people with a learning disability, including multi-disciplinary community teams, supported living and a short breaks service

Community services

Our community services support people to remain healthy and stay out of hospital from birth right through to the end of their life.
Our community services include:

- Adult nursing and therapies including physiotherapy, audiology, podiatry and palliative care
- Children's nursing and therapies including health visiting, child protection and safeguarding, school nursing, speech and language therapy and occupational therapy
- Services supporting the management of long-term conditions such as pulmonary rehabilitation, cardiac rehabilitation and IV therapy
- Community dental services including minor oral surgery, urgent care services and special care dentistry for people with additional needs
- Health improvement services focused on helping people to stop smoking, get more active, eat healthily, manage their weight and improve their oral health
- Urgent and intermediate care services, designed to help people avoid being admitted to hospital unnecessarily, or reduce their length of stay. This includes intermediate care units and walk-in centres

How we are commissioned

The majority of our services are commissioned by the clinical commissioning group or local authority within our footprint: Bury, Oldham, Heywood, Middleton and Rochdale, Stockport, Tameside and Glossop and Trafford.
Some of our services are commissioned by NHS England, including dentistry, our low secure units and our acute child and adolescent mental health services.

Developing our Trust Strategy

Pennine Care's vision is to deliver the best care to patients, people and families in our local communities by working effectively with partners, to help people live well.

This is supported by five overarching strategic goals:

1. Put local people and communities first
2. Provide high quality whole person care
3. Deliver safe and sustainable services
4. Be a valued partner
5. Be a great place to work

Whilst the vision and goals have been in place for some time, the complex and ever-changing external environment has made it difficult for the Trust to move forward with rapid change and improvement at scale.

Therefore, in addition to having a five year strategic plan (2016 to 2021), an annual business plan has been developed to provide greater clarity and focus on the direction of travel.

Pennine Care's primary purpose is to help communities to live healthy lives.

To do this we will:

- Place the development of high quality, compassionate and continually improving care and support at the heart of everything we do;
- Develop an enabling culture and environment within the organisation that supports this, where every member of staff can be their best and where people want to work;
- Develop valuable partnerships with a wide set of stakeholders to improve health outcomes and provide person-centred, place based care because we know we can't do this on our own;
- Use these partnerships with our staff, with people who use our services, and with our commissioners, to develop future service offers that are deliverable within the resources available and which don't compromise our quality aspirations or breach core quality standards.

Our Value Proposition:

We believe we have a lot to offer within the health and care systems we operate within:

- We are a champion for preventative approaches and care in home settings, supporting people to stay healthy and well and to recover where possible;
- We are passionate about the development of integrated care and keen to strengthen our partnerships to support the delivery of person-centred care and support;

- We have significant expertise and experience in both universal and specialist community services; and secondary and specialist mental health care which we want to use positively to support the development of new service models outlined in locality plans;
- By combining our expertise in physical and mental health we believe we can offer an integrated person-centred approach that treats people holistically.

Our Value Model

We therefore see a valuable role for us in designing future health and care systems and integrated service models within Greater Manchester, and in the future delivery of those service models through stronger, more collaborative partnerships.

We will continue to be active partners in the development of Local Care Organisations within the localities we currently serve, bringing our particular expertise and experience to effect changes in how and where care is provided. It is our ambition to be strong partners in whatever delivery models are developed in the future.

We will remain an expert provider of those services that require our specialist expertise and leadership, particularly our mental health services, working increasingly in collaboration within wider GM networks with other specialist providers to make the most of our collective expertise and to ensure a strong voice for these services.

Delivery Priorities 2017/18

The table below details progress made against the delivery objectives during 2017/18.

Quality – Drive and sustain quality improvement and innovation

- *Refresh the quality strategic plan to be clear on outcomes and implementation priorities*
  - ✓ Development of refreshed Quality Strategy initiated.
  - ✓ Detailed plans for Safer Staffing and Therapeutic Care in place.
  - ✓ The new Quality Committee will seek assurance and manage progress of the strategy through integrated performance reports.
  - ✓ Improvement to Innovation (I to I) programme group and sub-groups have been established.
  - ✓ Proposal for Target Operating System has been drafted.

- *Deliver CQC action plan priorities*
  - ✓ 66% achieved; 23% in progress.
  - ✓ Workshops with leaders and managers have shown positive progress.

- *Move from Requires Improvement to Good across all services*
  - ✓ The new Quality Committee will oversee progress and seek assurance, with delivery of the work plan undertaken by the Quality Group.

- *Develop and implement trust approach to quality improvement*
  - ✓ Improvement to Innovation work stream progressed focuses on culture change needed to stimulate a consistent environment of continuous improvement and the development of resources which enable staff to deliver QI change projects.
  - ✓ AQuA session with the board planned to inform the development of a QI strategy.

Carried over into 2018/19
"Ward to Board" strategy and engagement programme is now taking place in 2018/19 as part of the Trust's Well Led review.

People – Ensure that the workforce is able to deliver safe and effective services

- *Refresh people strategic plan to be clear on outcomes and implementation priorities*
  - ✓ Independent consultant review of the current workforce strategy outlined that the strategy is generally sound, but that the strategy design needs to be clearer on priorities and measures and needs to separate out the 'People' and 'OD' strands to ensure emphasis on both.
  - ✓ The strategy is in the process of being refreshed and redrafted.
- *Develop a robust workforce strategy implementation plan*

- ✓ A new workforce strategy delivery group, with a full implementation plan, is to be established in Q4. A full programme management approach will be employed to ensure delivery of the implementation plan.

- *Undertake cultural audit and build findings into refreshed OD strategic plan*
  - ✓ Cultural audit planned for 2018/19

Partnerships – Form effective partnerships within each of our localities to transform services

- *Work with partners to support the development of LCOs and the delivery of locality plans*
  - ✓ In Q1 work was undertaken to review the emerging LCO forms to establish the Trust's position within each of the 6 locality systems. This enabled the development of an ambition for each locality which articulated our unique offer and how we will ensure that we are a trusted and valued partner.
  - ✓ Executive director sponsors are linked to each borough and their respective LCO arrangements and locality plans, working in conjunction with relevant managing directors.
  - ✓ An LCO network has been established across the Trust; including mechanisms for mapping stakeholders, sharing of LCO proposals and governance arrangements.
  - ✓ A development workshop was held with divisional and corporate management teams 19 September and from this, a Trust LCO Network was established need to ensure central oversight of emerging new organisational forms and to share learning.
  - ✓ Places have been secured on all local alliance management forums.
  - ✓ Partnerships have been established in each locality to support the delivery of locality plans.

- *Support implementation of the GM mental health strategy and implement priorities from the Trust's own mental health strategy*
  - ✓ Consolidation of the GM and Pennine Care mental health strategies into a single delivery programme.
  - ✓ **Adult acute / alternative to admission schemes -** a Trust-wide proposal developed in conjunction with commissioners. Discussions are being progressed in terms of third sector partners to support delivery of the new model.
  - ✓ **GM: Core-24 implementation -** Supported the development of the business case and cost benefits analysis completed through GM. Investment confirmed in Stockport and Oldham.
  - ✓ **Implementation of the HMR Locality plan MH transformation schemes including the Living Well Hub -** A joint project group between PCFT, CCG and LA has been established as well as a local internal implementation. Original proposals being refined and a workshop is being convened to consider outcome measures.
  - ✓ **Trust wide review of CMHT -** Scoping work by MH Strategies will inform the development of a standardised operating policy for CMHT which will address CQC feedback in terms of differences in provision and approach across the boroughs and will better inform the current capacity and demand issues experienced.

- ✓ **Development of a Trust-wide Personality Disorder Strategy and associated pilots -** Engaged in the work being progressed at a GM level. Development of a strategy and some pilot approaches.
- ✓ **Delivery of trauma-informed training across the Trust, commencing in Stockport and HMR -** Training is being sourced externally and funded through HENW monies. Staff from the full clinical pathway within a borough will be trained to ensure the greatest impact and consistency in clinical approach.

- *Work within a small number of localities to evolve and implement opportunities for integrating mental health and community*
  - ✓ Pilot schemes have been identified in Stockport, HMR and Oldham that will support a more integrated approach to both physical and mental health service delivery, operating at a neighbourhood level.

- *Develop core standards for community services across the trust footprint*
  - ✓ Mapped out all of the current quality measures that exist within community services which identified a significant disparity between the types of assurance and the level of rigour that different services apply when considering the quality performance of their service.
  - ✓ Workshops have been held with frontline staff to develop an overarching set of 'quality principles'– these will form a framework for the development of in-depth quality standards for each of our community service lines.

- *Redesigned operational management structures which will enable locality working across our service lines*
  - ✓ Redesigned structure in place and appointments made.

Money – Ensure financial sustainability, addressing immediate pressures and future plans

- *Achieve revised forecast outturn for 2017/18*
  - ✓ At month nine, the Board approved a formal change in the forecast outturn from a planned deficit of £6.6m to a proposed deficit of £4.9m. The Trust remains on course to deliver the revised forecast.
- *Work with commissioners to agree financial position for 18/19*
  - ✓ "Work in progress" workshop session with the Board 28 February 2018 with final sign off the interim plan by Board 28 March 2018 which was submitted to NHSI on 8 March 2018.
- *Re-run LTFM and develop summary medium term financial plan*
  - ✓ LTFM being developed. Initial discussion at Part 2 Board session 28 February 2018.
- *Work with commissioners to agree programme of work between April and October 2018 to review service offer within financial envelope*

Service reviews are planned and work will be underway from April to inform a proposed revised service offer in October 2018.

Infrastructure – Ensure we have the right estate and IM&T to deliver our quality aspirations

- *Implement estates priorities*
  - ✓ Delivery of a range of capital investments:
    - Estates Lifecycle £345k
    - Medical Equipment Lifecycle £150k
    - Parklands Refurbishment £1,850,000
    - Catering Equipment £123k
    - MH Secure Window Replacement £215k
    - MH Curtain & Cubicle Track Replacement £45k
    - Place of Safety Upgrades £720k
    - Stockport Community MH Reconfiguration £150k
    - Ward Refurbishments £125k
    - Fire Safety £290k
    - Improving Premises Functionality £220k
    - Estate Utilisation and Rationalisation £907k

- *Implement the health informatics strategy*
  - ✓ Refreshed Health Informatics strategy for Board sign-off in March 2018.
  - ✓ Successful bids for further GM&HSC digital funding (£1.4million in 17/18).
  - ✓ Chief clinical information officer and chief information officer recruited.
  - ✓ Rollout of clinical forms to district nurses and community mental health teams progressing well.
  - ✓ NHS D cyber security assessment completed in December 2017.
  - ✓ Began a project to embed an information culture across the organisation and developed information dashboards for the Bury locality.

- *Complete the migration to a new child health system for four LCOs*
  - ✓ On track for March 2018 go live.

- *Improve the uptake of mobile working within community mental and physical health teams*
  - ✓ All health visiting teams have access to mobile devices.
  - ✓ All mental and physical health teams in HMR have access to mobile devices.

- *Initiate the rollout of electronic prescribing in partnership with GMMH*
  - ✓ A project manager has been recruited to work on the business case for e-prescribing.

- *Improve mental health and community services clinical recording and information exchange*
  - ✓ HMR CAONS team have deployed forms for recording of child physical health conditions including Looked After Children, eye assessments, paediatric diabetes and epilepsy.
  - ✓ District nurse wound care assessment forms have been deployed across all localities.
  - ✓ Mental health CPA documentation has been deployed within community health teams.

Carried over into 2018/19

- Draft and approve a business case for electronic document management and archived significant numbers of mental health records
  - A procurement activity is required to progress this project.
  - Replace the use of HMR PAS and start the rollout of electronic referral mechanisms across community and mental health teams
  - Delayed until 2018/19 due to slippage in the child health project.
  - Improve the recording of patient details within the main EPR (PDS)

Delayed until 2018/19 due to slippage in the child health project.

Divisional Business Unit Achievements 2017-18

Bury

- AQuA Motivational Interviewing and Shared Decision Making training.
- Developing a systems approach to staffing with the LCO.
- Pathway redesign taken place with key partners and stakeholders in 2017/18 for Community Eye Service, Cardiac, Respiratory, Paed OT, Stroke, Early Years, Palliative Care and Dietetics.
- Mobile devices and agile working programme rolled out across the borough.

HMR

- Implementing a redesigned Family Services model.
- Proactive service user engagement and involvement, supported by CQUIN.
- Presence at LCO discussions and transformation funding secured.

Mental Health

- Developing new proposals for addressing the mixed sex accommodation challenge.
- New leadership structure in place.
- Active presence/engagement in the Locality Plan/Transformation Plan for each locality.
- EIP business cases secured some investment (challenge remains re full compliance).

Oldham

- Positive engagement in ICO developments, taking leadership for urgent and emergency care.
- Integrated Health Teams – early adopter site (Oldham West) has developed with co-located health and care staff now working in a fully integrated way. Lessons learned were shared at a primary care-focused event and included a ‘readiness assessment’ for primary care clusters to fully engage and take forward.
- All frontline services have completed the self-management self-assessment and are working through their action plans to embed culture.
- Continue to utilise the Experience Based Design approach.

Specialist Services

- Refreshed Quality Strategy within each CBU.
- Developed and enhanced SSD online resources, expanding on the existing websites and social media.
- Development of the CAMHS Crisis Service business case and subsequent award of programme leadership.
- Active engagement of tier 4 and LSU Transforming Care redesign proposals.
- I Thrive.
- Perinatal infant/child pathway

Trafford

- Discharge to Assess beds funded through transformation monies.
- Multi-agency joint pathway redesign culminated in the creation of an “urgent care control room”.
- New asset-based assessment extremely successful in seeing improved customer and staff experience, more people self-managing and fewer people being transferred to long-term care.
- A range of videos produced by physiotherapists now online with the support of My Health My Community.
- Utilisation of clinical bases managed directly by Pennine Care has increased from 40% to 80%.

Performance Report Analysis

This section of the report will look in more detail at the performance of the Trust during 2017/18, including service developments, achievements, updates and financial performance. It also looks ahead at the future trends and challenges that may impact on the Trust during the next financial year.

How we monitor performance

We have a dedicated performance department and our robust systems ensure we can effectively monitor our performance and evidence where we are performing well.

We provide our commissioners with assurance through detailed contract reports and performance meetings.

Internally we have a robust assurance reporting process involving our divisional business units, executive directors, Board sub-committees and the Board itself in relation to core standards, contractual requirements and business plan objectives.

Linked to this, our Board Assurance Framework informs the Board of the overall effectiveness of key controls that seek to mitigate or manage principle risks. It also provides the Board with assurance regarding achievement of the Trust’s objectives.

Trustwide developments

Health and Wellbeing College

September 2017 saw the first anniversary of our Health and Wellbeing College.

When the college launched in September 2016 it had just 85 students and one campus in Oldham. Now the college has over 693 students on roll.

In July 2017, we launched our purpose built main campus at Ashton, right next door to our HQ. This offers an inspirational environment for people to improve their health and wellbeing through the range of courses we have on offer.

The college offers free recovery focused educational courses to support people to improve their health and wellbeing.

A range of mental health, physical health and life skills courses are offered. All are jointly produced by someone with professional skills or knowledge and someone with skills or knowledge gained through living with a particular condition.

New Cares Awards

This year we launched our first CARES Awards, which are our values-based way to recognise services or teams who've gone above and beyond to provide high quality care.

Nominations were received from 61 teams across nine categories, with a winner for each being chosen. An overall winner and a 'highly commended' runner-up were then announced at our AGM in September.

The Overall Winner in the Corporate Services category was the **Recruitment and Retention Team.**

The winners were praised for their work with Remploy to support people with disabilities back into employment.

The team developed a course to build the skills and confidence of potential candidates so they can pursue a career in healthcare.

This included a tour of adult inpatient mental health wards, help with IT skills, interview preparation and guidance on required documents and references.

Highly Commended in the **Specialist Services category** was the **Moving On Group.**

The Moving On Group, based at Heathfield House in Stockport, were highly commended for the range of rehabilitation activities that they provide for service users with mental health conditions.

These are aimed at helping them to develop skills and routine and prepare for life back in the community.

The team also successfully encouraged service users to take part in regular exercise, through initiatives like a 10,000 steps for ten days challenge and weekly football training sessions with Stockport County.

Other winners were:

Community Services Bury category

Millwood School Nursing Team for their efforts to improve the health of children with complex needs and learning disabilities, based at Millwood Primary Special School in Radcliffe.

Cross-Divisional Business Unit category

Criminal Justice Mental Health Team for their support of offenders who have mental disorders, particularly their work with case 'JB'.

Heywood, Middleton and Rochdale Community Services category

Children's Acute and Ongoing Needs Service for redesigning many services and combining them into one easy-to-access service.

Mental Health North category

Oldham Community Mental Health Team for working hard to improve the physical health of people with a severe mental illness.

Mental Health South category

Tameside and Glossop Memory Assessment Service for working tirelessly to keep meeting targets for access and waiting times.

Oldham Community Services category

Oldham Medicines Management Team for their work to review patient medicines; freeing up district nurses workload, improving patient safety and reducing waste medicines.

Trafford Community Services category

Trafford Leg Ulcer Team for demonstrating a 98 to 100 percent successful healing rate for patients with venous leg ulcers.

MMU Partnership

In March 2018, we officially launched our collaboration with the Manchester Metropolitan University to help shape future community healthcare and education.

This new Integrated Health and Social Care Partnership will bring together academic and clinical professionals, to apply research to clinical practice and catalyse innovations.

The joint venture ensures that the workforce is equipped with the necessary knowledge, skills and qualifications needed to deliver healthcare excellence in primary and secondary care across Greater Manchester.

Fluperheroes

Our annual flu vaccination campaign this year had the theme of 'FLUperheroes', encouraging staff to vaccinate themselves for the benefit of staff and patients.

Throughout the campaign we carried out three prize draws, with the chance to win high street shopping vouchers worth up to £500.

We managed to vaccinate more than 3,000 staff against flu. Not only does this demonstrate our commitment to protecting people, but we passed our milestone with a 60.1 percent uptake of front-line staff. This effort put us in the top five most improved Trusts in the country.

Mental Health and Specialist Services developments

Stockport Team for Early Management (STEM)

The Stockport Team for Early Management (STEM) is a service that offers extra support to people arriving at A&E overnight with mental health problems in Stockport.

The service operates from 9pm to 9am, supporting those who go to Stepping Hill Hospital for help due to self-harm, thoughts of suicide, or other mental health issues. It provides an alternative route to prevent people waiting in A&E or being admitted to hospital, providing patients with a thorough assessment of their mental health needs and short-term psychological support.

Once patients have been referred to STEM, they have the opportunity to relax in a dedicated room which is a comfortable environment and space for people to have the opportunity to spend time with both qualified staff and support staff.

The service is delivered by Pennine Care NHS Foundation Trust in partnership with Self Help, and is funded by NHS Stockport Clinical Commissioning Group.

The STEM service was recently awarded the 'Image and Pride in Nursing' which was presented at the Chief Nurse Conference in October 2017.

The Manchester Resilience Hub

In July 2017, following the Manchester terror attack which claimed the lives of 22 people, the NHS launched a dedicated mental health service to help people affected.

Called the Manchester Resilience Hub, the service focuses on helping people directly affected by the incident such as concert goers, immediate family members and emergency responders. It applies to children, young people and adults and is open to people across the UK, as many people who attended the concert were from Manchester and beyond.

Located in Ashton, the Hub is staffed by trained mental health professionals from the four Mental Health Trusts in the North West, including Pennine Care with experience of helping people who have experienced trauma. They have been able to give advice about what reactions are normal, whether people would benefit from more targeted support and help people access the services they need.

As well as outreaching to people thought to be most in need, the Hub have invited all people who have been affected to take part in an emotional wellbeing screening programme.

RAID and CORE 24

We have worked for a number of years with local commissioners to develop innovative mental health liaison services. We have a wide range of staff providing mental health expertise to other health and social care colleagues in hospital, intermediate care and community settings.

As part of the Five Year Forward View, mental health liaison is identified as a priority and the Trust is currently working with our neighbouring mental health trust colleagues to develop services further moving towards Core 24 compliant services across Greater Manchester.

The additional investment, which totals £14.2 million over 3 years across Greater Manchester should result in more robust support for all those experiencing mental health difficulties and crises within the general hospital setting and improved patient safety.

For the Trust, this will see an additional £6.4 million investment. Oldham and Stockport as Healthier Together sites will see implementation within 2018-2019 and work is underway on these sites. Tameside and Bury will also see some additional investment from January 2020. There will be additional clinical posts and our current services will be extended and integrated to ensure that support is available for all individuals within the general hospital 24/7.

Greater Manchester Child Crisis Pathway

We have been selected to lead on the implementation of a new Crisis Care Pathway for children and young people across the 10 Greater Manchester localities.

This is an exciting development that will make a real difference to children and young people who are experiencing a mental health-related crisis.

To ensure success, we will work closely with colleagues from the NHS, the private sector and the voluntary, community and social enterprise sector across Greater Manchester.

The ultimate aim is to dramatically improve the overall experience and outcomes for children and young people, along with those who care for and work with them.

The vision is to reduce the number of young people who require specialist mental health support. This will be achieved by improving the early identification of any issues and ensuring that the right help can quickly be offered.

The pathway will be rolled out in a phased approach over the next three years.

Aspen Ward Refurbishment

In March 2017 we commissioned a programme of refurbishment for the two adult wards based at Royal Oldham Hospital, Northside and Southside.

In February 2018, Southside formally reopened. The revamp includes: improved entrance to the wards, provision of single sex areas, upgraded bathrooms, refurbished lounge, dining and family spaces and access to outdoor space.

We have also improved air quality and ventilation to ensure a more comfortable environment for staff, patients and visitors and upgraded our security features in line with CQC guidelines. This will improve patient safety across the ward.

To further reflect the revamp it was also decided to change the ward names. Over a period of months, our therapy teams worked with patients in activity sessions selecting a variety of names. These were narrowed down to six names and the Pennine Care Board chose the names 'Aspen' to replace Southside ward and 'Oak' to replace Northside ward.

Community Services developments

Bury Stroke Team introduces new video conferencing software

The Bury community Stroke Team has introduced innovative video conferencing software to help improve the experience of patients and also save time and money.

OmniJoin, provided by Brother UK, is a secure web conferencing tool which allows video and audio calls to be made online.

Feedback from patients has been positive and the time saved from travelling means four service users can be seen per session, instead of three. The service has also saved money by reducing travel expenses; one staff member saving £10.60 in mileage in one session.

There is also a cost saving for service users, as they can be seen at home instead of travelling to a local health centre.

Staff can also use the software for meetings and conferences, to help reduce the need to travel.

Babyfriendly reaccreditation for baby health visitors

Mums in Bury can be reassured of receiving the very best help and support with their baby, after our health visitors in Bury passed a strict international accreditation process with flying colours.

The team has successfully retained their prestigious Baby Friendly Initiative accreditation – scoring 100 per cent in many areas.

Established by UNICEF and the World Health Organisation, Baby Friendly involves services meeting a very strict set of standards. These are designed to make sure parents receive the very best support and advice around bonding with their baby and their preferred method of feeding. Baby Friendly has particular focus on breastfeeding, as it is beneficial for both mum and baby.

The service first achieved the accreditation in 2015; this re-accreditation process is designed to check that the service is continuing to meet the Baby Friendly high standards.

Nurses keep children out of hospital

Our paediatric nurse practitioners in the Rochdale borough have been working hard to keep children out of hospital and reduce pressure on busy services.

The nurses, part of the Children's Acute and Ongoing Needs Service, offer support for 0 to 19 year olds who have a minor illness. They provide assessment and treatment, or a referral to another appropriate service, when a GP appointment is not available. The team can also give health education to parents to help them look after their children's health in future, where appropriate.

When asked for feedback, 50 percent of parents who came to see the nurses said they would have gone to a local A&E or urgent care service, if this support wasn't available.

Bury nurses help nearly 1,000 children avoid hospital

Children's nurses in Bury have helped to ease pressure on hospital services by providing community care closer to people's homes.

Our children's community nurses in Bury provide care to children and young people who have a long-term condition, complex health needs, or who need palliative care. Between September and December 2017, they cared for 928 children.

The service is for children and young people aged from birth to 16 years (or up to 19 years if they are under the care of a doctor).

Thanks to the nurses, Elizabeth Brooks, 15, from Ramsbottom, avoided a hospital admission and was able to sit her GCSE mock exams.

Elizabeth was initially referred to the nursing team for wound care in June 2017 and the nurses visited her daily for several weeks. In November 2017, Elizabeth had surgery and was again supported by the nurses to recover.

Therapists trial new technique to support children with paralysis

Our children's occupational therapists in the Rochdale borough have introduced a new technique, called Constraint Induced Movement Therapy, to help children with muscle weakness in one arm.

The child is given a mitten to wear on their stronger hand to encourage the use of the weaker arm and hand in everyday tasks such as brushing their teeth, feeding themselves and opening things. The approach is coupled with intensive exercises to further improve the use of the weaker arm.

The therapy is used with children who have experienced a brain injury which affects one side of their body.

This new approach has delivered some impressive results that have made a significant difference to young people.

Text support service helps over 200 Rochdale young people

A text-based health advice service has supported over 200 young people in Heywood, Middleton and Rochdale (HMR).

ChatHealth is a text message service for 11 to 19 year olds, where they can text a concern or question. A school nurse is able to view the message via a secure website and reply confidentially.

The initiative is delivered by our school nurses in the Rochdale borough. Young people can get in touch to book an appointment, or get advice on issues such as bullying, emotional health and wellbeing, sexual health, alcohol and drugs and general illnesses.

Between March 2016 and November 2017, the nurses responded to young people on 277 occasions.

Oldham staff save dad's foot

Podiatrists and nurses from Oldham have been praised for the excellent care they provided to a local dad.

Billy Duckworth, 58, from Bardsley, thanked them for managing his condition at home and saving his foot from amputation.

Billy needs round the clock care after complications with spinal surgery he had 12 years ago left him tetraplegic. This means he is paralysed with limited movement in his hands. He also has type 2 diabetes and frequently experiences muscle spasms which can cause pressure ulcers on his feet.

When Billy started to experience severe complications as a result of the ulcers, it was important that he received urgent specialist care, or risk losing his foot.

Normally this care would be provided in hospital; however the level of day-to-day care and specialist facilities that Billy needs, meant that going into hospital was challenging.

Thanks to our staff, Billy was able to receive this vital care in his own home. This not only saved his foot from amputation; it also enabled him to be more comfortable and helped to reduce pressure on busy hospital services.

Oldham IV therapy service

Our Oldham IV Therapy Service, based at Butler Green Intermediate Care Unit, is helping to keep people out of hospital.

The service provides intravenous (IV) therapy at the community-based unit, or in people's own home, which saves people having to go into hospital.

People can require IV therapy following an illness or injury and there are many examples of how the service has made a real difference to people's lives.

Karen Cannon, 53, from Saddleworth, was required to attend hospital for eight hours a day, twice a week, to receive fluids and medicines through a drip. The team ensured Karen could receive IV therapy safely at home, saving her from having to make constant trips to hospital.

Peter English, 70, from Failsworth, has cancer of the bile duct, which means he frequently develops sepsis. To treat the sepsis, Peter was required to have a several day course of intravenous (IV) antibiotics.

Thanks to the service, Peter was able to pop into Butler Green for his IV therapy; saving him a stay in hospital of up to a week. The flexibility and convenience of this service means that Peter was able to stay at home with his wife and fit treatment around his life and family.

Colourful support for Trafford children

A Trafford speech and language therapist has developed a handy resource to help children in the borough to develop their language and vocabulary.

Andrew Ryder, who works in Trafford Children's Speech and Language Therapy Service, first created his own resources for Colourful Semantics to support training he was delivering in a local school.

Colourful Semantics is a popular, evidence-based intervention using visual prompts to support children with severe language impairments, by helping them to link grammar (syntax) to a word's meaning (semantics).

With the help of his daughter, Andrew created packs of laminated picture cards and worksheets at home using Velcro and colourful symbols which can be arranged to form sentences.

After posting a picture of his work on the service's Facebook page, Andrew was inundated with requests from parents or other professionals who wanted a copy. He has now established an online resource where other parents can download the resources.

Trafford safeguarding nurse shortlisted for national award

A Trafford nurse who specialises in safeguarding children has won a national award for her positive attitude.

Trafford Safeguarding Families Nurse Liz Spencer was crowned winner in the Learner of the Year post-registration category of the 2017 Student Nursing Times Awards.

Liz was nominated for the award by her tutor at Manchester Metropolitan University and impressed the judging panel with her commitment to learning and developing as a nurse.

Future trends and challenges

We recognise that the health and care system in GM will need to change, particularly with the development of Local Care Organisations. We also recognise that Pennine Care does not yet have a long term plan for financial sustainability and that to achieve this may require changes to our current operating model.

To this end, we will work with partners to explore what organisational forms can best deliver system strategies over the next few years; but we are clear that our primary motivator will be doing what is right for our services, for the people who use them and for the people who work within them. We will put this above organisational self-interest and sovereignty.

However, we are also clear that structural change and the movement to any different organisational forms will only be considered if a compelling case can be made that this will deliver better quality and value for money.

Our priorities will be to support changes in clinical practice and the transformation of service models, with a preference that over the next year any structural change is limited to how we develop delegated accountability and governance arrangements; develop shared leadership that can act on behalf of partners, and operate to shared risk and benefit frameworks within the flexibilities of our existing regulatory frameworks

Focus for 2018/19

Pennine Care will continue to be responsible for providing the existing service portfolio during 2018/19, whilst we undertake detailed work with our partners to determine our longer term strategy and operating model. However, this will be reviewed within the context of the following exceptions:

- Where we are unable to negotiate an agreed service offer with our commissioners that delivers core quality standards within the available resource;
- Where we agree arrangements through our partnerships for alternative or shared leadership that offers better quality and value for money;
- We are decommissioned for services.

We will support the quality improvement of our own services to build a solid base for service development and transformation through our partnership work.

We will also provide our expertise and experience in mental health and community services to the development of new service models and in particular, in our leadership to the co-production, development and implementation of agreed integrated neighbourhood teams and out of hospital models of care.

The Trust is open to exploring collaborations with other providers that best enable the delivery of these models of care through joint leadership and shared governance. We will consider, therefore, the potential for new partnership delivery vehicles in the future to better deliver our collective integrated care ambitions. In the meantime we are open to discussions on delegated governance, shared leadership, and shared risk and benefit frameworks.

Where appropriate and with the support of partners, we are willing to use the governance platform of Pennine Care to provide any 'hosting' or 'lead provider' arrangements as required. We will also provide our expertise and experience in working with the third sector to develop capacity and engagement of voluntary and community organisations in new care models, particularly with regard to preventative and recovery approaches.

A key priority will be to work in partnership with other specialist mental health providers to ensure a consistent service offer across Greater Manchester and to collaborate on areas of mutual benefit, for example, use of estates and workforce planning. We are also willing to explore the potential for shared back office and clinical support services across organisations, including using the governance platform of Pennine Care for the provision of these where appropriate and where supported by partners.

Financial performance and information

The key headlines of financial performance for the financial year ending 31 March 2018:

- The Trust is reporting a net deficit of £2.209m. The deficit includes the impact of net impairments (i.e. changes in the valuation of the Trusts fixed assets) which amount to a benefit of £1.976m. Adjusting for this as an exceptional item means that the normalised reported position is a deficit of £4.185m.

The following table summarises the actual financial performance for the period ending 31 March 2018:

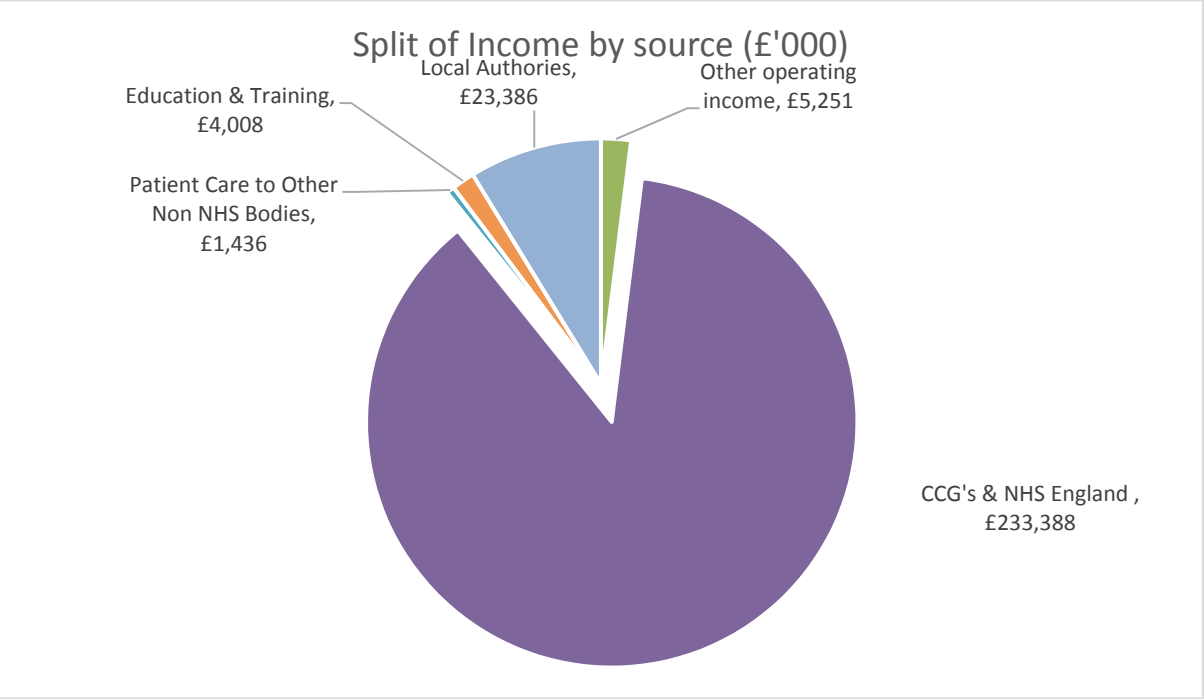
	£ 000's
Income	267,469
Expenditure	(265,170)
Earnings before interest, tax, depreciation and Amortisation, and net impairments	**2,299**
Non-operating costs (including depreciation, dividend and net impairments)	(4,508)
Net surplus / (deficit)	**(2,209)**
Normalising adjustments:-	
Impairment Losses (Reversals) Net	(1,976)
Normalised (deficit) per accounts	**(4,185)**

- The Trust delivered cost improvement savings of £5.0m, this represented 80% of the planned target at the start of the year and 1.9% of Trust operating expenditure
- Capital Investment for the year totalled £7.144m and the Trust had a closing cash balance of £17.417m

The Trusts finance and use of resources rating was a 3. Further details of this can be found in the Single Oversight Framework section page 77.

Income

The following chart shows the split of the Trusts total income by source; the majority of income is received from NHS Commissioners, mainly Clinical Commissioning Groups (CCGs), for the delivery of patient care and from Local Authorities for public health provision.



Total income for the year was £267.5m, (a reduction of £6.1m from the previous year).

Of the total income received 98% (£260.5m) related to clinical income for the provision of patient care. The majority of this income (£233.4m) was received from NHS Commissioners (CCGs & NHS England) for the provision of Mental Health (including specialist services) and physical community health services (including dental) with a further £23.4m received from local authorities for the provision of public health services such as health visiting.

The following tables highlight the income received from key commissioners compared to the previous year.

CCGs and NHS England	2017/18 Income	2016/17 Income
	£'000	£'000
Oldham CCG	52,763	50,267
Bury CCG	41,401	38,365
Heywood, Middleton and Rochdale CCG	35,089	37,859
Stockport CCG	27,968	27,023
Tameside and Glossop CCG	24,202	24,129
Trafford CCG	25,059	23,598
NHS England	21,067	19,930
Other	5,839	8,238
Total	**233,388**	**229,409**

During the year the Trust has secured additional investment across a variety of services in both Mental Health and Community Services; examples are the GM Resilience Hub in Mental Health (£0.7m); Ascot House, an Intermediate Care facility in Trafford (£1.2m); an additional £0.9m mental health transformation and a further £0.4m community resilience funding across Oldham services.

The reduction in income from Heywood, Middleton and Rochdale CCG is mainly as a result of commissioner led procurement exercises tenders with the services transferring to other providers, namely Improving Access to Psychological Therapies Services (£2.0m) and Integrated Neighbourhood Teams (£1.2m).

Local Authority	2017/18 Income	2016/17 Income
	£'000	£'000
Bury Metropolitan Borough Council	6,174	6,120
Rochdale Metropolitan Borough Council	7,076	7,663
Stockport Metropolitan Borough Council	3,019	3,141
Trafford Metropolitan Borough Council	5,820	5,822
Other Local Authorities	1,297	1,999
Total	**23,386**	**24,745**

The reduction in 2017/18 income with Rochdale Metropolitan Council is due to funding reductions in the Family Nurse Partnership (£0.3m) and CAMHS (£0.2) services.

In addition, the Trust received £7.0m (2%) for the delivery of non-patient care services, such as education and training support, research and development income and the provision of non-clinical services to other NHS bodies. In the previous year 2016/17 this was equal to £12.6m (5%). The reduction in 2017/18 is due to two main factors:

- In 2016/17 the Trust secured £3.2m from the Sustainability and Transformation Fund for achievement of a £5.18m surplus which was in excess of the control total set by NHS Improvement. In 2017/18 this was reduced to £0.5m as the Trust did not achieve the control total
- Although the Trust is continuing to pursue recovery of an overpayment of c.£1m in respect of VAT against the initial build of Prospect Place (a 45 bed

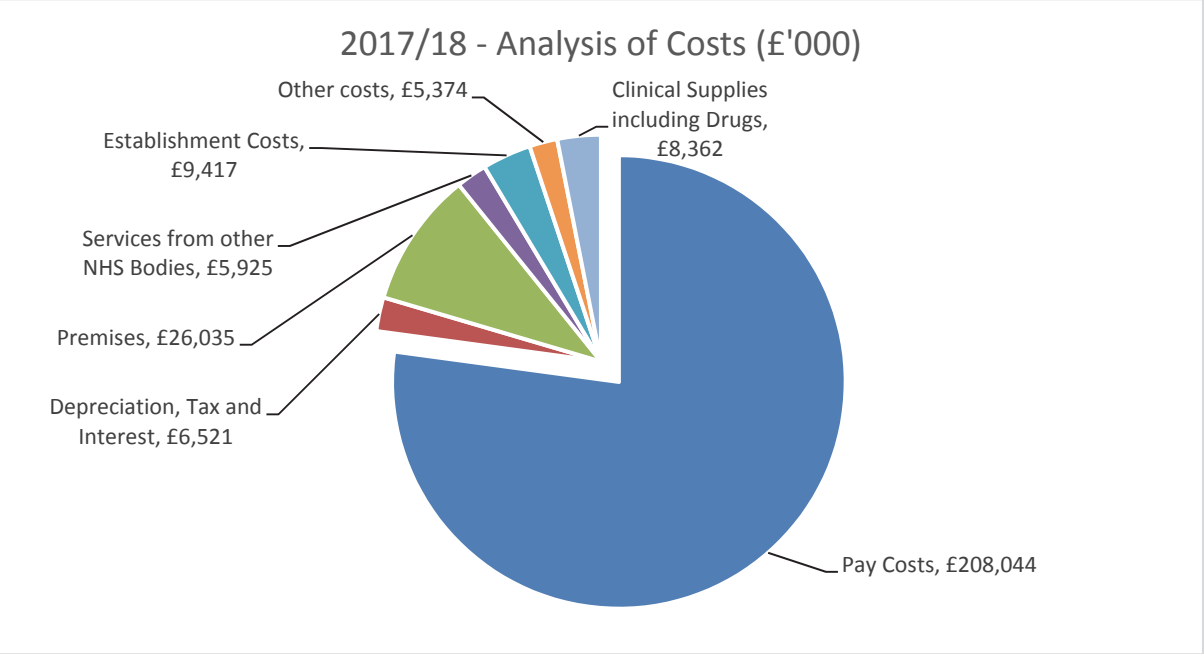
low secure unit) discussions have not yet concluded and therefore to be prudent, receipt of this funding has not been reflected in the 2017/18 accounts.

The Trust can confirm, in accordance with Section 43(2A) of the NHS Act 2006, that its income from the provision of goods and services for the purposes of the health service in England was greater than its income from the provision of goods and services for any other purposes. The work required to generate the non- health care income has had no adverse impact on the provision of goods and services for the purposes of the health care.

Expenditure

Despite the reduction in income, total expenditure for the year was £269.7m an increase of £1.26m (0.5%) against the previous year. The increase in costs, over and above the income received, is primarily due to the Trust being unable to safely withdraw efficiency savings from Mental Health Services without alternative service provision being in place, the additional investment into Mental Health (primarily inpatient services) required in light of the CQC findings. The Trust continues to work closely with all stakeholders to transform services in a safe and sustainable manner.

The chart below sets out the major components of cost the Trust has incurred throughout the year:



The average number of staff employed by Pennine Care during 2017/18 was 5,246 whole time equivalent (WTE) (5,414 WTE staff in 2016/17) and expenditure on pay costs, was the largest item of expenditure totalling £208.0 million (77%) of all costs, this compares to £209.1m, (79%) in 2016/17.

The largest element of non-pay expenditure is the cost of premises (£26.0m). This reflects the diversity of the services provided across a wide geographical footprint with a range of services being provided across 128 sites.

A further £9.4m has been spent on establishment expenses, which includes costs such as transport and travel, clinical negligence and legal fees, with £8.3m being spend on clinical supplies including drugs.

Cost Improvement Plans

In line with the national guidance the Trust received an inflationary tariff uplift of 0.1% (£0.2m) in 2017/18 against NHS services commissioned by NHS Commissioners. This was made up of a 3.1% increase for cost inflation offset by the requirement to deliver 2.0% efficiency savings.

The Trust set a cost improvement target of £6.2m within its 2017/18 plan. Although the target set was insufficient to cover all known cost increases, the board of directors considered this to be the maximum level of savings that could be safely withdrawn from services without adversely impacting on quality and capacity.

Quality impact assessments ensured that the plans identified did not compromise patient care and quality whilst the delivery of the programme was overseen by the Trust's Quarterly Performance and Quality Assurance Meetings with regular reporting to the Board of Directors via the Finance Strategy Committee.

As a result of the dedication and hard work by staff, 80% (£5.0m) of the 2017/18 CIP was delivered.

Capital and Cash

During the year the Trust has completed £7.1m of capital investments; this has been in line with the capital strategy approved by the Board of Directors.

A summary of the capital investments undertaken in the year is presented in the table below:

Scheme	£'000
IM&T (including mobile working)	2,545
Estates - life cycle investment	562
Equipment	153
Estates Scheme Minor improvements/ Resilience	1,161
Oldham Ward Refurbishment (Parklands)	1,644
Place of Safety (S136 Refurbishment)	763
Service re-configuration (Stockport Community and Tameside EIT Teams)	316
Subtotal	**7,144**

The planned capital expenditure for 2017/18 was £8.367m compared to the actual capital spend of £7.144m. Slippage is a result of delays in implementing schemes of the capital expenditure, which is now included in the capital programme for 2018/19

During 2017/18 the Trust was fortunate enough to receive a capital allocation of £1.662m from the Department of Health to support digital transformation. The funding has enabled the Trust to progress at pace with the roll out of mobile working and development of an electronic patient record.

The liquidity of the trust is a measure of the immediately available cash (plus easily converted assets). This is used to determine how long we can continue to pay what we owe as it becomes due.

Despite the Trusts overall deficit position there has been an increase in the cash balance of £3.6m during the year, giving closing cash balance of £17.4m. The average daily cash balance during 2017/18 was £20.9m and the closing cash balance of £17.4m which represents approximately 24 days of planned operating expenditure.

The increase was due to additional cash of £1.9m received from NHSI/ DOH in July 2017 as sustainability and transformation funding for the over achievement against the 2016/17 control total as well as being due to timing differences between income being received and the costs incurred for the provision of services provided as well as changes in the timing and source of funds for the capital programme as outlined earlier.

Better payment practice code

The Trust continues to monitor its performance against the Better Payment Practice Code that requires payment of all trade creditor invoices with 30 days of receipt and a valid invoice (unless other terms have been specifically agreed with the supplier). The target set is 95% for both value and volume of invoices. The results for the year were 95.48% by value and 95.86% by volume which is a slight reduction on 2016/17 (96.70% by value, 97.38% volume).

Finance and Use of Resources

The assessment of the Trust's financial performance by NHS Improvement, the Independent Regulator of Foundation Trusts' is based on a Single Oversight Framework (SOF). Within this there are five key financial performance measure known as the Use of Resources Ratings. The measures have been applicable to the Trust during 2017/18. The financial risk is rated from 1 to 4, where 4 equals the highest risk, and where 1 is considered the lowest risk with no regulatory concerns. The overall score is determined by a simple average, with the result rounded up.

The measures are designed to thoroughly assess the Trusts financial robustness and efficiency :

- **Capital Service Capacity** - the degree to which the organisation's generated income covers its financing obligation.
- **Liquidity** - days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown
- **Income and Expenditure (I&E) margin** - the degree to which the organisation is operating at a surplus/deficit.
- **I&E margin:** distance from financial plan - variance between a foundation trusts planned I&E margin in its annual forward plan and its actual I&E margin within the year.
- **Agency Spend** - measures the agency spend for the Trust against the NHSI target value, of £8.22m in 2017/18.

The table below details the financial performance by the Trust against the plan submitted to NHSI in December 2016. The Trust submitted a revised plan to NHSI in March 2017 which reflected the financial challenges faced by the Trust.

The actual performance in 2017/18 was broadly in line with the revised plan. The overall UoR score for the Trust for the financial year 2017-18 is a score of 3.

Use of Resource Metric	Plan	Actual
Capital Service Capacity	2	4
Liquidity	2	2
I&E Margin Rating	1	4
I&E margin: distance from financial plan	1	4
Agency Spend	3	2
Overall Score	2	**3**

The improvement against the agency metric is due to focused efforts in 2017/18 to reduce agency usage, spend in 2016/17 was £12.4m, this reduced to £9.1m in 2017/18.

Social responsibility

The Trust is committed to its responsibility as a large public sector organisation to make a wider contribution to our local communities. The Trust's Corporate Social Responsibility Strategy 2013 – 2018 set out clear objectives under six key areas:

- **Travel**
  To promote a range of travel policies that reduce the amount of money we spend on travel and to increase the range of 'green' transport schemes for our staff to access
- **Procurement**
  To promote a corporately responsible approach to procurement which considers, where feasible, supporting local businesses
- **Facilities management**
  To promote an approach to managing our services and facilities which drives greater efficiency and sustainability
- **Buildings**
  To promote an approach to new and existing buildings which reduces our carbon footprint and maximises green approaches
- **Workforce**
  To become an employer of choice and a great place to work. To promote health and wellbeing to the people who work for us, along with their families. To support people in our communities to get work ready through work experience opportunities and apprenticeships
- **Community engagement**
  To work in partnership with our local communities to support resilience activities which promote self-care, self-management and enable people to live well.

An update on our progress against all the above key areas can be found on the Trust website: https://www.penninecare.nhs.uk/about-us/social-responsibility/.

Giving Back Month

We entered the final year of delivering the strategy during 2017/2018, with the final close ending on a notable high with the 'Giving Back month' in December 2017. This month long campaign focused on supporting the homeless and vulnerable during a time of year which is particularly difficult for many. This was the largest ever giving back campaign we've had, with a fantastic response from staff who generously donated food and gifts, raised money and pulled together collection boxes for the less fortunate at Christmas.

The campaign was widely promoted and the social responsibility strategy group representatives actively promoted the campaign in their localities and generated an enormous response from staff, which helped ensure that people in our localities received the essentials they desperately needed. A summary of the donations provided can be seen below.

The objectives from the strategy are now embedded in business as usual but we will continue to closely monitor our contribution to our localities to ensure we continue our positive work.

Sustainability

Pennine Care remains committed to providing services in a way that is sustainable and supports our corporate and social responsibilities.

There is a clear need for the NHS to take a lead in energy reduction to reduce the impact that healthcare activities have on the environment, to improve health, to improve sustainability and to reduce our expenditure on energy. The NHS aims to reduce its carbon footprint by 10% by reducing the amount of energy used in our organisation and close monitoring of meter readings to inform future saving measures. To date we have installed Smart gas meters in Trust properties and are currently in an installation programme for installing Smart electric meters in Trust properties. This provides live metering data for monitoring and targeting energy purposes. We have also instructed our energy partner to provide quarterly energy consumption reports for submission to the Environmental Management Group.

We have established, identified and implemented a backlog programme of replacing uneconomical heating, ventilation and air conditioning systems in premises to improve efficiency. This includes controlling air conditioning to prevent over cooling and the increasing energy consumption resulting.

Sustainability has become increasingly important as the impact of peoples lifestyles and business choices are changing the world in which we live.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. It is considered in regards to travel, procurement (environmental), procurement (social impact) and suppliers' impact.

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The Board of Directors approved our SDMP so our plans for a sustainable future are well known within the organisation and clearly laid out.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) tool. This has been recently recognised externally and to which we have received special recognition.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our board approved plans to address the potential need to adapt the of services and infrastructure to ensure the effects of climate change and adverse weather events do not adversely affect our business.

Performance

Since the 2007 baseline year, the NHS has undergone and continues to undergo a significant restructuring process and one which is still ongoing. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time:

Context info	2012/13	2013/14	2014/15	2015/16	2016/17
Floor Space (m2)	69886	78677	79682	81704	79463
Number of Staff	5157	5952	5847	5730	5527

Energy

Pennine Care has spent £ 1,763,936 on energy in 2017/18, which is a 5% increase on energy spending from last year. This is reflective of increased commercial supply levies and green taxes imposed by the energy regulator.

Our publicly procured framework energy provider, supplies us with a percentage of electricity, generated from renewable fuel sources currently circa 18 % (biomass, wind hydro and solar power power). The current framework agreements are due to expire in 2019/20. The Trust is currently reviewing the benefits of renewed publicly tendered and procured dual fuel supply contract.

The government has recently removed the benefits to the climate change levy which would have offset some of the cost of procuring 'green' electricity however we are actively monitoring this situation and are ready to move to 'green' electricity supplies when appropriate. Also, we are currently undertaking feasibility assessments for the installation of Solar Photovoltaic Systems at suitable premises.

Resource		2013/14	2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	13,610,275	13,290,788	12,874,786	12,856,250	12,152,090
	tCO_2e	2887.284	3031.648	2381.487	2378.059	2247.808
Oil	Use (kWh)	133000	166700	166400	204346	266587
	tCO_2e	42.4735	44.9250	44.8446	55.0710	72.5444
Coal	Use (kWh)	0	0		0	0
	tCO_2e	0	0		0	0
Electricity	Use (kWh)	7,801,300	7,657,320	7,417,645	6,883,365	6,537,183
	tCO_2e	4368.026	3784.707	3666.245	3402.171	3231.068
Total Energy tCO_2e		7297.783	6288.069	6496.178	5835.301	5551.420

Waste breakdown

Waste		2013/14	2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	325	309	336	*387*	*342*
	tCO_2e	6.825	6.489	7.056	*8.127*	*7.182*
Re-use	(tonnes)	44	78	143	*157*	*0*
	tCO_2e	0.924	1.638	3.003	*3.297*	*0*
Compost	(tonnes)	0	0	0	0	*2.31*
	tCO_2e	0	0	0	0	*TBC*
WEEE	(tonnes)	5	5.4	6	*6.5*	*6.5*
	tCO_2e	0.105	0.113	0.126	*0.1365*	*0.1365*
High Temp recovery	(tonnes)	120	22.78	41.14	*13.3*	*45.26*
	tCO_2e	2.52	0.478	0.863	*0.2793*	*0.9508*
High Temp disposal	(tonnes)	0	0	0	*0*	*0*
	tCO_2e	0	0	0	*0*	*0*
Non-burn disposal	(tonnes)	0	0	0	*42.11*	*41.30*
	tCO_2e	0	0	0	*0.8843*	*0.8676*
Landfill	(tonnes)	45	40.6	23.8	*17*	*2.25*
	tCO_2e	10.9988	9.9234	5.8171	*0.357*	*0.550*
Total Waste (tonnes)		539	456	549.94	*618*	*439.62*
% Recycled or Re-used		91.65	91.09	95.67	*97.25*	*TBC*
Total Waste tCO_2e		21.3728	18.6421	16.8651	*13.0811*	*9.6869*

We continue to improve the management of waste in all parts of the Trust, including providing suitable guidance and online training to assist staff in reducing the environmental impact of waste through beneficial use, where practicable. We continue to ensure and audit our disposal processes from 'cradle to grave'.

Water breakdown

Water		2013/14	2014/15	2015/16	2016/17	2017/18
Mains	m^3	67500	68660	66510	57920	58795
	tCO_2e	61	63	61	53	55
Water & Sewage Spend		£295,270	£321,885	£265,073	£309,032	340,250

With the changes to the retail water and wastewater market that came in to effect on 1 April 2017, businesses and organisations in England are now able to choose which company they want to supply their water services. The Trust is currently reviewing possible costs saving associated with changing supplier.

Carbon footprint

The information provided in the previous sections of this sustainability report uses the Environmental and Regulation Information Centre (ERIC) returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the information shown in the table below uses a scaled

model based on work performed by the NHS Sustainable Development Unit (SDU).

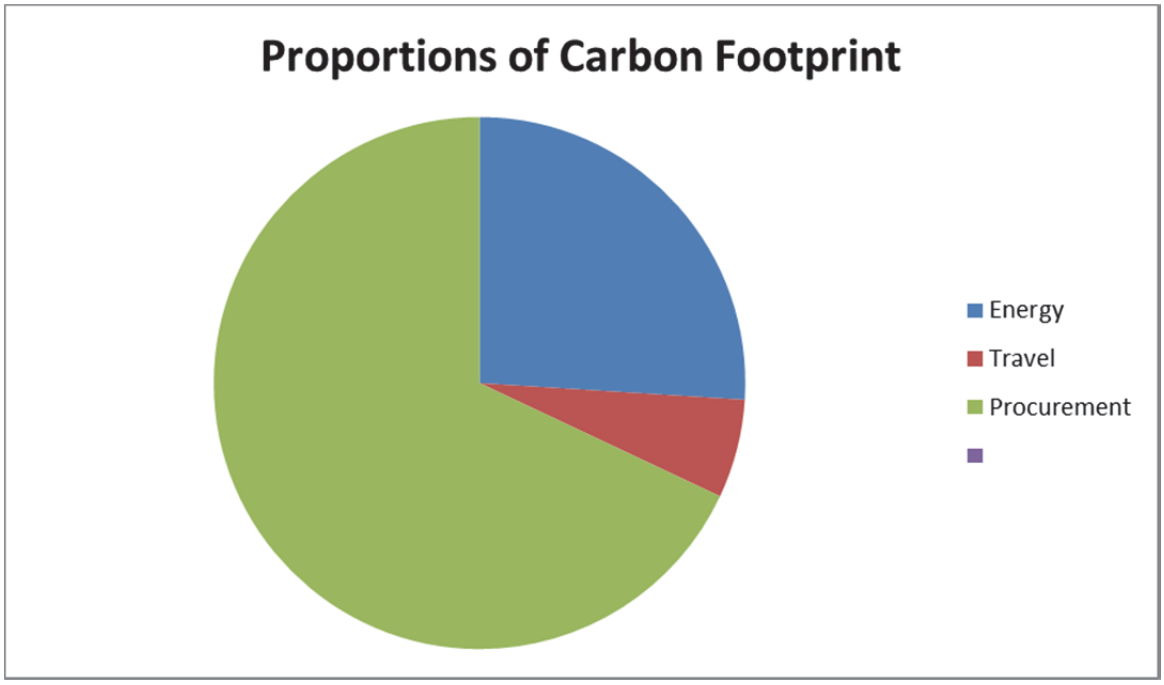
The Trust has introduced environmentally friendly schemes such as cycling to work, lift share and reduced CO^2 car lease arrangements with financial incentives to encourage staff to be more sustainable.

As noted in the table above; year on year the Trust continues to reduce the square metre size area (downsizing) of its property and facilities estate to be more streamlined, manageable and efficient.

Pennine Care Trust's exact annual carbon emission performance will be confirmed in annual estates information return (ERIC) when full information becomes available.

In the meantime we strive to identify and take full advantage of all opportunities to reduce our carbon impact to the environment. This covers the full range of our activities including routine minor improvement projects such as installation of LED and other low energy lighting and improved automated controls on heating and cooling systems wherever possible. In addition we are improving the building fabric of properties and increased insulation levels to revised British Standards to reduce energy usage and utility costs.

We remain vigilant of emerging technology which may offer an opportunity for the trust to improve the impact of its carbon footprint.



Accountability Report

The purpose of this section of the Annual Report is to meet key accountability requirements to Parliament, and includes the following sections:

- Directors Report
- Remuneration Report
- Staff Report
- Disclosures set out in the NHS Foundation Trust Code of Governance
- NHS Improvement's Single Oversight Framework
- Statement of Accounting Officer responsibilities
- Annual Governance Statement

Claire Molloy
Chief Executive
25 May 2018

Director's Report

The Board of Directors is responsible for preparing the annual report and accounts and considers that, taken as a whole, they are fair, balanced and understandable. Furthermore the Board considers that the annual report and accounts provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

In accordance with the General Companies Act (s416) the Trust is required to disclose the membership of its Board and its principal activities.

As an NHS Foundation Trust, the principal purpose of the organisation, in accordance with its constitution, is the provision of goods and services for the purposes of the health service in England. The Trust's principal activities are detailed in the performance report overview from page 7.

The constitution requires that the Board of Directors comprises a Non-Executive Chairman, not less than five other Non-Executive Directors and not less than five Executive Directors.

As at 31 March 2018, membership of the Board of Directors was as follows:

Evelyn Asante-Mensah ..... Chair
Joan Beresford ..... Non-Executive Director / Deputy Chair
Lord Keith Bradley ..... Non-Executive Director
Michael Livingstone ..... Non-Executive Director
Daniel Benjamin ..... Non-Executive Director
Dr Julia Sutton-McGough .. Non-Executive Director
John Scampion ..... Non-Executive Director
Claire Molloy ..... Chief Executive
Martin Roe ..... Executive Director of Finance / Deputy Chief Executive
Dr Henry Ticehurst ..... Medical Director
Jackie Stewart ..... Executive Director of Nursing and Health Care Professionals (Interim)
Keith Walker ..... Executive Director of Operations
Judith Crosby ..... Executive Director of Service Development and Sustainability

The Board of Directors

Overall responsibility for the implementation of strategy, policy and the performance of the Trust lies with the Board of Directors. The Board has an extensive range of skills including finance, business planning and operational management, as well as medical and nursing expertise.

The Directors confirm that, as far as they are aware, there is no relevant audit information of which the auditors are unaware. The Directors also confirm that they have taken all of the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The Board of Directors holds its formal meetings in public on a monthly basis, chaired by the Chair, Evelyn-Asante Mensah.

There have been several changes to the Board of Directors during 2017/18. Following the resignation of the former Chief Executive in February 2017, a number of interim leadership arrangements were introduced pending the appointment of a new Chief Executive. A robust and independent process to recruit a new Chief Executive commenced in January 2017, led by GatenbySanderson. In May 2017, the Board Appointment and Remuneration Committee approved the appointment of Claire Molloy as Chief Executive, subject to approval by the Council of Governors. The Council of Governors approved Ms Molloy's appointment on 16 May 2017. The recruitment process is outlined in more detail on page 46, where the work of the Appointment and Remuneration Committee is reported.

Ms Molloy commenced in post as Chief Executive on 11 September 2017. Upon commencement of the new Chief Executive, Martin Roe resumed his substantive role of Executive Director of Finance / Deputy Chief Executive; Henry Ticehurst relinquished Acting Chief Executive responsibilities; and Emma Tilston relinquished her Executive Board role.

On 27 September 2017, Ian Trodden (Executive Director of Nursing and Healthcare Professionals) left the Trust. Jackie Stewart was appointed as the Interim Executive Director of Nursing and Healthcare Professionals.

John Schofield concluded his term of office as Chair on 31 October 2017. In May 2017, the Council of Governors approved the process to recruit a new Chair. To ensure an open and objective recruitment process the Council appointed the NHS Leadership Academy as an external advisor. On 29 September 2017, the Council of Governors appointed Evelyn Asante-Mensah as Chair with effect from 1 November 2017 for a period of three years. The recruitment process is outlined in more detail on page 82 where the work of the Council of Governors is reported.

With regards to other Non-Executive Directors, Tony Berry and Paula Ormandy concluded their terms of office as Non-Executive Directors on 31 May 2017 and 31 August 2017 respectively. Ian Bevan (Non-Executive Director) left the on Trust 16 November 2017. The Council of Governors appointed Dr Julia-Sutton McGough and Daniel Benjamin as Non-Executives from 1 September 2017 and 4 September 2017 respectively for terms of three years.

Meetings of the Board of Directors

Meetings of the Board of Directors are held in public on a monthly basis and the papers for each meeting are published on the Trust website. Additionally, the Governors are provided with a copy of the agenda prior to any meeting of the Board and a copy of the minutes once approved at the following meeting.

The Board of Directors met 13 times during the period 1 April 2017 to 31 March 2018. Three meetings were held in private session (26 July 2017, 27 September 2017, and 29 November 2017); and there was one extraordinary meeting of the Board (in private) held on 13 December 2017. The table below shows the attendance of the individual directors:

Member	Attendance (Actual / Eligible)
Judith Crosby	13/13
Lord Keith Bradley	13/13
Martin Roe	12/13
Dr Henry Ticehurst	12/13
Michael Livingstone	12/13
Joan Beresford	11/13
Professor Sandra Jowett	11/13
Keith Walker	9/13
Jackie Stewart	8/8
Dr Julia Sutton-McGough	8/8
Claire Molloy	7/8
Daniel Benjamin	7/8
John Schofield	7/7
Ian Bevan	7/7
Ian Trodden	6/6
Evelyn Asante-Mensah	5/6
Emma Tilston	5/5
Professor Paula Ormandy	4/5
Antony Berry	1/2
John Scampion	1/2

All our Non-Executive Directors are considered to be independent as they have not been employed by the Trust and do not have any financial or other business interest in the organisation. None have close family ties with Pennine Care NHS Foundation Trust's advisers, directors or senior employees. The Trust maintains a Register of Interests for all directors, which may be made available for viewing by contacting the chief executive's office.

The NHS Foundation Trust Code of Governance states that reappointing a non-executive director for a term beyond six years (eg: two three-year terms following authorisation as a foundation trust) should be subject to particularly rigorous review, since it could be relevant to the determination of a non-executive's independence; however non-executive directors may in exceptional circumstances serve longer than six years (eg: two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. None of the current non-executive directors have served terms of office greater than six years.

Assessing the Board's Performance

In line with the Foundation Trust Code of Governance, the Executive Directors undergo annual individual performance evaluations led by the Chief Executive and including the Chairman. Non-executive directors are appraised annually by the Chairman of the Trust following a process agreed with the Council of Governors, who have the power to reappoint or remove them from post, as laid down in the Trust's constitution.

During 2017, work concluded with Clareo Potential to review the collective and individual performance of the Board as a team. In November 2017, the Board commissioned Deloitte LLP to conduct an independent review of the Trust's governance arrangements against NHSI's Well-led Framework. The final report

was issued in February 2018 with the associated action plan to address the recommendations arising from the review approved by Board in March 2018. Further information regarding the Well-led review can be found in the Annual Governance Statement on page 93.

Working with the Council of Governors

The Board of Directors and Council of Governors work closely together. The Board of Directors is responsible for running the Trust's services and developing strategies and plans for the future. It is also accountable for the organisation's compliance with national standards, performance targets and financial requirements. The Council of Governors has a statutory responsibility to hold the non-executive directors of the Board individually and collectively to account for the performance of the Board of Directors and details on how this is undertaken are reported in the Council of Governors section of this report (page 82).

The Chair of the Trust chairs the meetings of both the Board of Directors and the Council of Governors. A report on all items discussed and approved by the Council of Governors forms a standing agenda item at each meeting of the Board of Directors and the Chief Executive is invited to attend each meeting of the Council of Governors to deliver an organisational update. Governors are also invited to participate in the schedule of service visits undertaken by the Non-Executive Directors. During 2017/18 arrangements have been in place for Governor representatives to observe monthly meetings of the Board of Directors and each meeting of the Audit Committee, Finance Strategy Committee, and the Performance and Quality Assurance Committee. These arrangements are currently under review in light of the revised Board governance architecture described on page 93.

Non-Executive Directors' Terms of Office

The Trust was granted Foundation Trust status with effect from 1 July 2008. At the inaugural meeting of the Council of Governors on 2 July 2008, the existing Chairman and non-executive directors were appointed for the unexpired period of their respective Terms of Office with the predecessor NHS Trust.

Name	Appointment Start Date	Appointment Expiry Date
John Schofield	2 July 2008 (reappointed 1 November 2011 and 1 November 2014)	31 October 2017
Antony Berry	1 April 2011 (reappointed 1 April 2014 and 1 April 2017)	31 May 2017
Paula Ormandy	1 August 2014	31 July 2017
Joan Beresford	1 November 2014 (reappointed 1 November 2017)	31 October 2020
Sandra Jowett	1 December 2014 (reappointed 1 December 2017)	30 November 2020
Keith Bradley	1 September 2015	31 August 2018
Michael Livingstone	21 September 2015	31 August 2018
Ian Bevan	1 October 2016	16 November 2017*

Julia Sutton-McGough	1 September 2017	31 August 2020
Daniel Benjamin	4 September 2017	4 September 2020
John Scampion	19 February 2018	18 February 2021

* Mr Bevan left the Trust part way through his term of office

Formal Sub-Committees of the Board

The Trust's governance arrangements were previously underpinned by a quarterly integrated Performance and Quality Assurance Committee structure, established to support the strategic focus of the Board of Directors by providing high level scrutiny of integrated divisional and corporate data, including performance relating to quality, finance, workforce, activity and compliance. Additionally, a Finance Strategy Committee met on a quarterly basis to discuss, review and advise on financial matters not discussed in detail by the Board, focussing on financial reporting and strategic financial issues.

In November 2017, against the context of the challenging environment the Trust finds itself operating in, the Board recognised a need to review the governance processes to increase its focus on both quality and finance.

In December 2017, the Board approved proposals to dissolve the aforementioned committees and establish three new Board sub-committees. As at 31 March 2018, the Board committee structure comprises of six formal sub-committees of the Board of Directors, as follows:

- Audit Committee
- Appointment and Remuneration Committee
- Quality Committee
- Performance and Finance Committee
- People and Workforce Committee
- Charitable Funds Committee

Following each meeting, the Chair of the Committee submits a report to the Board of Directors. The work of the sub-committees is described below.

Audit Committee

Chaired by a non-executive director, this group is responsible for:

- reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that support the achievement of the Trust's objectives.
- ensuring the establishment of an effective internal audit function in line with mandatory NHS Internal Audit Standards, which provides appropriate independent assurance to the Audit Committee, chief executive and the Board.
- reviewing the work, findings and implications of and responses to the work of the External Auditor, as appointed by the Council of Governors.
- testing assurance processes and reviewing the findings of other significant internal and external assurance functions and their implications for the governance of the Trust.

It is also important that the independence of our external auditors in reporting to the Council of Governors, non-executive directors and the Trust does not appear to be compromised but equally the Trust should not be deprived of expertise where it is needed and can be obtained from Grant Thornton as a whole. To this end a policy has been developed that seeks to set out what threats theoretically exist and thus provide a definition of non-audit work that can be shared by the Trust and the external auditors. It then seeks to establish the approval process and corporate reporting mechanisms to be put in place for any non-audit work that the external auditors are asked to perform. The policy was approved at the November 2008 Audit Committee.

Audit Committee membership as at 31 March 2018:

- John Scampion – Chair
- Professor Sandra Jowett
- Lord Keith Bradley
- Daniel Benjamin

There have been four meetings of the Audit Committee during the period 1 April 2017 to 31 March 2018 and the table below shows each member's attendance:

Member	Attendance (Actual / Eligible)
Michael Livingstone	4/4
Professor Sandra Jowett	3/4
Lord Keith Bradley	2/4
Joan Beresford	3/3
Daniel Benjamin	3/3
Ian Bevan	2/2
Dr Julia Sutton-McGough	2/2
Antony Berry	1/1
John Scampion	1/1
Professor Paula Ormandy	0/1

Appointment and Remuneration Committee

Chaired by the Chairman, and with a membership comprising all non-executive directors, this committee is responsible for reviewing the size, structure and composition of the Board and making recommendations with regard to any changes. It also decides and reviews the terms and conditions of office of the Trust's executive directors in accordance with the requirements of the NHS Act 2006, the Trust constitution and all relevant Trust policies.

It is for the non-executive directors to appoint the executive directors and, in January 2017, the Appointment and Remuneration Committee approved the establishment of a task and finish group to progress the arrangements for recruiting a new chief executive following the resignation of the previous postholder, Michael McCourt . This group comprised the Chair, the Deputy Chair, the Senior Independent Director, the Trust Secretary, the Director of Workforce and the Workforce and OD Governance Manager, the Lead Governor and Deputy Lead Governor.

To ensure independence and objectivity in the recruitment process, a series of interviews were conducted with external recruitment agencies; the outcome of

which was the appointment of GatenbySanderson to manage the process from an external perspective. Subject to the necessary confidentiality, the Governors were kept appraised of progress throughout and a number of them were involved in the assessment and interview panels in May 2017, through which the final selection was made. The Appointment and Remuneration Committee met on 11 May 2017 to formally approve the recommended appointment of Claire Molloy as the new chief executive, and this was in turn approved by the Council of Governors on 16 May 2017.

Following the resignation of Ian Trodden as Executive Director of Nursing and Healthcare Professionals as of 27 September 2017, the Committee resolved to implement an interim arrangement for the role in light of the fact that the new chief executive would want time to review the current ED portfolios. Following a recruitment and interview process, the Committee appointed Jackie Stewart into the post of Interim Executive Director of Nursing and Healthcare Professionals from 28 September 2017.

The process for recruiting substantively into this position commenced in January 2018 and following a thorough assessment process which included a presentation to a range of stakeholders including multi-disciplinary staff, service user and carer representatives, governors and commissioners and a formal interview by a panel comprising the Chief Executive, Non-Executive Directors and an independent, external assessor, the Committee approved a recommendation from the interview panel to appoint Clare Parker into the post of Executive Director of Nursing, Healthcare Professionals and Quality Governance. Claire will take up the position from May 2018.

There have been seven meetings of the Appointment and Remuneration Committee during the period 1 April 2017 to 31 March 2018 and the table below shows each member's attendance:

Member	**Attendance (Actual / Eligible)**
Professor Sandra Jowett	7/7
Joan Beresford	6/7
Michael Livingstone	6/7
Lord Keith Bradley	5/7
Ian Bevan	4/4
Professor Paula Ormandy	4/4
John Schofield	3/4
Evelyn Asante-Mensah	3/3
Daniel Benjamin	2/3
Dr Julia Sutton-McGough	2/3
Antony Berry	2/2
John Scampion	0/2

Quality Committee

Chaired by a non-executive director, the Quality Committee seeks assurance that effective and appropriate systems are in place to drive quality improvements; and seeks assurance the Trust is delivering high quality care. The Committee's terms of reference were approved by the Board of Directors in February 2018; and it meets on a monthly basis.

Performance and Finance Committee

Chaired by a non-executive director, the Performance and Finance Committee oversees the performance of the Trust, and seeks assurance, in respect of Finance, Investment and Performance. The Committee's terms of reference were approved by the Board of Directors in February 2018; and it meets on a monthly basis.

People and Workforce Committee

Chaired by a non-executive director, the People and Workforce Committee seeks assurance in relation to the development of the People and Workforce Strategy, and its implementation and effectiveness. The Committee's terms of reference were approved by the Board of Directors in February 2018; and it meets on a bi-monthly basis.

Charitable Funds Committee

The Charitable Funds Committee is constituted by the Board of Directors, as corporate trustee, to manage the affairs of the Trust's charitable fund on its behalf and ensure statutory compliance with the Charity Commission regulations. The Committee meets on a quarterly basis.

Board Directors' Profiles

EVELYN ASANTE-MENSAH OBE commenced in post as Chair of the Trust in November 2017, bringing an impressive track record with her, having held senior positions in a variety of health and voluntary organisations over the last 25 years. Among her notable roles, Evelyn was chair of Central Manchester Primary Care Trust and then NHS Manchester over a 12 year period, also holding a board-level role at Manchester Mental Health and Social Care Trust. She is currently chair of the Arawak Walton Housing Association, which provides homes to people in Stockport and Trafford and is a board governor at Manchester Metropolitan University.

Evelyn was awarded an OBE in 2006 for services to ethnic minorities in the field of health. Her particular areas of interest are in tackling inequalities in health and social care and promoting equality and diversity.

JOAN BERESFORD was appointed as a Non-Executive Director in November 2014. Joan took early retirement from Stockport Metropolitan Borough Council where, for the last 18 months of her service, she was Head of Integrated Commissioning based in Adult Social Care working closely with health commissioners and providers. She has 41 years' service in local government having worked for Manchester City Council for 22 years prior to joining Stockport. During this time she has undertaken a range of roles including administration, management, project management and eight years as a qualified Social Worker. Joan was appointed Deputy Chair from 1 January 2017.

PROFESSOR SANDRA JOWETT was appointed as a Non-Executive Director in December 2014. Sandra has worked with the NHS for much of her career, through her research and strategic leadership roles in a range of public and private sector organisations. She has worked in four universities and was, until December 2015, Deputy Vice-Chancellor at the University of Cumbria. Prior to this she was a director of the UK arm of a global research company,

responsible for its public policy research. For 15 years she led research teams at the National Foundation for Educational Research, undertaking largely government-commissioned work to inform service development and national policy in health and education. Sandra is committed to the delivery of high quality, innovative services and to working with colleagues in the Trust as they continue to improve the health and well-being of the communities we serve. Sandra was appointed Senior Independent Director from 1 January 2017.

LORD KEITH BRADLEY was appointed as a Non-Executive Director in September 2015. Keith was Associate Vice President of the University of Manchester until 2013 and is now Honorary Special Advisor to the University.

Formerly Member of Parliament for Manchester Withington 1987-2005, he was Parliamentary Under Secretary of State for Social Security, Deputy Chief Whip (Treasurer of the Queens Household), Minister of State at the Home Office and a member of the Health Select Committee.

Keith was appointed to the Privy Counsel in 2001 and ennobled in 2006. He is a member of the Government's Advisory Board on female offenders and a Trustee of the Centre for Mental Health and the Prison Reform Trust. Keith also serves as Chair of Salford University.

MICHAEL LIVINGSTONE was appointed as a Non-Executive Director in September 2015. Up until the end of 2014 Mike was the Strategic Director of Children's Services at Manchester City Council. He has nearly 30 years' experience in local government having qualified as a social worker in 1985 and been a senior manager for over 15 years.

Mike also spent five years with the national inspectorates as a lead inspector with the Social Services Inspectorate in the Department of Health and with Ofsted, working closely with other inspectorates including the CQC.

Whilst a member of the senior management team in Manchester, Mike worked with the GM Combined Authority on public service reform including the arrangements for greater integration of health and social care and greater devolution to the region.

DANIEL BENJAMIN was appointed as a Non-Executive Director in September 2017. Daniel has over 30 years' of commercial experience, including working for IBM (in the IT industry) for 25 years in a variety of commercial and advisory roles. In his early years Daniel worked in the Manchester office of a major international firm of chartered accountants.

From 2012 to 2014, Daniel was a director of corporate services at the Information Commissioner's Office (ICO), where he had board responsibility for finance. Since leaving the ICO he became a trustee and treasurer of three charities, which range from £0.5m to £4.5m in size of turnover.

Daniel has a significant amount of health, voluntary sector and community service experience, currently serving on four sets of boards. In addition, Daniel has spent time in the public sector as a director responsible for governance.

DR JULIA SUTTON-MCGOUGH was appointed as a Non-Executive Director in September 2017. Julia has established a record of leading and delivering strategic projects in the pharmaceutical industry, charity sector and NHS.

Since 2010, Julia has run her own consultancy business. This has included the management of projects for Sue Ryder Charity and Warrington Health Plus Community Interest Company, where she was a senior cluster manager. Before starting her own business, Julia was an executive board member at Sue Ryder Charity, also holding posts as director of strategic initiatives and lead for strategy and performance.

During the early part of her career Julia spent time in the pharmaceutical industry, with eight years at SmithKline Beecham, AstraZeneca and Schering Health Care. Her roles included study management, clinical quality assurance and product management.

Julia is currently involved in the development of a pilot scheme 'Clinical Pharmacist in Practice' on behalf of NHS England.

JOHN SCAMPION was appointed as a Non-Executive Director in February 2018. After taking a history degree, John began his working life as a social worker in London. After a couple of years he switched to accountancy and qualified as a chartered accountant in 1981.

He joined the NHS in 1983 and has worked there ever since, originally in London, but since 1987 in and around Greater Manchester, where he has held board level posts in Manchester, Rochdale, Oldham, Tameside, Central Manchester Hospitals and The Christie. Since retiring from full time executive roles he was chair, until 2013, of The Lifeline Project, a social enterprise company providing drug rehabilitation services. He was chair of Manchester Mental Health and Social Care Trust until it merged with Greater Manchester West in 2015. He is a Trustee of the Buxton Opera House and of a small charity, Improving Chances, which he set up with his wife to support a school for children with special needs in Uganda. John chairs the Trust's Audit Committee, which oversees the system of governance for the organisation.

JOHN SCHOFIELD was appointed as Chairman in November 2007 and concluded his term of office on 31 October 2017. A qualified accountant, John held many senior financial and general management positions during his career. He started his career as a trainee accountant with British Gas then moved to FEB Ltd. (subsidiary of Sandoz), where he worked in the UK and overseas. John then worked for Terosyl Ltd, Bury, for a short period before taking up the position as Financial Director of Seddon Atkinson Vehicles Ltd (subsidiary of FIAT Ltd) and then later promoted to Managing Director.

IAN BEVAN was appointed Non-Executive Director in October 2016 and left the Trust on 16 November 2017. Ian was previously a Non-Executive Director at Calderstones Partnership NHS Foundation Trust. Ian is a chartered management accountant, who spent the early part of his career as a unit accountant at Christie and Wythenshawe hospitals. Since then he spent his career in the transport industry, holding posts as finance director with Lancaster City Transport, GM Buses, GNER and Northern Rail. He was managing director with Northern Rail between 2010 and 2013.

PROFESSOR PAULA ORMANDY was appointed as a Non-Executive Director in August 2014 and concluded her term of office on 31 August 2017. Paula leads a programme of research in long-term conditions as an experienced health service researcher at the University of Salford. Her expertise focuses on information needs and information provision in clinical practice to facilitate self-management of long-term conditions, particularly the use of digital and social media to make information accessible and developing evidence based practice. She is Vice President for Research for the British Renal Society, having started her career in nursing within renal services.

ANTONY BERRY was appointed as a Non-Executive Director (NED) in April 2011 and concluded his term of office on 31 May 2017. Prior to this, Tony served 18 months in a NED role for Oldham Community Health Services prior to their merger with Pennine Care. Tony is a Fellow of the Chartered Institute of Building and holds post graduate status with the Royal Institute of Chartered Surveyors. Tony has a career spanning over 30 years in housing development, estate management and social housing, and is currently Chief Executive of Ashton Pioneer Homes, a community based Housing Association in Tameside, with a strong emphasis on service quality and excellence, customer engagement, and continuous improvement.

CLAIRE MOLLOY commenced as Chief Executive in September 2017. Claire has over 20 years' experience in the NHS, working a variety of roles across different settings. For four years prior to her appointment, she was Chief Executive at Cumbria Partnership NHS Foundation Trust; which has many similarities to Pennine Care, as a provider of both community and mental health services across multiple boroughs. Community and mental health care is a particular passion of Claire's, which was a major reason for her taking the role. The Trust offers something unique as a provider in Greater Manchester and this needs to benefit patients and the wider health and social care system.

MARTIN ROE is the Executive Director of Finance / Deputy Chief Executive; however he served as Acting Chief Executive from March 2017 until September 2017 whilst the process was underway to recruit a substantive Chief Executive. Martin has been a financial director for over 20 years, working in a range of NHS organisations. He has been Director of Finance at Pennine Care since it was formed in 2002 and was the project lead for the Trust's Foundation Trust application. Martin also has executive responsibility for estates, and health and safety.

DR HENRY TICEHURST was appointed as the Medical Director from 1 June 2010. Henry was previously Lead Consultant in Bury, leading a team of medical staff and driving forward improvements in one of our five boroughs. Before becoming Lead Consultant, Henry was a Consultant Psychiatrist in a number of our localities. From March 2017 to September 2017 Henry's portfolio was extended to incorporate Acting Deputy Chief Executive as part of the interim leadership arrangements whilst the process was underway to recruit a substantive Chief Executive.

KEITH WALKER was appointed as Director of Operations in August 2014. The role was conferred Executive Director status from 1 December 2014. Prior to August 2014, Keith held the post of Service Director for Specialist Services.

As Executive Director of Operations, Keith is responsible for overseeing the entire operations of the Trust's services. His priorities are to ensure that services are safe and effective, that patients receive high quality care and that staff are supported in the workplace. He also oversees the delivery of the Trust's financial savings programme, as well as the performance of contracts. Keith's overall aim is to ensure that Pennine Care is a place where staff want to work, all people feel valued and partners want to work with us.

Keith is a qualified mental health nurse and has worked in the NHS for 22 years. Before joining Pennine Care in 2006, he worked in a number of clinical and management positions within adult and children's mental health services.

JUDITH CROSBY was appointed as Executive Director of Service Development and Sustainability in September 2015, having previously held the roles of Director of Finance and Deputy Director of Finance. In her current role, Judith leads on the design and implementation of the Trust's Service Development Strategy. This involves ensuring that plans are in place to deliver safe and sustainable services in line with commissioning requirements across the health and social care system.

Judith has been with Pennine Care since its creation in 2002, having previously worked in for other NHS organisations in Stockport, and Tameside and Glossop.

EMMA TILSTON held the position of Acting Executive Director of Finance from March 2017 to September 2017 as part of the interim leadership arrangements whilst the process was underway to recruit a substantive Chief Executive. Emma has 24 years of NHS finance experience, 22 of which have been gained at Pennine Care and its predecessor organisations. Emma's substantive role is Director of Finance.

IAN TRODDEN held the position of Executive Director of Nursing and Healthcare Professionals from 2014 until he left the Trust in September 2017. Ian became a Registered Mental Health Nurse in 1985 and has spent more than 25 years in clinical, managerial and leadership roles working across community and mental health services.

Remuneration Report

Annual statement 2017/18

There have been no major decisions or changes to senior managers' remuneration during 2017/18.

For the period April 2017 to March 2018 the employees involved have received a 1% pay award.

Senior managers' remuneration policy

The Appointments and Remuneration Committee is responsible for setting and agreeing senior managers' remuneration, along with their terms and conditions. Read more about the committee on page 46.

Details of senior managers' remuneration are provided on page 55.

Future policy table:

Component	Salary and fees	All taxable benefits	Annual performance-related bonuses	Long-term performance-related bonuses	All pension-related benefits
Description	This is the basic salary	Senior manager car allowance	We do not offer these	We do not offer these	In line with the NHS Pension Scheme
How the component supports our long and short term strategic objectives	Recruitment and retention of senior managers	Recruitment and retention of senior managers	N/A	N/A	Recruitment and retention of senior managers

With regards to the maximum that could be paid in relation to salary and fees and pension related benefits, we follow applicable regulatory guidance. In relation to taxable benefits, the maximum that could be paid would be determined on an individual basis by the Appointments and Remuneration Committee.

With regards to senior managers paid more than £142,500 (Prime Minister's Salary), periodic reviews are undertaken in order to satisfy that the remuneration is reasonable. This process includes benchmarking.

For remuneration in relation to non-executive directors see page 56. The fees of non-executive directors are set by the Chairman and Council of Governors.

Service contract obligations:

There are no obligations on the Trust in relation to senior managers' contracts that have not been disclosed elsewhere.

Policy on payment of loss of office:

The standard notice period for all senior managers is six months, unless negotiated otherwise.

There were no payments for loss of office.

Statement of consideration of employment conditions elsewhere in the foundation trust:

The Appointment and Remuneration Committee takes into consideration the national Pay Review Body recommendations.

Where a change directly affects a senior manager's employment conditions, we would consult with that employee.

Benchmarking activities are undertaken where deemed appropriate.

Annual report on remuneration

Please refer to the Directors' Report on page 41 for details of the membership and purpose of the Appointment and Remuneration Committee.

Section A: Total remuneration 2017/18 and 2016/17

		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	Title	£000s (Band of £5k)	£s (nearest £100)	£000s (Band of £5k)	£000s (Band of £5k)	£000s (Band of £2.5k)	£000s (Band of £5k)
Executive Directors							
Ms Claire Molloy	Chief Executive (from 11 September 2017)	95 - 100	-	-	-	12.5 - 15.0	110 - 115
Mr M Roe	Deputy Chief Executive / Executive Director of Finance; Acting Chief Executive (1 March 2017 to 11 September 2017)	155 - 160	-	-	-	22.5 - 25.0	175 - 180
Mr M McCourt	Chief Executive (until 28 February 2017)	-	-	-	-	-	-
Ms E Tilston	Acting Executive Director of Finance (from 1 March 17 to 11 September 17)	50 - 55	-	-	-	7.5 - 10.0	60 - 65
Dr H Ticehurst	Executive Medical Director; Acting Deputy Chief Executive (from 1 March 2017 to 11 September 2017)	165 - 170	-	-	-	22.5 - 25.0	185 - 190
Ms J Stewart	Executive Director of Nursing and Healthcare Professionals (from 28 September 17)	65 - 70	-	-	-	7.5 - 10.0	70 - 75
Mr I Trodden	Executive Director of Nursing and Healthcare Professionals (until 28 September 17)	60 - 65	-	-	-	7.5 - 10.0	70 - 75
Ms J Crosby	Executive Director of Service Development & Sustainability	130 - 135	-	-	-	17.5 - 20.0	145 - 150
Mr K Walker	Executive Director of Operations	130 - 135	-	-	-	17.5 - 20.0	145 - 150
Ms K Calvin-Thomas	Executive Director of Planning, Performance & Information (until 31 July 16)*	-	-	-	-	-	-

Chair							
Ms E Asante-Mensah	Chair (from 1 November 2017)	15 - 20	-	-	-	-	15 - 20
Mr J Schofield	Chair (until 31 October 2017)	25 - 30	-	-	-	-	25 - 30
Non-Executive Director							
Mr J Scampion	Non Executive Director (from 19 February 2017)	0 - 5	-	-	-	-	0 - 5
Mr D Benjamin	Non Executive Director (from 4 September 2017)	5 - 10	-	-	-	-	5 - 10
Dr J Sutton-McGough	Non Executive Director (from 1 September 2017)	5 - 10	-	-	-	-	5 - 10
Mr M Livingstone	Non Executive Director	15 - 20	-	-	-	-	15 - 20
Lord K Bradley	Non Executive Director	15 - 20	-	-	-	-	15 - 20
Ms J Beresford	Non Executive Director	15 - 20	-	-	-	-	15 - 20
Ms S Jowett	Non Executive Director	15 - 20	-	-	-	-	15 - 20
Mr I Bevan	Non Executive Director (from 1 October 2016 until 16 November 17)	5 - 10	-	-	-	-	5 - 10
Mr A Berry	Non Executive Director (until 31 May 2017)	0 - 5	-	-	-	-	0 - 5
Mr P Ormandy	Non Executive Director (until 31 July 2017)	5 - 10	-	-	-	-	5 - 10
Mr R Ainsworth	Non Executive Director (until 31st December 2016)	-	-	-	-	-	-

* Ms Calvin Thomas was on full time secondment to Devolution Greater Manchester prior to leaving the Trust on 31 July 2016

		2016/17	2016/17	2016/17	2016/17	2016/17	2016/17
		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	Title	£000s (Band of £5k)	£s (nearest £100)	£000s (Band of £5k)	£000s (Band of £5k)	£000s (Band of £2.5k)	£000s (Band of £5k)
Executive Directors							
Ms Claire Molloy	Chief Executive (from 11 September 2017)	-	-	-	-	-	-
Mr M Roe	Deputy Chief Executive / Executive Director of Finance; Acting Chief Executive (1 March 2017 to 11 September 2017)	140 - 145	3,000	-	-	20.0 - 22.5	160 - 165
Mr M McCourt	Chief Executive (until 28 February 2017)	165 - 170	-	-	-	22.5 - 25.0	190 - 195
Ms E Tilston	Acting Executive Director of Finance (from 1 March 17 to 11 September 17)	10 - 15	-	-	-	0 - 2.5	10 - 15
Dr H Ticehurst	Executive Medical Director; Acting Deputy Chief Executive (from 1 March 2017 to 11 September 2017)	160 - 165	-	-	-	22.5 - 25.0	185 - 190
Ms J Stewart	Executive Director of Nursing and Healthcare Professionals (from 28 September 17)	-	-	-	-	-	-
Mr I Trodden	Executive Director of Nursing and Healthcare Professionals (until 28 September 17)	130 - 135	-	-	-	17.5 - 20.0	145 - 150
Ms J Crosby	Executive Director of Service Development & Sustainability	130 - 135	-	-	-	17.5 - 20.0	145 - 150
Mr K Walker	Executive Director of Operations	125 - 130	-	-	-	17.5 - 20.0	145 - 150
Ms K Calvin-Thomas	Executive Director of Planning, Performance & Information (until 31 July 16)*	40 - 45	-	-	-	- 2.5 - 0	40 - 45

Chair							
Ms E Asante-Mensah	Chair (from 1 November 2017)	-	-	-	-	-	-
Mr J Schofield	Chair (until 31 October 2017)	45 - 50	-	-	-	-	45 - 50
Non-Executive Director							
Mr J Scampion	Non Executive Director (from 19 February 2017)	-	-	-	-	-	-
Mr D Benjamin	Non Executive Director (from 4 September 2017)	-	-	-	-	-	-
Dr J Sutton-McGough	Non Executive Director (from 1 September 2017)	-	-	-	-	-	-
Mr M Livingstone	Non Executive Director	15 - 20	-	-	-	-	15 - 20
Lord K Bradley	Non Executive Director	15 - 20	-	-	-	-	15 - 20
Ms J Beresford	Non Executive Director	15 - 20	-	-	-	-	15 - 20
Ms S Jowett	Non Executive Director	15 - 20	-	-	-	-	15 - 20
Mr I Bevan	Non Executive Director (from 1 October 2016 until 16 November 17)	5 - 10	-	-	-	-	5 - 10
Mr A Berry	Non Executive Director (until 31 May 2017)	15 - 20	-	-	-	-	15 - 20
Mr P Ormandy	Non Executive Director (until 31 July 2017)	15 - 20	-	-	-	-	15 - 20
Mr R Ainsworth	Non Executive Director (until 31st December 2016)	10 - 15	-	-	-	-	10 - 15

* Ms Calvin Thomas was on full time secondment to Devolution Greater Manchester prior to leaving the Trust on 31 July 2016

Section B: Total pension entitlement 2017/18

Name and Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pensiom at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer value at 31st March 2017 £000
Claire Molloy Chief Executive (from 11 September 17)	2.5 - 5.0	10.0 - 12.5	45 - 50	145 - 150	1,001	108	893
Martin Roe Deputy Chief Executive/ Executive Director of Finance; Acting Chief Executive (1 March 2017 to 11 September 2017)	7.5 - 10.0	27.5 - 30.0	70 - 75	220 - 225	1,741	263	1,478
Henry Ticehurst Executive Medical Director; Acting Deputy Chief Executive (from 1 March 2017 to 11 September 2017)	0 - 2.5	5.0 - 7.5	55 - 60	170 - 175	1,129	103	1,026
Jacqueline Stewart Executive Director of Nursing (from 28 September 17)	12.5 - 15.0	40.0 - 42.5	50 - 55	160 - 165	1,077	296	781
Judith Crosby Executive Director of Service Development and Sustainability	0 - 2.5	2.5 - 5.0	50 - 55	150 - 155	1,041	85	956
Ian Trodden Executive Director of Nursing (until 27 September 17)	2.5 - 5.0	7.5 - 10.0	60 - 65	180 - 185	1,215	124	1,091
Keith Walker Executive Director of Operations	0 - 2.5	0 - 2.5	30 - 35	70 - 75	430	50	380
Emma Tilston Acting Executive Director of Finance (from 1 March 17 to 11 September 17)	7.5 - 10.0	17.5 - 20.0	35 - 40	85 - 90	555	140	415

Section C: Pay multiples 2017/18

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median full time equivalent remuneration of the organisation's workforce, including estimated annual remuneration for temporary and agency staff.

The rounded remuneration of the highest paid director in Pennine Care for the full financial year 2017/18 was £175,000 (2016/17: £182,000). These figures are based on an annualised salary. As the highest paid director was not in post for the full year, for 2017/18 this figure is higher than the total payment disclosed to the highest paid director within the senior managers' remuneration table.

This was 7.61 times (2016/17: 7.95) the median remuneration of the workforce, which was £22,997 (2016/17: £22,862).

There were no employees receiving annualised remuneration in excess of the highest paid director. Total remuneration includes salary, non-consolidated performance related pay and taxable benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Section D: Expenses of directors and governors

Expenses claimed 2017-18	Number in post	Number claiming expenses	Total expenses claimed £'00
Governors	33	19	35
Executive and Non-Executive Directors	18	15	100
Expenses claimed 2016-17	**Number in post**	**Number claiming expenses**	**Total expenses claimed £'00**
Governors	39	17	35
Executive and Non-Executive Directors	16	15	151

Section E: Notes to the remuneration report calculation

The basis for calculating the pension benefits associated with the NHS Pension Scheme members is determined in accordance with the 'HMRC method', which is derived from the Finance Act 2004 and modified by Statutory Instrument 2013/1981.

The calculation required is:

$$\text{Pension Benefit Increase} = ((20 \times PE) + LSE) - ((20 \times PB) + LSB) - EC$$

Where:

PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year; PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year; LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year;

LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year; EC is the employee's contribution paid during the year.

Notes on Cash Equivalent Transfer Value for section B:

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time.

A CETV is a payment made by a pension scheme when the member leaves a scheme and chooses to transfer the benefits accrued.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures include the value of any pension benefits in another scheme or arrangement.

Claire Molloy
Chief Executive
25 May 2018

Staff report

We have a diverse workforce and employ 5,500 substantive staff. This is the head count, or number of people, who work for Pennine Care including medical consultants, nurses, therapists and specialist practitioners. Our staff work in a variety of settings including the community, hospitals and clinics.

In addition we employ approximately 1,400 staff on our bank, who work for us flexibly when we require additional staffing support. We simply would not be able to deliver high quality care to our patients without their continuing hard work, commitment and dedication.

Workforce demographics

The following table shows our average staff numbers:

Staff Group	Non Permanent	Permanent	Total
Administration & Estates	188	1,095	1,283
Healthcare Assistants & Other Support Staff	90	1,159	1,249
Medical & Dental	29	133	162
Nursing, Midwifery & Health Visiting Learners	8	2	10
Nursing, Midwifery & Health Visiting Staff	143	1,720	1,863
Scientific, Therapeutic & Technical Staff	93	871	964
Bank	877	0	877
Total	**1,428**	**4,980**	**6,408**

The following table shows our split of male and female employees:

Category	Male	Female	Total
Trust Board	7	6	13
Senior Manager	43	23	66
Employee	4,575	877	5,452
Total	**4,625**	**906**	**5,531**

Notes

These figures are a headcount and are a snapshot, correct as at 31 March 2018.

Bank staff are not included.
Secondary assignments are not included, to prevent double counting.

Analysis of staff costs

Staff group	Expenditure 2017/18 £000s
Administrative and clerical	28,064
Agency staff external	9,089
Allied health professionals	16,656
Chairman and non-executives	166
Executive board and senior managers	12,474
Healthcare assistants and other support staff	6,342
Healthcare scientists	4,207
Medical and dental	18,842
Nursing, midwifery and health visiting	95,633
Scientific, therapeutic and technical	16,737
Total	**208,210**

Staff health and wellbeing

We continue to place importance on promoting positive health and wellbeing for our staff, and a number of interventions and actions have been undertaken. The Trust's overall cumulative sickness absence rate for 2017/18 was 5.24% which is a statistically equivalent to the 2016/17 rate that was 5.25%.

Our Board recognises the importance of staff health and wellbeing and is committed to a vision which gives high priority to the needs of each employee, wider service areas and the organisation as a whole.

We recognise that a healthy and supported workforce will impact significantly on the quality of services provided to our service users.

A Health and Wellbeing Strategy was implemented in 2016 which outlines our approach to supporting our staff. It contributes to the Greater Manchester Health and Social Care Partnership's top priority of tackling health outcomes.

This Health and Wellbeing Strategy provides a framework which aims to ensure that:

- We continue to develop a workplace culture that promotes and supports the health and wellbeing of all staff
- The health and satisfaction of staff continues to improve
- The impact of this strategy on staff has a direct impact on improving the patient experience
- Absences through ill health, grievances and turnover are reduced

- Staff are provided with relevant and appropriate information to help them to learn how to improve their own health
- Interventions are put in place which empower staff to improve their health
- The reputation of Pennine Care as a great place to work continues to grow

The following are examples of how we are supporting delivery of these objectives.

Staff health and wellbeing resource:

In November 2016, we launched a brand new staff health and wellbeing resource, themed around the Five Ways to Wellbeing.

Occupational Health Service:

The Trust's Occupational Health Service supports staff who have physical injuries, ongoing sickness and any other problems concerns that may be linked to their physical health.

Staff Wellbeing Service:

Our Staff Wellbeing Service is for employees who need help and support with psychological difficulties that are impacting on work. This includes mild to moderate common mental health problems.

This year, we have continued to develop the service and it now offers an expanded range of online, face-to-face and group support. This includes counselling, Cognitive Behavioural Therapy (CBT) and mindfulness.

Sickness Absence:

	2016/17	2017/18
Total days lost	54,640	55,349
Total staff years	4,861	4,752
Average working days lost (per WTE)	11.24	11.6

Managing Attendance Policy:

Our Managing Attendance (sickness absence) Policy was developed in partnership with staff side colleagues. This introduces consistent standards across the organisation for all staff, supporting the effective management of sickness and ensuring staff are appropriately supported both during their absence and in returning to work. We review our health supportive initiatives and services to ensure that these provide the right level and area of support for staff. In addition to this the HR Team provide coaching and development opportunities for our managers to improve their skills in the area of absence management and support.

Equality and diversity

We are committed to equality and diversity and have supporting governance structures in place through our Equality and Diversity Work Group and our People and Workforce Steering Group.

This enables data monitoring, information provision and identification of themes, all of which support Trust and Local discussions about the development of improvement plans where needed.

The following have been the key areas of action in 2018:

- Accessible Information Standard Workgroup established and Policy drafted
- Workforce Race Equality Standard (WRES)
- Equality data guidance and understanding
- Review of the equality analysis process including the development of a new Equality Assessment document
- Networking and partnership working with other health and social care providers
- Provision of training and awareness and specific topic provision
- Positive recruitment and support for staff with disabilities
- Establishing our first LGBTQ Staff Network and re-establishing our BME Staff Network.

We monitor and analyse our workforce equality data by protected characteristics. We know that we can be more representative of the demographics of the communities we serve and this continues to be an area for improvement.

We continue to implement the Workforce Race Equality Standard and have produced a baseline report which is being used in local services to help identify any areas for improvement or action.

We have worked with staff side representatives to develop support for staff from equality groups and to address discrimination and barriers to progression in the workplace.

We have ensured that our Council of Governors has undertaken equality training, which included equality monitoring. There is also a requirement for our governors and members to be representative of the communities we serve.

We have a range of policies in place to ensure that staff with disabilities, or who become disabled while in our employment, are fully supported to ensure they have fair access to employment, career development opportunities and training.

Our Equal Opportunities Policy sets out the principles of our equality approach. This is reinforced through our other policies, for application by managers.

We are a ‘two ticks employer’ which ensures that individuals with disclosed disabilities have priority access to interviews. We have strengthened our commitment to this scheme through additional work with Remploy to support individuals back into the workplace through supportive placements, bank work and substantive employment.

Our managing attendance and sickness policy ensures that adjustments are considered as part of enabling individuals to return to work, and in sensitively

working with individuals in a supportive way where disabilities may impact on health.

We continue to support the Dying to Work Charter, which is a national initiative to support employees who become terminally ill in employment and have reviewed our policies and good practice guidelines to reflect our commitment to upholding a supportive and enabling approach.

Our Occupational Health Service provides advice on reasonable adjustments to support individuals to return and remain in work.

As part of the Workforce Race Equality Scheme we monitor recruitment information and access to training by all protected characteristics (including disability) and ensure that fair and consistent application of practice is in place.

We continue to update and adjust the support we offer to ensure we are meeting best practice and legislative requirements.

Staff policies and actions applied during the financial year

This year the Trust has reviewed some key policies to ensure that they are best meeting the needs of our employees. These include the IPDR and Progression of Pay Policy, the Grievance Policy, Relocation Policy, Substance Misuse in the Workplace Policy, Partnership Working Policy and our Redeployment Policy. Work is currently underway with some of these policies through our Policy Review Group to ensure a partnership approach to policy development is maintained. 2018/2019 will be a busy year for our policy review as a large number of our policies will be up for renewal and we are currently working through a policy schedule to support progress. In addition to this some key policies are a priority for us in response to the Staff Opinion Survey and the Gender Pay Gap reporting. These include Dignity at Work, Stress in the Workplace and Flexible Working.

The Trust has also developed a new Transgender Policy in partnership with out LGBT network lead and staff side colleagues. We have put in place a supportive awareness session for managers and leaders to enable exploration and awareness of Transgender in employment and service delivery. This Policy is the starting point for us to look at our services and our employment support and policies to ensure that we are working to best practice and supporting inclusion of our Transgender community.

Human Rights

Equality, diversity and human in service delivery is central to our strategic goal to ‘put local people and communities first’. PCFT provides mandatory online training for all staff and a full day EDHR training course for managers and staff. Bespoke training courses are also provided. The E and D Advisor and officer facilitate one to one advice sessions and team meeting briefings on specialist subject matters and general EDHR advice.

All policies, processes, service and organisational developments, changes and improvements undergo an Equality Analysis Assessment (EAA), which considers 9 protected characteristics and also some unprotected

characteristics as identified in the Equality Act as well as cross-referencing against the Human Rights Act (HRA).

The Mental Health Act (1983) (MHA) and the HRA are compatible. This is because detention with compulsion (which is at the heart of the MHA) is recognised as a lawful option within Article 5 of the HRA. It is essential that all those undertaking the functions under the MHA understand the five sets of overarching principles contained within the MHA Code of Practice (2015) which should always be considered when making decisions in relation to providing patient care, support or treatment provided under the Act.

The five overarching principles are:

Least restrictive option and maximising independence

Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Empowerment and involvement

Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity

Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness

Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity

Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Staff must apply all the principles to all decisions. All decisions must be lawful and informed by good professional practice. Lawfulness includes compliance with the HRA and Equality Act 2010. All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

The Trust has a number of policies relating to the application of the MHA which looks at protecting patients legal rights and helping patients to exercise those rights. The Mental Health Law Team, which is based within each one of

the five hospitals across the Trust's footprint, have a number of systems in place to monitor patients' detention status and trigger safeguards for patients. This includes the right to an independent mental health advocate; the right to information regarding their detention/treatment; the right to appeal to a tribunal and the hospital managers; the right to a second opinion appointed doctor to review treatment for mental disorder, the right for their nearest relative under section 26 of the MHA to request for the patients discharge etc. There is also a legal duty on the Trust to automatically refer a patient's case to the tribunal in certain circumstances. For further information and examples of how we protect patients legal rights and how we deliver against these please see attached policies around Admission, Entry and Exit to an Inpatient Ward and Provision of Information to Detained Patients and their Nearest Relatives under s132, s132A and s133 of the MHA. All our Trust policies in relation to the MHA are in line with the requirements of the HRA, MHA, and the MHA Code of Practice (2015) which is attached for information.

Staff groups

The Trust and its UNION branch have been working together to set up self-organised groups for staff and volunteers who identify themselves as belonging to one or more of the following groups:

- Black and Minority Ethnic (BME).
- Lesbian, gay, bisexual and transgender (LGBTQ).

Pennine Care continues to work with our staff networks to work in partnership on issues that are pertinent to our employees and service provision considerations. Our Equality and Diversity Team works with our networks to support planned actions and initiatives arising from the networks, including budget and planning support as required. We work with the networks to develop actions over the next 12 months. This will include our annual support and attendance at the Manchester Pride parade and a revised launch of the BME Network.

Consultation, engagement and communication with staff

Effective employee involvement and engagement is crucial to effective service provision and the delivery of quality services through staff who are motivated, accountable and engaged. We expect all managers to understand the importance of involving and engaging with all of their staff as part of everyday good management practice.

Where there are specific decisions that may impact on employees' interests (such as organisational changes) we use a range of mechanisms to engage with our staff and Trade Union colleagues. Our commitment is set out in our Organisational Change Policy which outlines the importance of early engagement with staff and teams and sets out to involve them wherever possible in discussions and the formation of ideas to meet changing requirements. In addition we work in a collaborative manner with our Partnership Officers to support the development and implementation of robust and fair formal consultation papers and processes.

Our performance review system provides a focus on employees' contribution to the success of their team and the Trust objectives, capturing this assessment in a formal process for managers to provide direct feedback about individual performance, supporting individual's development and opportunities to contribute going forward.

We also have a range of staff engagement and communication methods in place to ensure that staff are involved in a wide range of opportunities, that they understand the organisational priorities and key issues and can contribute to formulation of plans and actions.

We also have a number of communication channels to ensure staff remain up to date. Some examples of trust wide channels are an intranet site, a weekly e-bulletin, a monthly managers' Priority Brief, a dedicated staff Facebook group and ad-hoc global email updates. Our chief executive publishes a regular online blog focusing on key topics for our workforce and our Quality Agenda priority.

Local divisional mechanisms include informal drop-in sessions with managing directors, quarterly service director updates and more. Managers are also encouraged and supported to utilise more personal and face-to-face communication channels with their teams – particularly where there is a requirement to share information about service changes.

There is also a Joint Negotiating and Consultative Committee and a Medical Local Negotiating Committee which is used to consult with union representatives on a range of topics. It also provides an opportunity for our senior leadership to discuss issues, initiatives or factors affecting our workforce with staff side colleagues.

Staff survey results

All of our staff are invited to complete the national NHS Staff Survey. As the following table shows, our response rate decreased in 2017/18 from the previous year.

	Pennine Care response rate	National response rate	Increase/decrease
2016/17	36 per cent	44 per cent	Increase
2017/18	32 per cent	45 per cent	Decrease

**1,659 completed questionnaires out of an eligible pool of 5,226*

The overall results from the staff survey carried out in 2017 are good.

Our Overall Staff Engagement Score is made up of three main key finding. These are as follows:

Staff recommending Pennine Care as a place to work or receive treatment (reflected on a range of 0 to 5) shows a movement from 3.73 to 3.68, this is however a statistically maintained position for the Trust and is equal to the national comparison. Our staff motivation at work key finding has decreased from 3.97 to 3.90, whilst the national comparison has maintained its position.

The percentage of our staff feeling able to contribute towards improvements at work has a slight movement from 76% to 75%, this is however a statistically maintained position for the Trust and is statistically better than the national comparison. Our Overall Staff Engagement score therefore reflects a decrease for our Trust position from 3.84 to 3.80 and reflects an equal position to our national comparator score of 3.79.

Compared to our national reference group, we are reflecting a better performance in:

- Staff feeling satisfied with the opportunities for flexible working
- Staff witnessing potentially harmful errors, near misses or incidents
- Staff experiencing physical violence from staff
- Staff experiencing physical violence from patients, relatives or the public
- Staff working extra hours
- The organisations and managements interests in and action on health and wellbeing
- Staff able to contribute towards improvements at work
- Support from immediate line managers
- Staff experiencing discrimination at work

Key Findings where staff experiences have decreased at Pennine Care NHS Foundation Trust or compared to our national comparators since the 2016 survey are:

- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
- Staff motivation at work
- Staff feeling that their role makes a difference to patients and service users
- Staff reporting errors, near misses or incidents
- Staff reporting the most recent experience of violence
- Staff feeling unwell due to work related stress in the last 12 months
- Quality of appraisals

The overall summary of our Staff Survey results evidences that across the 31 Key Findings compared to our 2016 results we have improved/increased in KF11 (% appraised in the last 12 months) and decreased in 4 key findings (KF29: reporting errors/incidents; KF18: attending work feeling unwell; KF4: staff motivation; KF3: role makes a difference to patients). We have not had any change in results for the remaining 27 key findings.

As an overall comparison to our reference group for the 2017 results, we are:

- Average for 18 Key Findings
- Better than average for 9 Key Findings
- Worse than average for 5 Key Findings

Our Top 5 and Bottom 5 ranking results for 2017 compared to 2016 results are as follows:

Top 5 ranking scores:

	2016/17		2017/18		Trust improvement/ deterioration
Top 5 ranking scores (Key Findings)	**Trust**	**Trust**	**Trust**	**National Average**	
KF15: Percentage of staff satisfied with the opportunities for flexible working patterns	63%	63%	64%	58%	**No Change** Trust above (better than average)
KF 28: Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	20%	24%	19%	23%	**No change** Trust below (better than average)
KF 23: Percentage of staff experiencing physical violence from staff	1%	1%	1%	2%	**No change** Trust below (better than average)
KF 16: Percentage of staff working extra hours	70%	71%	68%	71%	**No change** Trust below (better than average)
KF 19: Organisation and management interest in and action on Health and wellbeing	3.75	3.74	3.78	3.70	**No Change** Trust above (better than average)

Bottom 5 ranking scores

	2016/17		2016/17		Trust improvement/ deterioration
Bottom 5 ranking scores (key findings)	**Trust**	**National Average**	**Trust**	**National Average**	
KF17: Percentage of staff feeling unwell due to work related stress in the last 12 months	40%	39%	42%	40%	**No Change** Trust above (worse than average)
KF12: Quality of appraisals	3.04	3.10	3.02	3.10	**No Change** Trust below (worse than average)
KF24: Percentage of staff / colleagues reporting most recent experience of violence	86%	88%	85%	88%	**No Change** Trust below (worse than average)
KF29: Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	93%	91%	92%	**Decrease** Trust below (worse than average)
KF18: Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	52%	55%	54%	53%	**Increase** Trust above (worse than average)

Plans to address and improve

The Staff Survey results have been highlighted to the Board and further plans will be developed in line with the key priorities for the Trust and the planned OD Cultural Audit work. In addition the results will be triangulated on a quarterly basis with the Go Engage pulse check. Locally the Divisions are

working through their results to devise and plan local actions and engagement plans with the aim of improving the employment experience at Pennine Care.

Through both Trust wide and local engagement actions we will ensure that our commitment to being a great place to work is prioritised. Our current workforce priorities supported by the Staff Survey results are:

- Promoting respect and improving awareness of bullying and harassment and promotion of our Trust policy and personal behaviours commitment.
- Finalising the review of the IPDR process and reflect current proposed national changes to ensure that quality discussions are enabled through the IPDR process and support quality in service delivery.
- Promoting employee engagement, involvement in service decision making and ensuring that staff feel valued and recognised for their contributions.

Monitoring of improvements in performance

Divisional plans will be integrated into the Local People Plans and as agreed monitored through the Divisional Business Units Quarterly Assurance Meetings. At a Trust-wide level we will continue to run staff temperature checks to assess the in year position.

Additional payment information

The following tables provide details of highly paid staff and off-payroll expenses.

Table 1: Off-payroll engagements longer than 6 months

All off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months.

	Number
Number of existing engagements as of 31 March 2018	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: New Off-payroll engagements

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months.

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	1
Of which...	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	1
No. of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll board member/senior official engagements

Off-payroll payment engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year.	0
Number of individuals that have been deemed board members and/or senior officials with signifi cant financial responsibility during the financial year. This figure must include both off-payroll and on-payroll engagements.	8

Any off-payroll expenditure is monitored and authorised via agreed processes. Expenditure on senior off-payroll arrangements requires approval through formal executive director meetings to agreed limits. Any expenditure on off-payroll arrangements for directors requires approval at the Trust's Appointment and Remuneration Committee.

Expenditure on consultants

During 2017/18 expenditure on consultants was £370k.

Exit Packages agreed in 2017-18

Exit package cost band (including any special payment element)	2017-18 *Number of compulsory redundancies	2017-18 *Number of other departures agreed	2017-18 Total number of exit packages by cost band	2016-17 *Number of compulsory redundancies	2016-17 *Number of other departures agreed	2016-17 Total number of exit packages by cost band
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Less than £10,000	**3**	**3**	**6**	6	3	9
£10,001-£25,000	**0**	**3**	**3**	3	0	3
£25,001-£50,000	**5**	**2**	**7**	8	1	9
£50,001-£100,000	**1**	**0**	**1**	11	0	11
£100,001 - £150,000	**0**	**0**	**0**	0	0	0
£150,001 - £200,000	**0**	**1**	**1**	0	0	0
Total number of exit packages by type (total cost	**9**	**9**	**18**	**28**	**4**	**32**
Total resource cost - £000	**330**	**302**	**632**	**1,173**	**50**	**1,223**

Where the NHS Foundation Trust has agreed early retirements, the additional costs are met by the NHS Foundation Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

*This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous year.

Early Retirements on ill health grounds

	2017-18	2016-17
	Number	**Number**
Number of persons retired early on ill health grounds	**8**	9
	£000	**£000**
Value of early retirement on the grounds of ill-health	**564**	497

Statement of compliance with the NHS Foundation Trust Code of Governance

The Board of Directors and the Council of Governors of Pennine Care NHS Foundation Trust recognise the importance of good corporate governance, as described in the NHS Foundation Trust Code of Governance (originally published by Monitor).

Pennine Care 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.

As at 31 March 2018, the Trust was compliant with all the code's provisions except for provision B.7.1 relating to the term of office served by John Schofield, Chairman beyond six years (i.e. two three-year terms), as outlined in page 50.

Please refer to the performance report from page 7, the director's report from page 40 and Council of Governors and membership section from page 43 for full disclosures.

Summary of the requirements of Schedule 7 to the Regulations

Disclosure requirement	Reference
Any important events since the end of the financial year affecting the NHS foundation trust.	Refer to the performance report from page 7
An indication of likely future developments at the NHS foundation trust.	Refer to the performance report, future priorities and challenges from page 7
An indication of any significant activities in the field of research and development.	Refer to the quality account, from page 107
Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.	Refer to the performance report, our staff from page 62
Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period.	Refer to the performance report, our staff from page 62
Policies applied during the financial year for the training, career development and promotion of disabled employees.	Refer to the performance report, our staff from page 62
Actions taken in the financial year to provide employees systematically with	Refer to the performance report, from page 62

information on matters of concern to them as employees.	
Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests.	Refer to the performance report, from page 62

NHS Improvement's Single Oversight Framework

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

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

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

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

Segmentation

Our segmentation position as at 31 March 2018 is 3. Further information regarding the Trust's segment position and enforcement action taken by NHS Improvement can be found in the Annual Governance Statement on page 93.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2017/18 Actual	2017/18 Plan
Financial sustainability	Capital service capacity	4	2
	Liquidity	2	2
Financial efficiency	I&E margin	4	1
Financial controls	Distance from financial plan	4	1
	Agency spend	2	3
Overall scoring		3	2

Further details can be in Note 24 of the Annual Accounts.

Statement of Accounting Officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Pennine 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 [name] 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 Pennine Care 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
- 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*.

Claire Molloy
Chief Executive
25 May 2018

Statement as to disclosure to the auditors

So far as I am aware, there is no relevant audit information of which Pennine Care NHS Foundation Trust's auditor is unaware.

I have taken all the steps that I ought to have taken as director in order to make myself aware of any relevant audit information and to establish that the Pennine Care NHS Foundation Trust's auditor is aware of that information.

Evelyn Asante-Mensah OBE
Chair

Joan Beresford
Non-Executive Director/Deputy Chair

Lord Keith Bradley
Non-Executive Director

Professor Sandra Jowett
Non-Executive Director

Michael Livingstone
Non-Executive Director

Dr Julia Sutton-McGough
Non-Executive Director

Daniel Benjamin
Non-Executive Director

John Scampion
Non-Executive Director

Claire Molloy
Chief Executive

Martin Roe
Executive Director of Finance/Deputy Chief Executive

Dr Henry Ticehurst
Medical Director

Judith Crosby
Executive Director of Service Development and Sustainability

Keith Walker
Executive Director of Operations

Jackie Stewart
Interim Executive Director of Nursing and Health Care Professionals

Council of Governors and Foundation Trust Membership

Foundation Trust Governance structures comprise three essential elements:

- Board of Directors
- Council of Governors
- Membership

Board of Directors

Please see directors' report on page 41.

Council of Governors

Pennine Care has a Council of Governors that comprises 46 members who represent our local communities, staff and stakeholder organisations.

The Council of Governors has a range of statutory powers and duties set out in the NHS Act 2006 and the Health and Social Care Act 2012. These include the power or duty to:

- appoint and, if appropriate, remove the Chairman;
- appoint and, if appropriate, remove the other Non-Executive Directors;
- decide the remuneration and allowances and other terms and conditions of office of the chair and the other Non-Executive Directors;
- approve (or not) any new appointment of a Chief Executive;
- appoint and, if appropriate, remove the NHS Foundation Trust's Auditor;
- receive the NHS Foundation Trust's annual accounts, any report of the Auditor on them, and the annual report at a general meeting of the Council of Governors;
- hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.
- represent the interests of the Trust's members, the public and staff in the governance of the Trust.
- regularly feed back information about the Trust, its vision and its performance to the members, public and stakeholder organisations that elected or appointed them.

Elected Governors are elected by members of their respective constituencies at regular intervals which must not exceed three years, after which time they are eligible to stand for re-election to serve further terms of office. Between 1 April 2017 and 31 March 2018, the Council of Governors was composed as follows:

Elected Public Governors

Name:	Constituency:	Term of office:
Ken Kendall	Bury	1 July 2016 to 30 June 2019
Derek Rowley	Bury	1 July 2015 to 30 June 2018
Clive Brown	Bury	1 July 2017 to 30 June 2020
Lucette Tucker	Bury	1 July 2017 to 30 June 2018
Ann Yates	Bury	1 July 2015 to 30 June 2017
John Starkey (Lead)	Oldham	1 July 2015 to 30 June 2018
Norma Bewley	Oldham	1 July 2015 to 30 June 2018
Kath Oldham	Oldham	1 July 2017 to 30 June 2020
Jim McDermott	Oldham	1 July 2017 to 30 June 2019
Beryl Whiteley	Oldham	1 July 2014 to 30 June 2017

Karen Kelland	Heywood, Middleton and Rochdale	1 July 2016 to 30 June 2019
Margaret Stoneman	Heywood, Middleton and Rochdale	1 July 2016 to 22 January 2018
Mohammed Sarwar	Heywood, Middleton and Rochdale	1 July 2015 to 30 June 2018
Ryan Cowan	Heywood, Middleton and Rochdale	1 July 2017 to 1 February 2018
Paul Carter	Stockport	1 July 2016 to 30 June 2019
Brian Wild	Stockport	1 February 2017 to 30 June 2019
Mary Foden	Stockport	1 July 2017 to 30 June 2020
Graham Davies	Stockport	1 July 2015 to 30 June 2018
Wendy Hartley	Tameside & Glossop	1 July 2016 to 30 June 2019
Stephen Moss	Tameside & Glossop	1 July 2016 to 30 June 2019
Joyce Howarth	Tameside & Glossop	1 July 2016 to 30 June 2018
John Reddy	Tameside & Glossop	1 July 2017 to 30 June 2020
Martin Stevenson	Trafford	1 July 2016 to 30 June 2018
Irving Normie	Trafford	1 July 2016 to 30 June 2019
Lorraine Chipeta	Trafford	1 July 2015 to 30 June 2017
Judy Williams	Trafford	1 July 2014 to 30 June 2017
Jeanette Scott	Rest of England	1 July 2017 to 21 February 2018

Elected Staff Governors

Name	Class	Term of Office
Caroline Poole	Allied Health Professionals	1 July 2016 to 30 November 2017
Charlotte Williams	Allied Health Professionals	1 July 2017 to 2 August 2018
Julia Nicholson	Corporate and Support	1 July 2017 to 30 June 2020
Lynzi Shepherd	Corporate and Support	1 July 2017 to 3 September 2017
Richard Cliff	Corporate and Support	4 September to 30 June 2018
Richard Valle-Jones	Medical and Dental	1 July 2016 to 30 June 2019
Jan Trainor	Nursing	1 July 2017 to 30 June 2018
Sara Handley	Nursing	1 July 2017 to 30 June 2020
Liz McCoy	Social Care	1 July 2017 to 30 June 2020

Appointed Stakeholder Governors

Name	Organisation	Date of Appointment
Lisa Featherstone	Bury CCG	29 September 2015
Vacant	Bury Council	/
Cllr Jean Wharmby	Derbyshire County Council	14 August 2018
Charlotte Booth	Heywood, Middleton and Rochdale CCG	13 March 2017
Cllr Peter Joinson	Rochdale MBC	10 May 2013
Graham Foulkes	Oldham CCG	1 June 2013
Cllr Eddie Moores	Oldham MBC	1 July 2016
Vacant	Stockport CCG	/
Cllr June Somekh	Stockport MBC	27 June 2013
Vacant	Tameside and Glossop CCG	/
Cllr Jackie Lane	Tameside MBC	1 July 2008
Vacant	Trafford CCG	/
Cllr Michael Young	Trafford Council	1 April 2014 to 17 October 2017
Cllr Dylan Butt	Trafford Council	18 October 2017

The Trust maintains a full register of Governors' interests, which can be viewed on the Trust's website at www.penninecare.nhs.uk or by contacting the Trust Secretary. This register details disclosure of any company directorships or other material interests in companies or related parties that are likely to do business, or are possibly seeking to do business, with the Trust.

As required by Section 156(1) of the Health and Social Care Act 2012, the Trust can confirm that during 2017/18, 15 Governors claimed expenses totalling £1,568.88.

Governors and the Board

The Council of Governors has a statutory responsibility to hold the Non-Executive Directors of the Board individually and collectively to account for the performance of the Board of Directors. It fulfils these duties in a variety of ways including attendance at all Board meetings – which includes Governor attendance at 'closed' (private) Board meetings, and observation of the Board sub-committees (Audit Committee; Performance and Quality Assurance Committee and Finance Strategy Committee). The Governors have their own sub-committee structure, supported by senior management, which includes the Council of Governors Strategy Group to oversee the agenda and work programme of the Council; and a Council of Governors Performance and Quality Assurance Committee, at which the Council seeks assurance the Trust is meeting appropriate standards of healthcare.

The above arrangements are currently under review in light of the independent review of the Trust's governance arrangements, including the Council of Governors, against NHSI's Well-led Framework. For further information regarding the Well-led review can be found in the Annual Governance Statement on page 93.

The Governors also attend service visits with Non-Executive Directors, where they are able to develop their understanding of the Trust's services, talk to staff and patients and provide feedback on their observations. In turn, the Non-Executive Directors, along with other Board members, are invited to attend every meeting of the

Council of Governors, with Non-Executive Director attendance also scheduled into local constituency meetings with the Governors and divisional teams.

Should a dispute arise between the Council of Governors and the Board of Directors, there is a dispute resolution procedure set out in Annex 6 of the Trust's constitution that shall be followed. Briefly this sees the Chair, or Deputy Chair if the dispute involves the Chair, endeavouring to achieve the earliest possible conclusion to resolve the matter through discussion with the Governors and Directors. The procedure further sets out the steps to be followed to respond to the dispute to its conclusion.

There have been five full meetings of the Council of Governors between April 2017 and March 2018. The table below shows the attendance of individual Governors at the full Council of Governors meetings during 2017/18:

Public Governors	**Attendance (Actual/Eligible)**
Ken Kendall	3/5
Derek Rowley	2/5
Clive Brown	3/5
Lucette Tucker	2/4
Ann Yates	0/1
John Starkey (Lead)	5/5
Norma Bewley	4/5
Kath Oldham	4/4
Jim McDermott	4/4
Beryl Whiteley	1/1
Karen Kelland (Deputy Lead)	4/5
Margaret Stoneman	0/4
Mohammed Sarwar	2/5
Ryan Cowan	2/4
Paul Carter	5/5
Brian Wild	5/5
Mary Foden	5/5
Graham Davies	0/2
Wendy Hartley	2/5
Stephen Moss	3/5
Joyce Howarth	4/5
John Reddy	3/5
Martin Stevenson	0/5
Irving Normie	1/5
Lorraine Chipeta	0/1
Judy Williams	0/1
Jeanette Scott	2/5
Staff Governors	**Attendance (Actual/Eligible)**
Caroline Poole	4/4
Charlotte Williams	0/0
Julia Nicholson	4/4
Lynzi Shepherd	2/2
Richard Cliff	3/3
Richard Valle-Jones	4/5
Jan Trainor	2/5
Sara Handley	1/4

Liz McCoy	4/5
Appointed Governors	**Attendance (Actual/Eligible)**
Lisa Featherstone	1/5
Charlotte Booth	1/5
Cllr Peter Joinson	4/5
Graham Foulkes	0/5
Cllr Eddie Moores	0/5
Cllr June Somekh	3/5
Cllr Jackie Lane	2/5
Cllr Michael Young	2/3
Cllr Dylan Butt	2/2

Appointment and Remuneration Committee

Chaired by the Trust Chair, this Committee is responsible for appointing Non-Executive Directors, setting the remuneration and terms and conditions of, and evaluating the performance of, the Non-Executive Directors. The Committee has met six times during the period 1 April 2017 to 31 March 2018 and the table below shows the attendance of the individual governors:

Public Governors	**Attendance (Actual/Eligible)**
Ken Kendall	4/6
Derek Rowley	1/6
Clive Brown	4/6
Lucette Tucker	2/5
Ann Yates	0/1
John Starkey (Lead)	6/6
Norma Bewley	4/6
Kath Oldham	3/5
Jim McDermott	2/5
Beryl Whiteley	0/1
Karen Kelland (Deputy Lead)	2/6
Margaret Stoneman	0/5
Mohammed Sarwar	0/6
Ryan Cowan	1/5
Paul Carter	5/6
Brian Wild	3/6
Mary Foden	4/6
Graham Davies	0/1
Wendy Hartley	2/6
Stephen Moss	1/6
Joyce Howarth	6/6
John Reddy	1/6
Martin Stevenson	1/6
Irving Normie	1/6
Lorraine Chipeta	0/1
Judy Williams	0/1
Jeanette Scott	1/6
Staff Governors	**Attendance (Actual/Eligible)**
Caroline Poole	3/5
Charlotte Williams	0/0

Julia Nicholson	2/5
Lynzi Shepherd	2/2
Richard Cliff	3/5
Richard Valle-Jones	1/6
Jan Trainor	1/6
Sara Handley	2/5
Liz McCoy	0/6
Appointed Governors	**Attendance (Actual / Eligible)**
Lisa Featherstone	1/6
Charlotte Booth	0/6
Cllr Peter Joinson	1/6
Graham Foulkes	0/6
Cllr Eddie Moores	0/6
Cllr June Somekh	1/6
Cllr Jackie Lane	0/6
Cllr Michael Young	1/4
Cllr Dylan Butt	0/2

During 2017/18, the Council of Governors Appointment and Remuneration Committee ensured appropriate oversight and made recommendations to the full Council in relation to:

- The Chairman's annual appraisal
- The Chairman's and Non-Executive Directors' remuneration
- Appointment of a new Chair (Evelyn Asante-Mensah)
- Reappointment of Non-Executive Directors (Sandra Jowett and Joan Beresford)
- Appointment of new Non-Executive Directors (Julia Sutton-McGough, Daniel Benjamin and John Scampion)
- Reviewed and updated Terms of Reference

In April 2017, the Appointment and Remuneration Committee approved the establishment of a task and finish group to progress the arrangement of recruiting a new Chair, following the end of the term of office for the previous Chair, John Schofield. This group comprised of the Senior Independent Director, the Trust Secretary, the Workforce and OD Governance Manager and seven Governors.

To ensure independence and objectivity in the recruitment process, an external recruitment agency – the NHS Leadership Academy - was appointed, to manage the process from an external perspective. The task and finish group approved the candidate pack, advert and job description.

A series of assessment and interview panels were held in September 2017, which comprised a majority of Governors and the final selection was made. The Appointment and Remuneration Committee met on 29 September 2017 and agreed to formally recommend the appointment of Evelyn Asante-Mensah as the new Chair with effect from 1 November 2017 for a term of three years, and this was in turn approved by the Council of Governors on 29 September 2017.

In July 2017, interviews were held to fill the two Non-Executive Director vacancies left by Antony Berry and Paula Ormandy. The Appointment and Remuneration Committee met on 18 July 2017 and agreed to recommend the appointments of Julia Sutton-McGough and Daniel Benjamin from 1 September 2017 and 4 September

2017 respectively for terms of three years; and this was in turn approved by the Council of Governors on 2 August 2017.

Following an agreed process, which comprised an automatic entitlement for Non-Executive Director re-appointment based on a number of agreed criteria, the Appointment and Remuneration Committee recommended to the Council of Governors the re-appointment of Joan Beresford as Non-Executive Director for a second term of three years with effect from 1 November 2017. This recommendation was approved by the Council of Governors on 2 August 2017. The Appointment and Remuneration Committee also recommended to the Council of Governors the re-appointment of Sandra Jowett as Non-Executive Director for a second term of three years with effect from 1 December 2017. This recommendation was approved by the Council of Governors on 1 November 2017.

Following the resignation of Ian Bevan as Non-Executive Director as of 16 November 2017, the Committee delegated authority to the Trust Secretary and the Workforce and OD Governance Manager to oversee the recruitment and interview process for a new Non-Executive Director. A stakeholder assessment panel and formal interview was held in February 2018, which comprised a Governor majority. The Appointment and Remuneration Committee met on 13 February 2018 and agreed to recommend the appointment of John Scampion as Non-Executive Director/Audit Committee Chair; and this was in turn approved by the Council of Governors on 13 February 2018.

External Auditor

In January 2018, the External Auditor Review Group met to consider a report from the Audit Committee detailing its assessment of the quality and value of the work by Grant Thornton since their appointment as the Trust's External Auditors by the Council of Governorsin 2015. This report set out the process by which the Audit Committee evaluated the performance of Grant Thornton, along with the results, available options and recommendations.

In considering the Audit Committee's conclusions, the External Audit Review Group resolved to recommend to the Council of Governors the re-appointment Grant Thornton as the Trust's External Auditor for a period of two years from 1 June 2018; and this was in turn approved by the Council of Governors on 13 February 2018.

Governor Development

The Board of Directors has a duty to ensure that Governors are equipped with the skills and knowledge they need to discharge their duties appropriately and, working closely with the Governors, the Trust Secretary develops and manages an ongoing induction and training programme that is shaped to ensure the Governors gain a clear and meaningful understanding of their statutory powers and duties, along with the structure of the Trust and range of services it provides.

The new cohort of Governors elected from 1 July 2017 were officially introduced to the Trust at a welcome session where they met the Board of Directors and their fellow Governors, and were given an overview of how their induction to the Trust would be facilitated over the coming weeks. Two induction workshops were held for the new Governors during their first months with the organisation, to which invitations were also extended to any existing Governors wishing to refresh their understanding of the Trust, the range of services provided and the role of the Governor in Pennine Care.

The Governors have been kept informed of the action plan arising from inspections of the Care Quality Commission; receiving a joint Board of Directors and Council of Governors development session on 6 December 2017. At this session, the Council also received updates from the Executive Directors on the NHSI Enforcement Undertakings, independent well-led review undertaken by Deloitte and a review of the Trust's Strategy.

Throughout the course of the year the Trust has continued to run regular development sessions for all our Governors on a wide range of subjects, including:

- Annual Report and Annual Accounts
- Quality Accounts
- Audit Committee Annual Report
- Role of the Non-Executive Director within Pennine Care
- Trust Constitution
- Friends and Family Test
- Financial Plan
- Trust Business Plan
- Programme Management Office
- Health Informatics Strategy
- Role of the Freedom to Speak up Guardian
- Manchester Resilience Hub

Our Governors have represented their local communities at Local Constituency Meetings; and in a range of meetings and events.

Nominated Lead Governor

The process for nominating a Lead Governor was established in September 2011, following a consultation exercise involving all elected and appointed Governors. As a result, it was agreed to run an election to select a Lead and Deputy Lead Governor who would have a specific role to play in liaising with NHS Improvement in 'specific circumstances'. The consultation also determined that the role of Lead Governor should be restricted to elected Public Governors and time-limited to 12 months, after which time the positions would be opened up to a further election process. It was also determined that those Governors who had previously held the position of Lead or Deputy Lead Governor should be eligible to stand for re-election to these roles if they so wished. Although not formally required as part of this role, it was agreed that the Lead and Deputy Lead would also undertake additional duties such as chairing the closed Governors' meetings that are held in advance of each full Council of Governors meeting.

During the reporting period 1 April 2017 to 31 March 2018 the Lead Governor was John Starkey, and the Deputy Lead Governor was Clive Brown (up to 30 September 2017) / Karen Kelland from (1 October 2018).

These arrangements are currently under review in light of the recommendations from the independent Well-Led Review.

Membership

Membership of the Trust gives staff, patients, partners and the public a real stake in the Trust and the organisation has been set the challenge of transforming itself into an outward facing, locally owned organisation, which can deliver better services to its communities as a result.

Membership is free and provides individuals with the opportunity to:

- Become actively involved in the work of the Trust and shape future plans
- Get a better understanding of mental health services, substance misuse services and community health services
- Help reinforce the Trust's vision to provide high quality health and social care that improves an individual's opportunity for social inclusion and recovery
- Elect Governors
- Stand for election as a Governor
- Make sure that their views and those of their communities are heard
- Receive information about the Trust and how it is performing.

There are now almost 22,600 members of the Trust, approximately 16,582 of whom are public members living, in the main, in the local areas receiving services from Pennine Care. The remainder of our membership comprises our staff across all disciplines and services, and across all geographical areas served by the organisation.

Membership Eligibility

Public

Members of the public, aged 16 and above and residing in one of the identified public constituencies are eligible to become members of Pennine Care NHS Foundation Trust. At the end of March 2018, there were seven public constituency areas, as listed below:

- Bury
- Heywood, Middleton & Rochdale
- Oldham
- Stockport
- Tameside & Glossop
- Trafford
- Rest of England

Staff

To maximise staff involvement in the organisation, staff automatically become members of the Foundation Trust, with the possibility of 'opting out' if they so wish. Membership is open to all permanent members of staff and any fixed-term staff who have been in post for 12 months or more. Members of staff who do not meet the criteria for staff membership may join the public constituency, where eligible.

The staff constituency comprises five classes, as follows:

- Allied Health Professionals
- Corporate and Support
- Medical and Dental
- Nursing
- Social Care

Further information on how to become a member of the Foundation Trust may be obtained from the Trust website at www.penninecare.nhs.uk or alternatively from:

Membership Office
Pennine Care NHS Trust
Trust HQ
225 Old Street
Ashton-under-Lyne
Lancashire
OL6 7SR

Telephone: 0161 716 3374

Additionally members wishing to contact Governors or Directors of the Trust are asked to do so via the Membership Office in the first instance, as detailed above.

Membership and Engagement

During 2017/18, the Trust recruited 246 new public members, whilst 212 left. The Trust continues to work on more meaningful engagement with members rather than aim for mass recruitment; whilst Governors in each borough continue to look at different ways of engaging with members in their Local Constituency Meetings and report to the full Council of Governors on a quarterly basis.

Over the course of the year, the Council of Governors has monitored the composition of the membership base and has recruited members who wished to be more actively engaged with the work of the Trust. As at 31 March 2018, the breakdown of members by public constituency was as follows:

Constituency	Number of members
Bury	2,275
Heywood, Middleton and Rochdale	2,881
Oldham	2,549
Stockport	2,469
Tameside and Glossop	3,042
Trafford	1,521
Rest of England:	1,845
Total	**16,582**

The Trust strives to engage meaningfully with its membership across the whole of the Trust footprint and participates in a range of events in order to link with existing and potential new members. The Trust continued with its series of public engagement events to reach into the communities, which aimed to promote the Governor role, health and wellbeing messages, signpost to services and link to partner and third sector organisations. The Trust has addressed concerns raised by members and offered appropriate responses to them.

The membership team places ongoing importance on promoting the role of Governor throughout the year – this has included internal forums such as the Trust's Corporate Welcome and Team Leader Programme to highlight the benefits of being a Staff Governor; along with presenting to external groups and meeting with members interested in the role of Public Governor.

The membership team continues to work collaboratively with various departments to increase recruitment and engagement with members of the public and staff; for example, Patient Experience, Involvement, Volunteering, Organisational Development and Communications. There has been a shift towards more digital

forms of engagement, providing the benefits of technological advancements and social media, whilst at the same time attempting to reduce costs. An animation was produced to promote membership and governor role electronically; this has been distributed widely and is available to view on the 'Get Involved' section of the Trust's website.

The membership team, often supported by our Governors, has arranged and attended various health-related events across the Trust footprint, including those run by local user and carer groups, Healthwatch organisations, third sector, charity and community groups. The Stockport "Big Conversation" Mental Health Event was repeated on world mental health day 10 October 2017 and, with approximately 150 people in attendance, proved to be very popular with local members and partner organisations.

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, while 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 risks relating to the achievement of the Trust's policies, aims and objectives, Pennine Care NHS Foundation Trust to evaluate the likelihood and impact of those risks being realised and, to manage them efficiently, effectively and economically.

The system of internal control has been in place within Pennine Care NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Trust's Risk Management Policy outlines the risk management process that is endorsed by the Board. The policy provides a clear, structured and systematic approach to managing risk and ensuring risk assessment is an integral part of clinical, organisation and financial processes. We are currently undertaking a review of how we present the assessed risks in the Risk Register and Board Assurance Framework, along with a refresh of the Board Governance architecture.

We provide staff with training to ensure they have the necessary knowledge and skills to work safely and minimise risks at all levels. The Trust promotes and encourages staff at all levels to assess risk and escalate their concerns via the agreed processes, recognising the need to promote a culture of reporting risks.

The Executive Team promote the assessment of risk in all areas of the organisation, with Executive portfolios covering all required areas. The Executive Director of Service Development and Sustainability has been identified as the Senior Information Risk Officer (SIRO) and oversees risks relating to information governance, raising relevant issues directly with the Board.

The Divisional Business Units are responsible for the operational management of risks. The Executive Director of Operations and his team of Managing Directors have an agreed escalation process to ensure that, wherever necessary, risks are referred to the relevant senior team. Effective management of risks is part of core business within services.

Risk management features as an agenda item with the Executive Team, with the Risk Register receiving review and scrutiny on a monthly basis.

Staff employed within the Trust receive mandatory training and role specific training, in line with policy and targets, ranging from basic risk awareness to more specific risk training to support clinical care delivery e.g. STORM training. Compliance is monitored both internally and externally. The suite of training courses ensures staff are able to identify, assess, report and escalate areas of concern/risk relating to service delivery, finance, information governance and clinical activities.

The Risk and Control Framework

Effective risk management requires the participation, commitment and collaboration from all staff. Risks are identifiable and assessed at local or central support level, to identify any threats and to ensure that adequate controls are in place to attempt to reduce/mitigate any potential consequence of the risk.

Risks can be escalated to a Corporate level if:

- Cannot be controlled at present level
- Likely to impact on the areas of the Trust
- Concerns a specific Performance Improvement Notice

Once accepted onto the Corporate Risk Register the Executive Team reviewed regularly, at least on a monthly basis.

The risk management approach is informed by inspection processes as the Care Quality Commission, Infection Prevention and Control, Health and Safety, Alerts, Audits – self-assessments by teams, and external peer reviews.

Risks are also assessed in response to Serious Untoward Incidents, complaints investigations and any external reviews.

Staff are trained in and familiar with the policy and the scoring system used, which provides consistency. The matrix looks at the likelihood of an occurrence and the impact of it. The risks are grouped into:

- High (15-25)
- Moderate (8-12)
- Low (4-6)
- Very low (1-3)

New risks are recorded onto the Ulysses system by the Divisional Business Units or central support staff. Then system allows information to be extracted in many ways for example Service Level, Divisional Level, Trust wide.

Reports are reviewed and scrutinised at both Divisional Business Unit and Trust wide Governance Forums. The Trust is undertaking a review of its Governance architecture currently, in line with the well-led review recently conducted. This includes committee structures, terms of reference and work plans, and processes for assurance and escalation. As part of the review, the Trust Board are undertaking a piece of work to agree current risk appetite. Board Development session held recently is to be followed with another facilitated sessions to support the Board to establish its risk appetite.

The Trust has a Performance, Quality and Assurance cycle that runs through the year. Each Divisional Business Unit presents on a quarterly basis their data/metrics

with supporting narrative regarding service delivery, performance, contractual, finance, workforce, quality and any risks.

This internal process involved a panel reviewing the Units data and narrative. The panel includes Trust Board members. This approach includes compliance with any Care Quality Commission (CQC) actions, and regulatory requirements. The actions generated from the CQC inspections are monitored both locally and centrally. Our action plan is supported by bi-monthly infographic documents. Recently the Trust has undertaken two workshops to establish both compliance and shared learning from the points highlighted by the CQC. The Trust is fully compliant with CQC registration.

Where a data risk is identified the risk is assessed as part of the Trust's information risk management framework, and in conjunction with the relevant Officers from the Information Governance and Health Informatics team, a risk assessment completed. The outcome of the risk assessment determines whether the risk is entered onto the Trust risk register, either at department, locality or corporate level. Details of data risk are discussed at the weekly meeting with the Trust Senior Information Risk Owner (SIRO), monthly at the Information Governance Managers Meeting, and bi-monthly at the Trust Information Governance Assurance Group, which has representation from each of the divisional business units, and key corporate departments. Data risk is identified via completion and analysis of the Trust information asset and data flow registers, via project/programme work streams or via the reporting of incidents or near miss on the Trust incident reporting system.

Current risks:

- Quality of Care: current risks relate to work being undertaken to improve safety and quality of services. These may have generated from inspections, self-assessments or clinical challenges. The safer staffing work underpins many of these risks, including recruitment issues. Negotiations continue with our Commissioners to establish a shared solution for the gap in safer staffing, and the challenges with Mixed Sex Accommodation.
- Finance and use of resources: the CQC action plan and safer staffing work demonstrates that not all risks can be resolved by the Trust in isolation, and that a partnership process and additional investment is required to meet regulatory and contractual compliance.
- Operational performance: several risks have been identified and assessed and subsequently escalated to Corporate level from operational services, including pharmacy, recruitment challenges, waiting time standards and team capacity issues.
- Estates: the Trust identifies and escalates risks that cannot be resolved at local level, these include estate related e.g. premises not fit for purpose due to team numbers increasing, risks associated with locking devices on our inpatient units or fire related risks.

The organisation widely promotes identification and reporting of incidents. Staff are trained in and familiar with the Ulysses system. On average we have 1150 incidents per month.

Patient safety incidents are uploaded to the National Reporting and Learning System (NRLS) by the risk team. The latest report published by NRLS shows the Trust in a

positive position, sitting in the middle of the table benchmarking against other similar organisations.

The Trust was deemed to be in breach of its Licence by NHS Improvement and, as a result, the Trust received an enforcement undertaking in relation to two areas of concern:

i. The Trust was forecasting a deficit of £6.6m for 2017/18 and it was likely that distress funding would be required in 2018/19.

ii. The Trust had received an overall CQC rating of "requires improvement".

There was an overall need for a joint exercise with the Trusts commissioners to develop services offer within the resource envelope available.

The Trust has applied for, and been accepted on, the NHSI "Moving to Good" programme for 2018/19 which commences in June 2018.

A number of specific actions were required to be completed by the 31 March 2018.

i. Clear policy on investment appraisal

ii. Revised financial forecast for 2017/18

iii. Detailed plan submission 2018/19

iv. High level medium to long term (3-5 years) financial recovery plan, demonstrating how the Trust can return to financial stability.

All of the above actions have been completed to NHSI's satisfaction.

The Trust has developed an Organisational Development Framework, agreed by the Board in March 2018. A 'Well Led' Review was commissioned and has been undertaken by independent auditors, and the recommendations from this review, that included feedback from partners and stakeholders across the system, are included in the OD development plan. The plan builds on other activities undertaken by the Trust such as the "Go Engage" programme and includes a structured diagnostic exercise to be completed early in 2018/19 utilising the NHSI Culture and Leadership model. This work will inform a detailed action plan to address any gaps that will be managed by the Trust Board.

By 31 March 2019 the Trust is required to complete a comprehensive review of its services (in collaboration with its commissioners) to determine whether they are sustainable in their current form. Following the service review the Trust will develop a medium to long term financial recovery plan to demonstrate how it can establish a sustainable business model by April 2021.

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

Governance

Internally the Trust has a robust assurance reporting process involving our divisional business units, Executive Directors, Board Sub-Committees and the Board itself in relation to core standards, contractual requirements and business plan objectives. Linked to this, the Trust Board Assurance Framework informs the Board of the overall effectiveness of key controls that seek to mitigate or manage principle risks. It also provides the Board with assurance regarding achievement of the Trust's objectives.

Following the resignation of the former Chief Executive in February 2017, a number of interim leadership arrangements were introduced pending the appointment of a new Chief Executive. A robust and independent process to recruit a new Chief Executive commenced in January 2017, led by GatenbySanderson. In May 2017, the Board Appointment and Remuneration Committee approved the appointment of Claire Molloy as Chief Executive, subject to approval by the Council of Governors. The Council of Governors approved Ms Molloy's appointment on 16 May 2017.

The Board commissioned Deloitte LLP to conduct an independent review of the Trust's governance arrangements against NHSI's Well-led Framework. The final report was issued in February 2018 with the associated action plan to address the recommendations arising from the review approved by Board in March 2018.

As required under the NHS Foundation Trust Condition 4(8) (b), the Board of Directors reviews the validity of its corporate governance statement on an annual basis by reviewing evidence and information ahead of formal approval which enables the Board to consider when support of a statement cannot be made.

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 Legislation

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

Carbon Reduction

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adapation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

We have robust arrangements in place for setting objectives and monitoring progress against them both strategically and on an annual basis.

The Board ensures that the financial strategy is affordable; savings plans are reviewed in detail and priorities for reinvestment are agreed. Corporate objectives filter down through the organisation into individual objectives; performance against objectives is monitored through a number of channels:

- Approval of annual budget by the Board of Directors prior to the commencement of the financial year
- Monthly reporting to the Board on key performance indicators that include finance, governance, activity and workforce and organisational development targets Supplemented by monthly meetings of the Performance and Finance Sub Committee which provides a more in-depth review.

- Monthly performance reports to the divisions and heads of corporate services including finance, governance, activity and workforce and organisational development targets
- Approval of the internal audit annual plan by the Audit Committee and regular review of progress against the plan by the committee throughout the year
- Quarterly reporting to NHS Improvement and compliance with the terms of authorisation

We monitor our performance against the standards required by the Care Quality Commission and we are fully registered with no conditions.

Where improvement work has been deemed necessary, this is completed according to plans signed off appropriately by the Board.

In addition to the Annual Plan submission the Trust has developed a 5 year high level long term financial model (LTFM) outlining a framework to return the Trust to a sustainable financial platform over a 3 year period. Further work will take place during 2018/19 to have a detailed, co-produced and deliverable LTFM in place by 31 March 2019.

Information governance

Responsibility for information governance throughout the Trust is delegated from the Board to the Medical Director, who is also our Caldicott guardian, and to the Director of Service Development and Sustainability, who is our Senior Information Risk Owner (SIRO).

There is an Information Governance Assurance Group that supports and drives the broader information governance agenda to provide the Board with the assurance that effective information governance best practice mechanisms are in place within the organisation.

This includes monitoring compliance with the national Information Governance Assurance Framework e.g. the IG Toolkit. The Assurance Group is supported operationally by the Information Governance Managers' Meeting.

The Caldicott guardian and the SIRO are both members and rotating Chairperson of the Assurance Group, and ensure that issues arising from the group are escalated to the appropriate committees or the Board.

The Trust has self-assessed against the Information Governance Toolkit, which assesses annual performance against and compliance with Department of Health information governance policies and standards. For the V14.1 submission for 2017/18 at 31 March the Trust declared a compliance of 71%, a slight increase in compliance against the 2016/17 assessment. However, despite being compliant against 44 of the 45 criteria, the Trust did not achieve the 95% training compliance, and therefore declared non-compliance against the Toolkit submission. The Trust has developed an improvement plan for 2018/19.

The Trusts information governance compliance is reviewed by our internal audit provider, who has provided significant assurance with only minor improvements that there is a sound system of control in place.

During 2017/18, the Trust has been embedding the new and revised information risk management framework, rolling out the revised data security assurance mandatory training, and a new Record Keeping mandatory training module, and are heavy involved in supporting the health and social care communities for the footprint

covered by the Trust with the development and implementation of new integrated care working systems and processes.

The Trust is also currently working through its readiness programme for the arrival of the new European General Data Protection Regulations (GDPR) from 25 May 2018.

All Information incidents are reviewed and managed by the Information Governance Department. Incidents are recorded and graded in accordance with the Health and Social Care Information Centre's (now known as NHS Digital) *"Checklist Guidance for Reporting, Managing and Investigating Governance and Cyber Security Serious Incidents Requiring Investigation."*

As part of the Trusts open reporting culture, any learning from incidents is shared throughout the organisation.

Incidents classified as 'Serious Incidents Requiring Investigation' (SIRI) severity level two are those that are classed as a data breach as defined in the Data Protection Act 1998.

Appendix 1, documents the Trust SIRIs for 2017/18, which has shown a decrease from the previous reporting period

During 2016/17, the Trust took part in a consensual audit performed by the Information Commissioner's Office (ICO) to review our data protection compliance processes. Recommendations from the ICO have been implemented, or are in the process of being implemented. In February 2018 the ICO informed the Trust that they were satisfied with the actions taken by the Trust and the audit was closed with no further ICO involvement required.

In February 2017, the Trust was issued with an Undertaking by the ICO in relation to a SIRI incident. The Trust signed the Undertaking, agreeing to take all the actions required by the ICO. In January 2018, the ICO – having completed a review of the action taken by the Trust against the Undertaking – were satisfied the Trust had taken appropriate steps, and closed the Undertaking with no further ICO action required.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) regulations (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 and Boards on the form and content of annual Quality Reports which incorporates the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Quality Report provides an overview of the quality of services the Trust provided over the past 12 months and identifies the Trust's priorities for quality improvement during 2017/2018. In developing the report the Trust has engaged with staff, patients and carers, Council of Governors and Trust Board.

The Quality Account details key priorities for quality improvement as the Trust moves to 2017/18.

In preparing the Quality Report, the Directors have taken steps to satisfy themselves that:

- The content of the Quality Report meets the requirements as set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance.
- The content of the Quality Report is consistent with internal and external sources of information.
- 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 in 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, confirms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

The Performance and Quality Assurance Committee is chaired by the Medical Director and membership comprises of all members of the Board. The role of the Performance and Quality Assurance Committee is to support effective and efficient decision making at Board of Director meetings based on assurance on the operational delivery and performance of the Trust, quality and effectiveness of service provision.

The Trust has a system in place to review and update policies, all policies are ratified at the formal business Executive Directors meeting.

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, the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Account attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The system of internal control is monitored throughout the year by the Board, the Audit Committee and other groups within the organisation including internal audit.

Through reports, monitoring and regular communication, any weaknesses can be identified and addressed. No significant internal control issues have been identified and the head of internal audit has issued significant assurance opinion on the systems of internal control and financial management processes.

The effectiveness of the system of internal control has been maintained and reviewed according to a well understood process involving the Board, Audit

Committee and others. The involvement of the Board has included individual executive and non-executive directors who approve, review and monitor the Assurance Framework, risk register, and key performance indicators and receive reports from sub-committees of the Board.

The Audit Committee reviews risks and gains assurance on controls from external and internal audit and approves the annual audit programme.

If identified, significant internal control gaps would be managed, mitigated and improved using these processes.

Conclusion

During the course of 2018/19 the Trust will be conducting a series of service reviews with its comissioners which will culminate in revised service offers that can be provided within the resource envelope available.
In accordance with the enforcement undertakings by the 31 March 2019 the Trust aims to have a plan in place to achieve financial sustainability by April 2021.

Claire Molloy
Chief Executive
25 May 2018

Appendix 1

During 2017/18 there were seventeen SIRIs and details are included below. They have all been investigated and closed by the ICO with no further action required, unless indicatsed otherwise.

Summary of Serious Incidents Requiring Investigation (SIRIs), involving personal data, as reported to the Information Commissioners Office in 2017/18

	Date of incident (month/year)	**Nature of incident**	**Nature of data involved**	**Number of data subjects potentially affected**	**Notification steps**
1	April 2017	Disclosed in Error	Clinical letter containing name, address and care plan	2	Verbal apology to parent
	Further action Investigation report completed. Staff to cross check that addresses handwritten on envelopes have been copied correctly from the EPR Shared lessons learnt within team Refresh IG Training ICO closed with no further action.				
2	April 2017	Disclosed in error	Clinic and referrals sent to the wrong address	2	The guardian of the child (local authority) was made aware face-to-face by the consultant paediatrician
	Further action Investigation report completed. Review of policy and procedures concerning updating of patient records in both manual and electronic systems for both Pennine Care and local authority To ensure that staff who manage change of patient details act timely follow robust policy and protocols and be aware of the impact of delays. Review of integration policy and to promote best practice and streamline LAC service to include medical assessment as part of its own service delivery. ICO closed with no further action.				
3	May 2017	Other	Personal identifiable information sent to an unsecure e-mail address	Unknown	No notification made as there was no evidence of a confidentiality breach
	Further action Member of staff suspended HR Investigation report completed and action plan put in place. ICO closed with no further action.				

4	May 2017	Unauthorised Access/Disclosure	Member of staff accessed a member of the public's record without consent	1	Written apology provided
	Further action Privacy Officer conducted a full audit and report HR Investigation report completed and action plan put in place ICO closed with no further action.				
5	June 17	Disclosed in error	2 medical reviews collected from printer and stapled together	2	Face to face apology given at home visit
	Further action Investigation report completed. Lessons learnt shared at team meeting ICO closed with no further action.				
6	July 2017	Disclosed in error	MHA Letter sent to the wrong address containing client details and section	2	Face to face apology.
	Further action Investigation report completed. Lessons learnt shared at team meeting Admin staff advised to obtain change of address details in writing. ICO closed with no further action.				
7	Aug 2017	Lost In Transit	Confidential letter to staff member posted to the wrong house number containing staff member personal details and sensitive information	1	Verbal and written apology made
	Further action Investigation report completed. Member of staff went to collect letter, house number does not exist All sensitive mail should have a return to stamp on reverse of envelope Adhoc audits to be undertaken ICO closed with no further action.				
8	Aug 2017	Lost or stolen paperwork	Car stolen: Session notes: patient	7	Face-to-face apology made

			formulation maps, homework. Limited pid: name, dob, NHS number, telephone number		
	Further action Police informed. Initial investigation conducted Staff member made aware of safe transportation of records. Incident initially reported to ICO, upon investigation the incident was downgraded to a SIRI level 1 due to loss of limited personal identifiable data. ICO closed with no further action				
9	Oct 2017	Lost or stolen paperwork	Lever arch file lost: Containing demographic, contact and access details	< 100	Verbal apology given to all patients/next of kin/carers
	Further action Office searched. All patients contacted as a matter of urgency who have key codes. Full review of IG security measures in each sector. Locked cabinets ordered where required. Estates contacted to change key code for building Ensure all staff are compliant with IG training. ICO closed with no further action. File subsequently located in the office, no loss.				
10	Oct 2017	Disclosed in error	2 clinical letters collected from printer, stapled together and sent to one parent	2	Verbal and written apology made
	Further action Investigation report completed. Administration processes changed to ensure the workload is shared equally to ensure that staff have enough time to cross check letters before posting. Lessons learnt shared at service governance meeting ICO closed with no further action.				
11	Nov 2017	Disclosed in error	Due to a franking error an envelope containing 7 letters for children which was being sent from Child Health Oldham to Child Health	7	verbal and written apology made

			Bury was opened by Royal Mail and all 7 letters were forwarded to one family:		
	Further action Investigation report completed. Return to sender stamps to be used. Increase in awareness when using the franking machine to ensure that all letters have been franked. Sharing of the incident and recommendations across all teams ICO closed with no further action.				
12	Nov 2017	Disclosed in Error	Allegation that a member of staff has breached a service user's confidentiality by discussing circumstances with family members	1	Face to face apology/ investigation with client
	Further action HR investigation ongoing.				
13	Dec 2017	Disclosed in Error	Fax containing sensitive information sent to a local trader rather than GP: Names, dob, NHS number, family circumstances	4	Face to face apology
	Further action Investigation report completed. Fax machine switched off. Confirmed the fax machine has been switched off. Reported to Safeguarding ICO closed with no further actions				
14	Jan 2018	Disclosed in error	Mother inadvertently saw information in her child's records which was private	3	Face to face apology given to child
	Further action HR investigation ongoing ICO informed. Awaiting feedback.				

15	Feb 2018	Disclosed in error	A MH Law letter containing details of a nearest relative detained under Section 3 of the Mental Health Act was sent in error to a past address	1	
	Further action Open: Investigation report requested and in progress Reported to ICO, awaiting response/feedback.				
16	Feb 2018	Disclosed in error	Letter sent to the correct patient but containing clinical information relating to another patient	2	
	Further action Open: Investigation report requested and in progress Reported to ICO, awaiting response/feedback				
17	March 2018	Disclosed in error	Letter sent to a child's foster parent copied into the birth parent	2	Verbal apology to both sets of parents.
	Further action Open: Investigation report requested and in progress Safeguarding Team informed Reported to ICO, awaiting response/feedback				

NHS
Pennine Care
NHS Foundation Trust

QUALITY ACCOUNT

2017/18

Contents

Part One: Quality Aspirations

1.1 Welcome Statement from the Chief Executive on Quality

Welcome to our Quality Account for 2017/18. This document provides an overview of the quality of the services we provided over the past 12 months and identifies our priorities for quality improvement during the coming year. In developing the report, we have engaged with our staff, service users, governors and the Trust Board.

My first day as Chief Executive at Pennine Care NHS Foundation Trust was 11 September 2017. I have 20 years' experience in the NHS, working in a variety of roles across different settings; community and mental health care being a particular passion of mine.

In the first few weeks in my new post I found we have a very caring and committed workforce who want to do their very best for people who use our services. Despite the amount of change and challenge facing the Trust, our staff have remained committed.

The Board of Directors have recognised the need to redress the balance between demand and quality. We want to place the development of high quality, compassionate and continually improving care as our primary goal. This means that there will be no more compromise on quality.

We recognise how difficult it is to balance quality, finance and demand; therefore in response we have started to work with commissioners as we are keen to develop clear quality standards for our services.

This year, the organisation welcomed the appointment of our new Trust Chair, Evelyn Asante-Mensah, who brings a wealth of experience to further enhance our Board. The new leadership arrangements signal an important change for Pennine Care.

The Board of Directors will see a refreshed Quality Strategy in 2018/19, with a focus on Quality Improvement and ensuring we meet regulatory compliance, and strive to sustain improvements across all our services.

The Quality Account details the huge amount of work teams have undertaken to progress our quality priorities and describes how the works delivered in the Sign up to Safety Campaign have been embedded into practice as the campaign comes to a close. Safety Plans was introduced last year and in this report we are able to describe the introduction of a new standardised discharge process for people admitted with a primary risk of suicide.

Four quality improvement topics were selected last year by our four stakeholder groups and the works completed so far are reported. The Care Planning initiative has made significant progress with the development of a new approach to care planning across our Mental Health Services. The Record Keeping initiative has developed and deployed a variety of clinical forms for use in several services and there are plans to procure systems to manage a diversity of clinical paper records. The Inconsistencies in Crisis Services initiative has carried out a core fidelity review for all home treatment teams along with

identifying gaps in provision and skill mix amongst other tasks; and finally the Bed Occupancy initiative completed a scoping exercise to determine the Trust's bed management function with plans to implement an enhanced centralised bed management function in the future.

We introduce in the report, two new Quality Priorities that focus on the Trust's 'big-ticket' items; Mixed Sex Accommodation and Learning From Deaths:

- Mixed Sex Accommodation provides challenges for us to meet expectations but more importantly, to improve the safety and quality of care and promote a positive experience for those that use our services.
- The Learning From Deaths initiative will ensure we have processes for identifying, reporting, investigating and learning from deaths. It is important that we make best use of the new framework published in March 2017 by the National Quality Board and meet the expectations.

The Quality Account presents a picture of the Trust's commitment to ensuring that quality will always be central to service delivery.

To the best of my knowledge, the information in this document is accurate.

Claire Molloy
Chief Executive

1.2 Our vision and strategic goals

Part Two

2.1 Priorities for Quality Improvement

Priority One: Sign up to Safety

When Sign up to Safety launched back in 2014, NHS England aspired to bring organisations together behind a common purpose; to create the conditions for making care safer. The campaign began with just 12 organisations but over the past three years has grown to include a community of nearly 500 organisations from across the NHS and beyond.

In 2014/15 our Quality Account described how Pennine Care NHS Foundation Trust was supporting the campaign and the goal to reduce avoidable harm by 50% and save 6,000 lives nationally.

The Trust developed a safety improvement plan which set out the organisations plans for 2015 to 2018 in relation to quality and safety. This key document was presented and discussed at all levels of the organisation and focussed on four key areas; falls, discharges and transfers, avoidable pressure ulcers and omitted and delayed medications.

These key areas are now discussed individually, illustrating the progress made and what we have achieved over the third and final year as well as how we aim to sustain that improvement in future years.

Falls

Why we consider this is important

Falls and fall-related injuries are a common and serious problem for older people. Individuals aged 65 and older have the highest risk of falling, with 30% of those older than 65 and 50% of those older than 80 falling at least once a year (NICE CG161, Falls in older people: assessing risk and prevention).

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and in some cases more serious injury resulting in death. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs. (*NICE 2013*)

What we promised to do

Through the Sign Up To Safety plan we pledged a reduction in significant harm from falls of 20% by 2018. Significant harm was defined as grade 4 and 5 incidents.

What we have done so far

We have set up an Inpatient Falls Steering Group for older people's mental health and intermediate care inpatient facilities. The Inpatient Falls Group continues to meet every two months. At this group all grade 4 and 5 incidents are discussed and lessons learnt shared for members to take back to their areas; actions and minutes of the meeting are distributed across all older-person's intermediate care and in-patient units.

A Falls Prevention information leaflet has been produced for patients and carers, which outlines the Trust's commitment to minimising falls.

The Trust Falls Prevention Policy is planned for publication by 31 May 2018. A new risk assessment has been developed. All bed rails have been removed from mental health in-patient units and intermediate care facilities. A small project is being undertaken by the Inpatient Falls Group looking at practice to determine if we are using NICE QS86 appropriately.

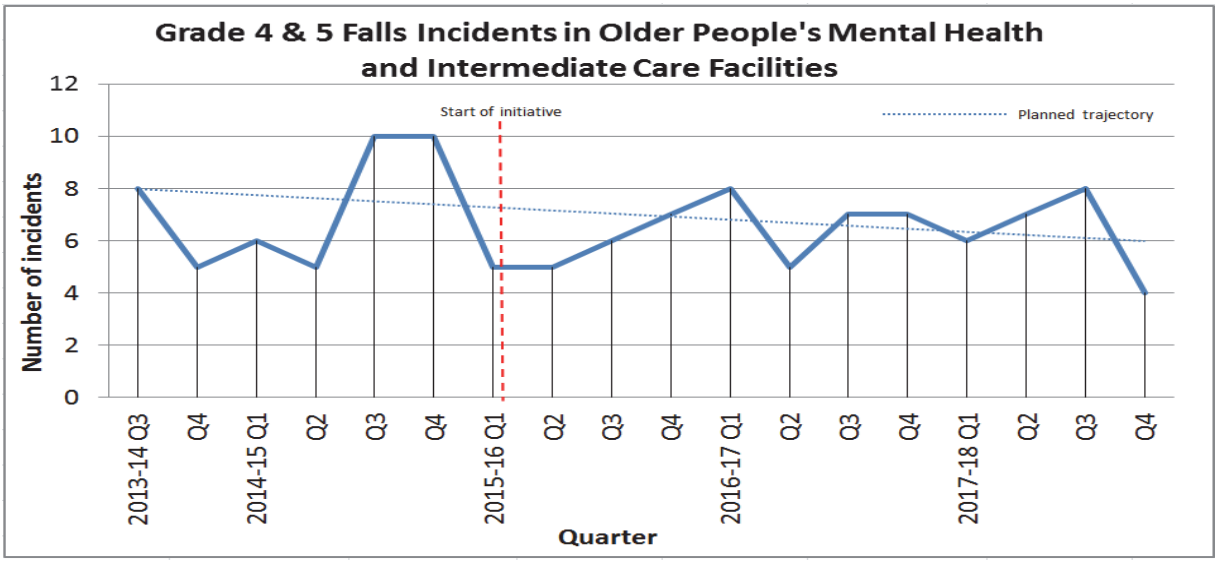
Falls prevention training sessions continue to be provided for inpatient and intermediate care staff and it is recognised that this is the single most important action within the Trust's 'factor control' with an aim of reducing serious harm. This training covers the key areas and is delivered by a physiotherapist, nurse and pharmacist and seeks to focus practitioners on prevention work for patients. The Group also discussed sending regular bank staff members on the training and agreed this would be beneficial. Feedback has been positive in relation to the training and it has been well attended.

How we tracked performance

Performance is tracked using our Safeguard system and data is available from the Patient Safety Lead for analysis by the Group. Individual wards are able to request bespoke reports as necessary.

Quarterly submissions were also presented to the Trust's Quality Group; it is expected that the new Quality Committee will undertake a review of falls interventions as part of the ending of the sign up to safety project.

Data is broken down by area, cause code and grade for discussion at the Inpatient Falls Prevention Steering Group.



How we shared lessons, good practice and improvements

The Falls Group reviews Investigation Reports that have been completed by teams to examine the lessons to be learned for the team, to assess the replicability of the situation that led to the fall occurring and to transfer both learning and good practice inter-borough.

Lessons and good practice are incorporated into the training through live case study.

The Inpatient Falls Group Chair suggested that a business case should be put forward for all wards to have bed sensors. One Mental Health in-patient unit confirmed that these are fitted on each bed and that they have proven very useful. The Group agreed that bed sensors seem standard in many units now and it would be beneficial to have them. The *Rambleguard* system seems to be the one that would be best and it was agreed to raise this with the Product Education Group and Medical Devices Committee as necessary.

The Risk Department have facilitated a work-shop with commissioner colleagues to understand and bring in line reporting and investigating requirements in relation to fractures resulting from falls and understanding actual harm to patients.

What we plan to do next

We planned to make better use of technology by procuring bed and chair alarms for all Older People Mental Health and Intermediate Care inpatient units. A training schedule for ward groups will be arranged and the effectiveness of these groups will be evaluated over the next twelve months by the In-patient Falls Group. The bed sensors have been procured for all older-person's in-patient units and their use is monitored by the Falls Group.

NICE Quality Standard (QS86 updated in January 2017) outlines the statements of compliance expected from providers and this guidance will be reviewed by the In-patient Falls Group and the new in-patient falls policy that reflects the guidance.

The Group continues to support the roll-out of training and a central budget has been agreed for this. The Group will continue to meet bi-monthly and under the terms of reference continue to work toward an overall reduction in serious harm occurring as a result of falls for patients under the care of the Trust on an In-Patient and Intermediate Care Unit at the time of the fall.

The Group has looked at innovative ways of reducing falls such as 'blue' zimmer frames, which as part of the NHS Academy of Fabulous Ideas, were trialled at another Trust. Work continues within the Group to look at procuring and testing these on our In-Patient

Units, with the aim of reducing falls in patients with cognitive impairment.

The Group has reviewed the post-falls neurological observation checklist and has made edits to this to assist the workforce to better capture a patient's physical symptoms (e.g. iris size; repetition of the observations guidelines etc.)

How we aim to sustain quality

We aim to sustain quality using the following methods:

- Disseminate new/ updated guidance through steering group
- Share good practice and learning through the steering group
- Continue programme of training for staff
- Network through attendance at future conferences, and feedback any developments and learning with the Falls Group

The Group will examine investigation reports and triangulate aspects of that report to highlight where the expected quality of falls prevention or post-vention (actions following the event) has fallen short of the policy.

How we will report further performance, lessons learned, good practice and improvements

The group discussed making information available to staff working on wards and in particular Managers of the ward; and therefore the Trust's project to use one system to access performance data relevant to individual teams (Tableau) has been used to develop a reporting page, known as a Tile. This Tile will enable all inpatient and intermediate care areas to access real time falls data and use it to monitor their own data and compare it to other areas.

Falls data continues to be reported on the monthly dashboard and in the quarterly Patient Safety reports to CCG colleagues.

The Patient Safety Lead will continue to liaise with Executive Leads for Safety to offer evidence of the work of the In-patient Falls Group and that of individual teams; the Executive Leads will share this with Board colleagues as appropriate.

Safe discharge, transfer and leave from inpatient facilities

Why we consider this is important

Safe, planned care should continue to be delivered on discharge from service to improve outcomes and better develop pathways of care across inpatients to community teams.

What we promised to do

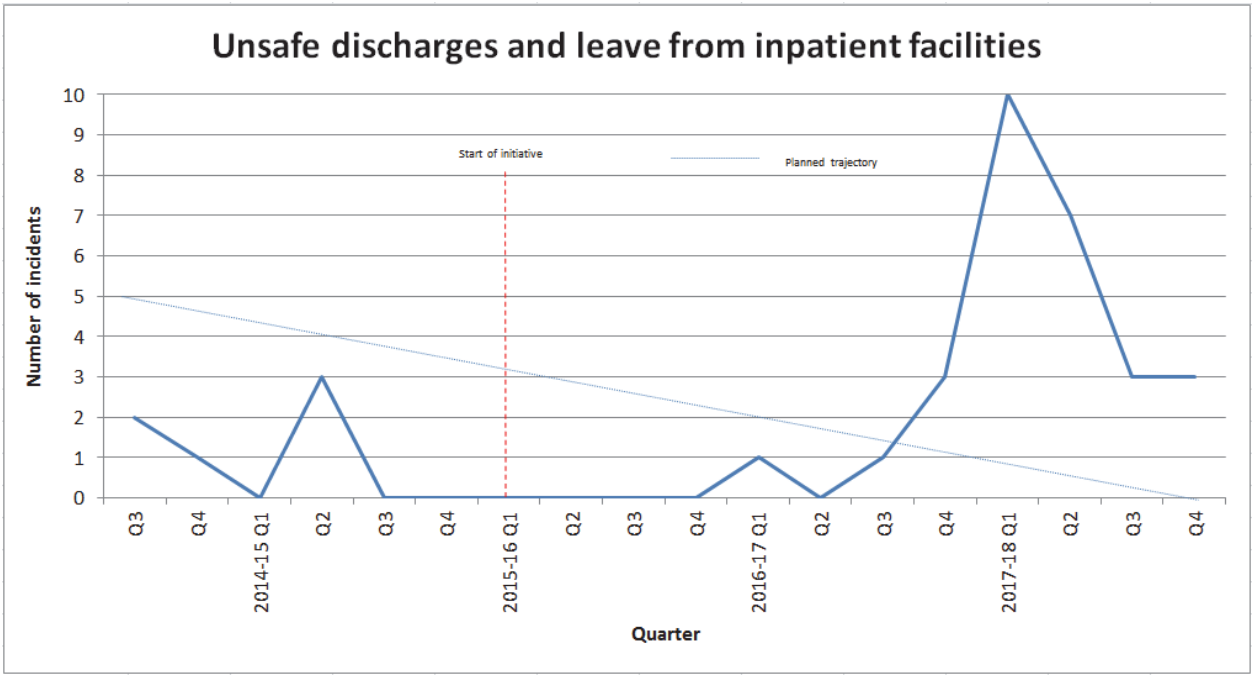
We aimed to complete benchmarking and robustly create consistent reporting mechanisms. We planned to complete clinical audits of discharges and leave standards within mental health inpatient facilities. We planned to identify themes from incidents to enable recommendations and actions for shared learning, benchmark compliance against training and analyse data relating to reported incidents.

What we have done so far

All work streams have been progressed and have been embedded in practice, and continued learning takes place if an investigation report or if an investigation occurs due

to unsafe discharges.

Safe, planned care is delivered on discharge from all inpatient service areas. This work has been delivered through the Trust wide Acute Care Forum, and the Trust wide Tier 4 meeting to develop more collaborative working and pathways for safe discharges to be implemented.



Through the lessons learned sessions, the evidence would suggest a greater awareness of incident reporting in relation to unsafe discharges/transfers of care between services within the organisation. This demonstrates an increase in incidents, but is apportioned to increased levels of awareness of the criteria which determines an 'unsafe discharge'.

The themes during 2017-18 fall into the following categories:

- Discharged to no fixed abode
- Patients unwilling to engage in follow-up services
- Quality of documentation following discharge between teams/service
- Lack of communication with partner agencies in relation to discharges
- Poor referrals for End of Life Care

How we shared lessons, good practice and improvements

Monitoring of incidents is undertaken. Lessons Learned sessions continue to be in place and unsafe discharges and case stories will continue to be shared through the 7-minute-briefings.

Processes are in place on the wards in relation to patients leaving the ward and a number of safe questions are asked.

A significant piece of work has been completed across the Trust in relation to unsafe discharges, which has introduced processes on acute wards, which are now embedded in practice.

What we plan to do next

We plan to continue to monitor through Tier 4 Community Meetings and Acute Care

Forum. Clinical audits are scheduled over the next twelve months to monitor unsafe discharges.

How we aim to sustain quality

We will continue to use the following methods to assist us to sustain quality:

- Review through Patient Safety Improvement Group (PSIG)
- Monitor through quality groups
- Monitor through lessons learned

We are confident that unsafe discharges and the learning from these incidents are embedded into practice and will in the long term be monitored via Patient Safety Improvement Group (PSIG), the Quality Group and the Lessons Learned Forum.

How we will report further performance, lessons learned, good practice and improvements

Lessons learned will continue to be shared through local Quality Governance frameworks; for example, use of the 7-minute briefings.

Reducing hospital and community acquired avoidable pressure ulcers

Why we consider this is important

Pressure ulcers, which are largely preventable, represent a major burden of sickness and reduced quality of life for patients and create significant difficulties and distress for patients, their carers and families.

Pressure ulcers add to the challenges faced by the NHS. Every year there are an estimated 110,000 newly acquired pressure ulcers developing in NHS services (NHS Safety Thermometer 2016)

Avoidable pressure ulcers are a key indicator of the quality of nursing care. Whilst it has to be accepted that it is not possible to prevent all pressure ulcers, with appropriate care, the majority can be prevented. Whilst treatment is mainly clinical, prevention is a shared responsibility. Reducing harms caused by avoidable pressure ulcers in both in-patient and community settings is a Trust quality priority.

What we promised to do

Over a three year period and by 31 March 2018, the Trust pledged to reduce harms caused by avoidable pressure ulcers in both inpatient and community settings by 50% (using the data collected in quarter one 2013/14 as the baseline).

The objective was ambitious and especially challenging in community services where staff may only be visiting a patient once or twice a week and care is carried out by family, social care agencies or carers within residential care settings.

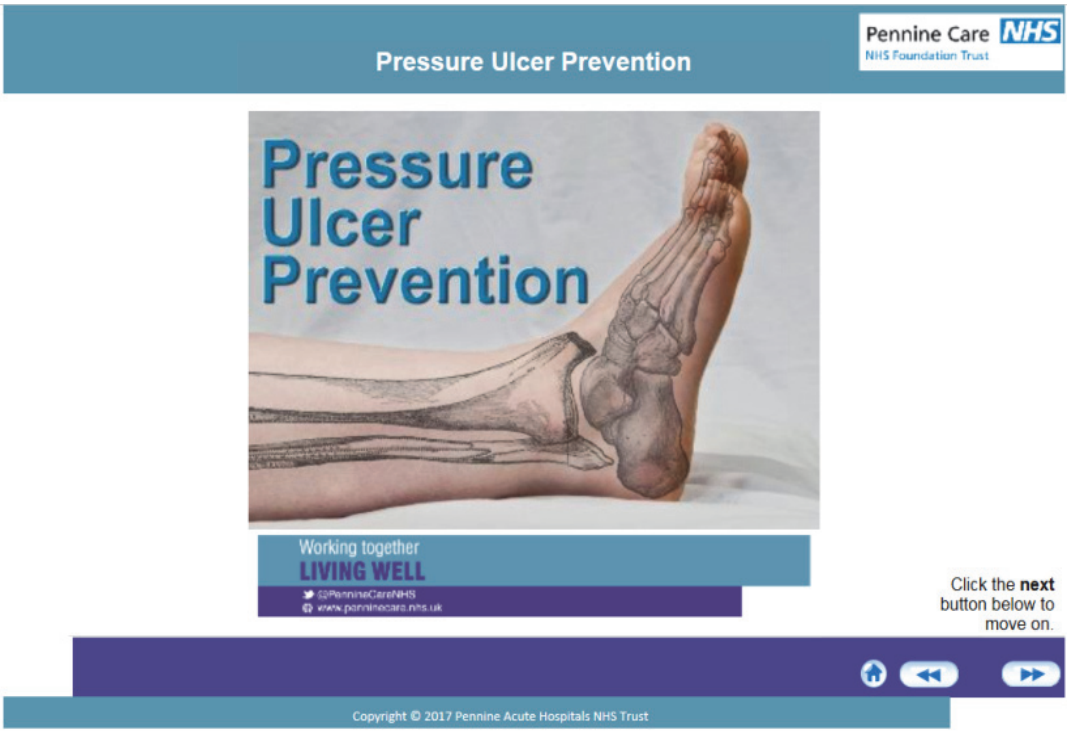
What we have done so far

Gaining an understanding of how pressure ulcers develop prepares us with the

knowledge to stop them occurring in the first place.

During quarter one 2017/18 the Pressure Ulcer Prevention e-Learning programme was launched. This programme was developed to help staff to be aware of how and why pressure ulcers occur and how to prevent them.

In quarter two a 'table top' review of Pressure Ulcers was undertaken with commissioning colleagues. The purpose of this review was to obtain assurance that when incidents occur a robust analysis which identifies learning, actions and areas for improvement is undertaken and that any learning, actions or areas for improvement are understood, shared and embedded into local services.



Key Lines of Enquiry included:

- Grading of pressure ulcers
- Reporting of pressure ulcers
- Investigation of pressure ulcers
- Learning from investigations after pressure ulcer incidents have occurred
- Mental Capacity Act and implementation in practice

The Pressure Ulcer Questionnaire and the Prevention and Management of Pressure Ulcer guidelines were reviewed and updated in quarter three 2017/18 to reflect local requirements, regional and national guidance.

The Trust also supported 'Worldwide STOP Pressure Ulcer Day' on 17 November 2017. This worldwide campaign aims to raise awareness about what Pressure Ulcers are and how to reduce harm by preventing them.

Tissue Viability nurses in Oldham invited health and social care professionals and carers to attend drop in sessions at Werneth Primary Care Centre to learn how to '*react to red skin'* and stop pressure ulcers developing. Information on a range of areas that are essential for pressure ulcer prevention was available throughout the day including demonstrations of pressure relieving equipment.

In quarter four 2017/18 a review of the 'Safeguarding Adults Protocol' *Pressure Ulcers and the interface with a Safeguarding Enquiry (*Department of Health and Social Care January 2018) was undertaken to ensure Trust guidelines and associated processes were aligned; the outcome of the review prompted further revisions to the Pressure Ulcer Questionnaire. The protocol provides a framework for health and care organisations to draw on when concerns are raised in relation to pressure ulcers that may have arisen as a result of poor practice, neglect/abuse or an act of omission.

Throughout 2017/18 the Trust has continued to be engaged with the work undertaken at a regional level in the development of a Greater Manchester Pressure Ulcer Framework. The framework has incorporated a significant amount of input from NHS Trusts; importantly it establishes links to NICE Guidance and provides opportunity to share best practice across a number of areas. The framework is not prescriptive so that individual organisations, depending on their own processes, can use and implement the recommendations as required. Key work streams include:

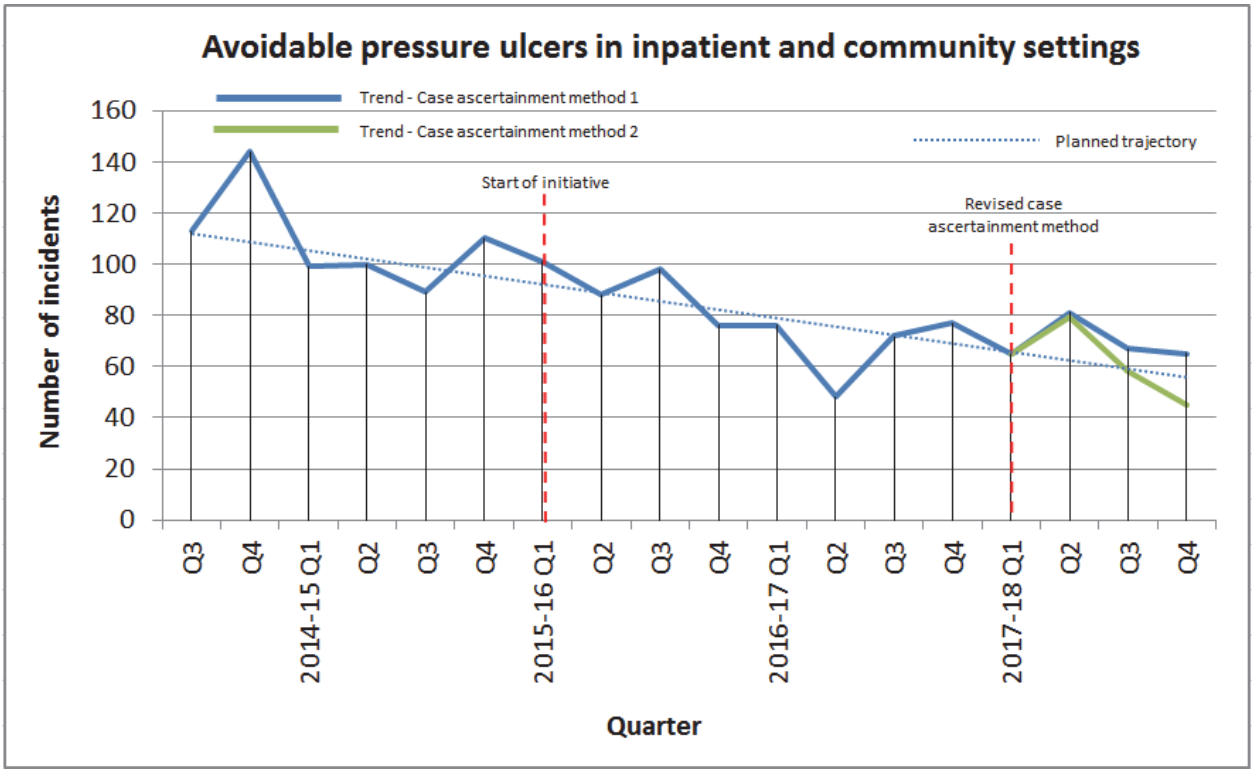
- Learning Lessons
- Leadership and Governance
- Education and Training
- Evidence Based Practice
- Standardisation

How we tracked performance

Performance against the improvement plan has been monitored via the Sign up to Safety Pressure Ulcer Sub-group. Patient safety data has been tracked through the Trust's incident reporting system, 'Safeguard'; this has allowed us to identify any themes and trends. The incidence of pressure ulcers continues to be monitored and reported on a monthly basis through local governance forums, Trust Board meetings and associated sub-groups and Committees alongside Commissioner led groups.

The chart below illustrates the progress made to date from the baseline data collected in quarter three during 2013/14. Figures reported throughout the campaign have included Pressure Ulcers which were not acquired whilst under the Trust's care – for example those reported as acquired in hospital prior to PCFT involvement (case ascertainment method 1). From quarter one 2017/18 figures that exclude these cases are now available and reported as case ascertainment method 2 – these figures are an accurate reflection of pressure ulcers developed whilst under the care of PCFT services. Both sets of data have been plotted against the original agreed trajectory.

Using case ascertainment method 2 (revised quarter one 2017/18) the Trust is able to demonstrate that we have exceeded the pledged 50% reduction and achieved a 60% decrease in avoidable pressure ulcers when measured against the quarter three 2013/14 baseline data.



How we shared lessons, good practice and improvements

Throughout the campaign, lessons learned have been reported through the Trusts established Quality Governance Forums and communicated to services. Action plans have been targeted at individuals, teams, Services, Divisional Business Units and Trust level. There is Trust wide representation at the Pressure Ulcer Sign up to Safety Sub-group and the organisation is represented at relevant regional meetings. Regular updates are also provided both within and outside of the Trust.

What we plan to do next

Reducing harms from avoidable pressure ulcers will continue to be a quality priority for the Trust. From April 2018, the Pressure Ulcer Prevention e-Learning Programme will be added to the core and essential skills (CEST) matrix for relevant staff. Performance against the target compliance and associate outcomes will be monitored and reported via the Quality Integrated Performance Report.

The prevention and management of pressure ulcers will be the focus of a Trust facilitated conference to coincide with 'Worldwide STOP Pressure Ulcer Day' on 15 November 2018.

The Trust will continue to be engaged and influence the ongoing work across Greater Manchester.

How we aim to sustain quality

Quality will be sustained by maintaining the focus on pressure ulcer prevention and management, reviewing patient safety data and sharing lessons learned. This will be supported by the addition of the Pressure Ulcer Prevention e-Learning Programme to the CEST matrix and the continued improvements to pressure ulcer reporting and investigation.

How we will report further performance, lessons learned, good practice and improvements

Performance and improvements will continue to be monitored through the Trust's quality governance forums.

Reducing omitted and delayed medications

Why we consider this is important

Doses of medicines are omitted or delayed in hospitals for a variety of reasons. Whilst many of these events may not seem serious, for some critical medicines and conditions, omissions or delays can cause harm. In 2011, the Trust declared compliance with the National Patient Safety Agency's Alert 'reducing harm from omitted and delayed medicines in hospitals' and has a list of critical medicines of which omission or delay of administration poses a risk to patient safety.

The Trust Medicines Policy (CL15) states that if a medicine is omitted then the appropriate code given on the front of the inpatient chart must be entered in to the administration box to record the reason for the omission or delay. There are ten codes to describe the various situations and some omissions or delays may be for valid clinical reasons. Failure to record the administration of a medicine or enter an omission code constitutes a medication error and must be reported via the Trust's incident reporting system (Ulysses/ Safeguard).

The following sections describe the work completed during 2017/18; the final year of a three year work stream. The primary objectives can be summarised as patient safety and safe and effective working practices.

What we promised to do

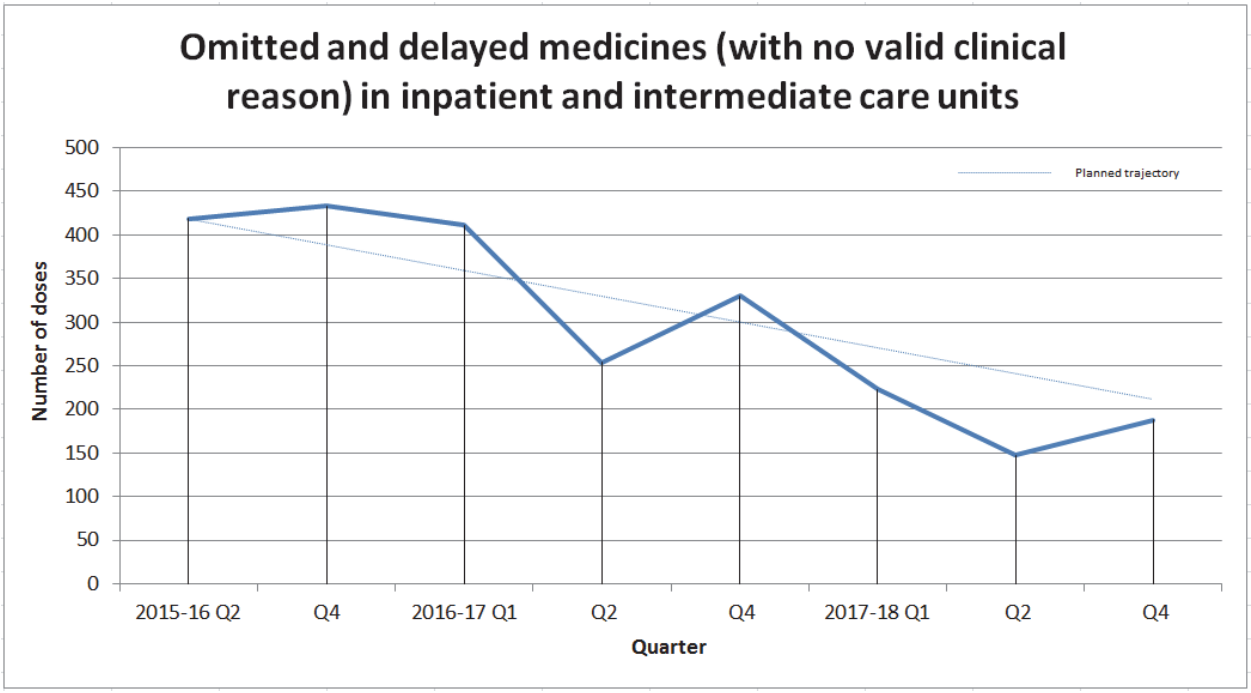
This initiative runs from 2015 to 2018 with an overall aim to reduce the number of omitted and delayed medicines (with no valid clinical reason) by 50% across inpatient and

intermediate care units.

What we have done so far and how we tracked performance

During 2017/18 three clinical audits of 'omitted and delayed medication doses across mental health inpatient and intermediate care settings' have taken place. For each clinical audit an update on progress, report and action plan have been produced and submitted to the Trust's Sign up to Safety Campaign Steering Group, the Drugs and Therapeutics Committee and the Quality Group.

The chart shows the substantial fall in the numbers of omitted and delayed medicines from across the three years. It is now possible to state that there has been a greater than 50% reduction in omitted and delayed medicine doses over the three years of the project.



How we shared lessons, good practice and improvements

The 7-minute briefing training, developed early in the programme about reducing unintended omissions and delays, continued to be delivered to inpatient nursing teams as needed.

Registered Nurses including bank and agency staff have continued to be made aware of the need to take full professional responsibility for administering medicines and avoiding omissions.

The post CQC inspection report of July 2017, relating to the re-inspection against the Key Line Of Enquiry for the domain 'Safe', identified notable improvements across mental health inpatient areas in respect of omissions, reporting omissions and the knowledge of Registered Nurses.

Quarterly 'Learning from Medication Error Incident' feedback bulletins have been written and disseminated across the Trust during 2017/18. These bulletins have contained pertinent feedback regarding omitted and delayed doses.

The need to reduce unintended omissions and delays in medication doses continued to be discussed at local Quality Governance Forums across both mental health and community based services.

The clinical audit data collection tool was further reviewed and an electronic audit tool developed and introduced.

What we plan to do next

We aim to reduce further and at least maintain the reduction in omitted doses of medication occurring in the Trust to the levels achieved during the Sign up to Safety Project. Periodic audit work will be carried out and reported through the Drugs and Therapeutics Committee and Trust Quality Governance arrangements. The Pharmacy team will continue to support inpatient services/ intermediate care units to further reduce or maintain a reduction in omitted doses and help embed any additional changes in practice needed.

How we aim to sustain quality

The following initiatives will assist to sustain quality: Training to provide all Registered Nurses with the required competencies and skills in relation to medicines administration has been ongoing and will assist to sustain quality. An e-learning module entitled 'The safe administration of medicines' is available (2 yearly refresher); 'face to face' bespoke training in response to incidents is delivered by Pharmacists; 'medicines round observation' provides support for staff involved in incidents and supported completion of a Competency Assessment Framework for the safe administration of medicines and further development and use of the 7-minute briefing for inpatient and intermediate care staff.

How we will report further performance, lessons learned, good practice and improvements

Going forward performance and improvements will continue to be monitored through the Drugs and Therapeutics Committee and the Trust Quality Governance arrangements.

Lessons learned, examples of good practice and new or innovative interventions and medication error feedback bulletins will continue to be shared.

Priority Two: Safety Plans

Last year we introduced a new work stream aligning to the suicide prevention agenda with the use of Safety plans and described the work we plan to undertake.

Safety plans have now been introduced into the Trust's risk assessment documentation for adult in-patients, Home Treatment Team (HTT) and Rapid Assessment, Interface and Discharge (RAID) Services whereby they are assessing an immediate risk of suicide. This is to ensure that no patient leaving a service does so without having recourse to a plan that indicates how they can access emergency help or support at a time of crisis.

Safety Plans

Why we consider this is important

The key driver for initiating this project was echoed through evidence from Serious Untoward Incident reports and contact with families that the quality of discharge care plans for suicidal patients could have been significantly improved. As a provider of Mental Health Services we ought to be discharging patients from our in-patient/crisis care/A&E settings with a collaborative plan to keep them as safe as possible; this is now a reality and the next challenge is to measure the quality of them.

A further driver was the recent National Confidential Inquiry into Suicides and Homicides report (Learning from 20 years of research), which outlines key aspects of improving safety for patients; one of which is reducing tick-box based risk assessments and moving towards front-facing personalised risk and care planning that is collaborative in principle and practice.

What we promise to do

The overall benefit for patients is a plan produced in collaboration with them and/or their carers that clearly identifies antecedents to feeling suicidal; how to return to a psychological place of safety using thoughts or techniques that work for them; using family and carer resources with in-patient care as part of a range of options rather than the only option; having key professionals (where appropriate) listed on the plan and when to call them; and having a clear statement about what it is that the person has identified that they want to live for; the document should also list the local crisis numbers for the Borough that the person lives and national numbers (e.g. Samaritans/Papyrus).

The benefit for carers is that they have a clear plan to support the person to have options in times of distress or anxiety. They have access to numbers to ring to ask for advice to help them provide the most appropriate response for their loved one. They are enabled to have a shared understanding of the person's antecedent triggers to feeling suicidal and what can assist the person to pull back and recover from those thoughts from becoming all-consuming.

The benefits for services are that there is a collaborative and partnership approach to risk and taking responsibility for a shared care pathway to manage that risk. There is a clear line of sight for the service to explore and assist the person to work through their Safety Plan ahead of any formal intervention such as admission to Home Treatment Team or A&E attendance.

What we have done so far

To improve performance this project is being worked into part of the Trust's Aggregated Learning initiative which has focussed on Collaborative Care Planning and Risk Assessment processes. The Safety Plan has formed an aspect of part of that overall aim to improve safety for discharging patients and to support carers.

The project aspired to develop a standardised discharge process for a person who was admitted with the primary risk of suicide to leave our care (In-Patient/ Home Treatment

Team/Rapid Assessment, Intervention & Discharge) with a Safety Plan that is co-designed with them and Pennine Care NHS Foundation Trust employees. The overall outcome is to further reduce the number of suicides within the Trust patient population and Greater Manchester footprint.

How we track performance

Activity was tracked using case-notes and discharge checklists against presenting problems on admission for patient safety incidents being scrutinised at the Patient Safety Improvement Group and through the investigation process at manager and clinical governance level. The Risk Department used the Serious Untoward Incident process of investigation to check that for any completed or attempted suicide post-admission or assessment that a Safety Plan was offered to the patient/family prior to discharge.

Progress of the implementation will be monitored by the Suicide Prevention and Self Harm (SPSH) Group at a local and Greater Manchester level and the Trust is encouraged that partner providers are also adopting the roll-out of safety plans within their services. The SPSH Group will invite key operational colleagues to speak about their experiences, obstacles and benefits of using the Safety Plans.

The path of progress against the planned trajectory will aim to see a sharp rise at roll out with communication and management support; it is expected that this will flatten as the process becomes embedded in custom and practice for the teams.

During 2017/18, the Risk Department has looked at all suspected suicides that have been reported to the Trust:

Quarter one – health records of any suspected suicide reported to the Trust where the person has been an in-patient within a month of the incident were reviewed to ensure they included a copy of the Safety Plan within the discharge pathway.

Quarter two – health records of any suspected suicide of a person as either an in-patient or under Home Treatment Team care within a month of the incident were reviewed to ensure they included a Safety Plan within the care records.

Quarter three – health records of any suspected suicide or Grade 4 incident of attempted suicide for a person who has been under the care of the in-patient team and/or Home Treatment Team were reviewed to ensure they included a Safety Plan within the care records.

Quarter four – health records of any suspected suicide or attempted suicide (Grade 4) where a person has been an in-patient, under Home Treatment Team care or assessed by RAID services within a month of the incident were reviewed to ensure they included a Safety Plan within the care records.

How we will share lessons, good practice and improvements

We will develop and present a quarterly report to the Sub-Quality committee, Mortality Review Group and to CCG colleagues through usual reporting processes. The Chair of the Suicide Prevention and Self Harm Group, or his Deputy will be responsible for reporting.

The Patient Safety Lead will be sharing learning lessons from suicides and promoting the use of safety plans during team talks, training and other site visits.

What we plan to do next

We will continue to understand how safety plans can improve patient safety for patients who experience both a chronic and acute risk of suicide. We will look at extending the

work into community mental health and early intervention team settings as separate documents to complement care plans.

How we aim to sustain quality

The patient safety improvement group will continue to critically review safety plans for patients who either undertake a serious harmful attempt to end their life or for patients whose tragic outcome is a loss of life where suicidality has been previously assessed as a risk linked to their mental illness. If a service has provided a safety plan of a quality that is deemed below the Trust standards, then this will form part of an action for the service.

The Suicide Prevention groups at a provider level and at a Greater Manchester level will keep the intervention of delivering safety plans to all suicidal patients on their agenda.

How we will report further performance, lessons learned, good practice and improvements

The Trust will use internal checks at the Patient Safety Improvement group to track performance of services' using safety plans. It will track performance with external stakeholders (Clinical Commissioning Group) for serious incidents. The Trust will use the process of 7-minute- briefings and governance learning bulletins to share good practice and lessons to be learned for services.

Priority Three: Quality Improvement Plan

Last year we introduced a new quality priority, the Quality Improvement Plan. The Quality Improvement Plan is reflected in our Quality Strategy and details emerging themes from the report published by the CQC, following its inspection of Pennine Care NHS Foundation Trust in summer 2016.

Four of the emerging themes were chosen through an innovative voting campaign by the four key stakeholder groups; patients and carers, staff, Council of Governors and the Trust Board, to be reported through the Quality Account over two years. This is year one of that reporting period.

These four workstreams are now discussed in detail, telling our reader why we consider each is important, what we aim to achieve over the project life, the progress made so far, how we are tracking performance and improvement, how we share lessons learned, good practice and improvements, and how we plan to sustain quality.

Care Planning

Why we consider this is important

The CQC inspection conducted in summer 2016 found that Pennine Care NHS Foundation Trust had breached regulations in relation to Person Centred Care and Governance, as the care planning process they found on our units and in our teams did not meet the standards expected for collaborative care planning.

As a Trust we prioritised this development as we believe involving service users in their own care and allowing choice should be at the centre of what we do.

What are the benefits of the initiative

Organisational: Regulatory compliance and assurance of best practice.

Patients and Carers: Involvement in care, choice and improved quality of care.

Staff: A user friendly tool that directs care delivery and supports/enhances recovery.

What we aimed to achieve

Last year we described our aim as to ensure that patients receive person centred care and treatment that is appropriate to them, meets their needs and reflects their preferences, ensuring systems and processes are in place and used effectively to collaboratively develop a care plan which is delivered appropriately and reviewed in a timely manner to meet the needs and preferences of the patient.

What we have achieved so far

We have made significant progress in developing a new approach to care planning across our Mental Health Services. All service lines of care were challenged with designing a fit for purpose format that considered the needs of service users and their families for the journey in Mental Health Services, their care pathway.

The staff rose to the challenge and we have new templates in the services across Young People, Adults of a Working Age and Older Adults.

The templates have been piloted and adjusted as the staff and service users provided feedback.

We received some training from Manchester Metropolitan University in 2017/18 for staff and we have incorporated the process into our clinical skills course we provide internally.

Current guidance states that the outcome of any assessment will be a care plan developed with the patient, the professional and other appropriate parties, such as family/carer. Pennine Care NHS Foundation Trust has made positive steps in the development of a template and ran training for a large number of staff; the next challenge is to embed this practice.

During 2018/19 we will agree the Trust branding for the new suite of templates, develop audit tools to test out the success of our implementation plans, continue to provide training and obtain feedback from staff and those who use our services.

What we plan to do next

The Trust Quality Committee will see this quality priority in the committee work stream. The Committee will need to be assured that effective and appropriate systems are in place to drive this quality improvement, and to be assured that the services are delivering high quality collaborative care plans.

A Trust Lead will be assigned to facilitate the second phase of this quality initiative. They will hold a series of meetings to ensure delivery of the agreed work stream.

How we track performance and improvement

A set of Key Performance Indicators linked to the initiative have been agreed and reporting arrangements use the internal Governance structures.

How we share lessons learned, good practice and improvements

An agreed communication process supports the initiative, using intranet, bulletins, blogs and other mechanisms.

How we plan to sustain quality

The Clinical Audit Programme will support this initiative, testing our compliance, learning from the findings and continually improving.

Record Keeping

Why we consider this is important

CQC inspection found that Pennine Care NHS Foundation Trust had breached regulation 17 in relation to record keeping. The Trust has identified this area for improvement via its aggregated learning workstreams.

What are the benefits of the initiative

Organisational: The Trust will meet the requirements of regulation 17.

Patients and Carers: I will be assured that everything about me is written accurately in my health record.

Staff: Timely access to detailed, up to date and accurate health records.

What we aimed to achieve

Pennine Care NHS Foundation Trust will ensure systems and processes are in place and used effectively to maintain a complete and accurate record of a patient's health, care and treatment reflecting Trust policy and professional standards.

What we have achieved so far

We have developed and deployed clinical forms for use in community children's services including Children's Community Nursing Team, Paediatric Diabetes, Paediatric Epilepsy, Paediatric Nurse Practitioners, Community Eye Service, Looked After Children enabling these teams to move away from paper records. We have deployed the Care Planning Approach and Risk assessment documents for all Mental Health Services. We have developed and deployed clinical forms for use in Healthy Young Minds Services. All of these developments allow the services to work electronically with a single record.

What we plan to do next

We intend to procure a system or systems to manage the wide diversity of clinical paper records that the Trust has, and to continue with the rollout of our electronic patient record to Community and Mental Health Services. We intend to securely share information with clinical professionals external to Pennine Care NHS Foundation Trust using the locality shared record.

How we track performance and improvement

The Health Informatics steering group governs all the projects in the health informatics programme and ensures that we have a good quality record that can be used across the Trust.

How we share lessons learned, good practice and improvements

The Health Informatics department is an active participant in our local professional group across the North West (the Informatics Skills Development Network), and we will be submitting several award nominations to their annual conference. Our Head of Information has set up a user group to share good practice and improvements, our Chief Information Officer and our Chief Clinical Information officer are active members of Greater Manchester Informatics groups.

How we aim to sustain quality

The Health Informatics clinical change team regularly complete lessons learned for all deployments which drives a continuous improvement culture. We are working closely with Manchester Metropolitan University to develop a unit to enable the scaling of good quality work linked to genuine research based outcomes.

Inconsistencies in Crisis Services

Why we consider this is important

The CQC inspection found that Pennine Care NHS Foundation Trust had breached regulation 17 due to the inconsistencies in service provision for Crisis Services in Mental Health.

What are the benefits of the initiative

Organisational: The Trust will meet the requirements of regulation 17.

Patients and Carers: I will receive quality care from skilled and up to date trained workforce.

Staff: Keep up to date with training and have a varied skill-mix within the team and have access to efficient use of systems.

What we aimed to achieve

The Trust will ensure that Crisis Services have robust systems and processes in place to enable the service to access, monitor and improve the quality and safety of the care they provide.

What we have achieved so far

- Carried out core fidelity review for all Home Treatment teams within the Trust.
- Identified gap in provision and skills mix to enable the Trust to provide a 24/7 CRHT offer in each of the boroughs.
- Updated the Home Treatment operational policy to include standardised operating procedures.
- Roll out of full Electronic Patient Record for all Home Treatment teams
- Working group established with CCG's to look at the core fidelity review

What we plan to do next

- Address inconsistencies in the current crisis provisions in collaboration with commissioners.
- Develop an integrated home treatment/safe haven model in collaboration with commissioners to move to 24/7 crisis provision.
- Develop training programme to enable staff to provide robust gatekeeping

How we track performance and improvement

- Reduce inappropriate admissions
- Reduce bed occupancy to 95%
- Effectively gate keep 100% of admission

How we will share lessons learned, good practice and improvements

Reporting arrangements are established leading to the Quality Group where accountability lies and the showcasing of quality work is celebrated.

How we will sustain quality

Evaluation will confirm what worked and what didn't and together with routine monitoring this will inform how we sustain quality across the Trust footprint.

Bed Occupancy

Why we consider this is important

The CQC inspection found Pennine Care NHS Foundation Trust had breached regulation 9 due to high bed occupancy, bed management arrangements and patients being admitted to other parts of the Trust.

What are the benefits of the initiative

Organisational: The Trust will meet the requirements of regulation 9**.**

Patients and Carers: I will have access to local bed provision when needed.

Staff: Reduction in pressure to undertake bed management duties.

What we aimed to achieve

The Trust will do everything reasonably practicable to make sure that the people who use inpatient services receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences; ensuring continuity of care is maintained by providing place based hospital care, making any reasonable adjustments when necessary and enabling patients to understand the care and treatment choices available.

What we have achieved so far

A scoping exercise has been undertaken to determine the current bed management function across the Trust to understand and address the variations in processes, capacity and procedures.

The Trust has undertaken a review of Delayed Transfers of Care (DTOC) reporting and recording to ensure a consistent and robust recording and escalation of DTOC's. Targeted work to improve DTOC performance across the Trust footprint has been completed.

We have piloted an extended bed management function in the North Division across 7 days; developed options for a centralised bed management function which encompasses discharge coordination to improve patient flow and developed a recording system to support more accurate bed states across the Trust.

Commissioning has been agreed and we have completed implementation of the chaplaincy and spiritual care service across the Trust as well as completed a review of gatekeeping processes across the Trust and a review of demand and capacity through the acute inpatient pathway to identify any unwarranted variances and significant pressure points.

We have engaged with commissioners around developing alternatives to admissions and deployment of transformation funds to support improved patient flow and reduced bed occupancy rates.

What we plan to do next

- Implement enhanced centralised bed management function across the Trust
- Utilise PARIS/Tableau to support the reporting of live bed states
- Identify suitable alternatives to admission
- Implement robust gatekeeping across the Trust
- Consider a review broader operational procedures and processes such as board rounds, bed management meetings and bed management protocol

How we track performance and improvement

- Reduce usage of private beds
- Continue to reduce DTOC's
- Work towards 95% occupancy rate
- 100% of admissions are robustly gatekept

How we will share lessons learned, good practice and improvements

Reporting arrangements are established leading to the Quality Group where accountability lies and the showcasing of quality work is celebrated.

How we will sustain quality

Evaluation will confirm what worked and what didn't and together with routine monitoring this will inform how we sustain quality across the Trust footprint.

Introducing our new Quality Priorities for 2018/19

We'd like to now introduce two new quality priorities, mixed sex accommodation and learning from deaths. These topics are 'big-tickets' for Pennine Care NHS Foundation Trust and planning a focussed project on each topic will support and enable us achieve regulatory and national requirements.

Each topic is now introduced individually, telling our reader why we consider these are important, what we aim to achieve, what we plan to do, how we plan to do them, how we will track performance and improvement, how we will share lessons learned, good practice and improvements and how we will sustain quality over the next three years.

Mixed Sex Accommodation

Why we consider this is important

National guidance from 2011/2012 (The NHS Operating Framework) requires all providers of NHS Health Care to confirm they were compliant with the National definition "to eliminate mixed sex accommodation except where it is in the overall best interest of the patients or reflects patients choice".

Department of Health (2011) have provided clarity in their guidance relating to breaches.

The CQC inspections held in 2016 and 2017 within Pennine Care NHS Foundation Trust highlighted areas of non-compliance with the guidance and therefore deemed to be regulatory breaches.

What we aim to achieve

We aim to achieve an improved Quality and Safe Care and to be regulatory compliant.

What are the benefits of the initiative

- Improved Quality Care
- Improved safety on our inpatient units
- Maintaining the privacy and dignity of those who require in patient care
- Regulatory compliance.

How we plan to do it

We have had an external diagnostic which resulted in a report being produced to guide the Trust. The Board of Directors have approved a paper on mixed sex accommodation (MSA). During 2018 we are going to undertake public consultations, a further staff consultation and a full programme of works to re-design our Estates to meet regulatory compliance and improve the safety and quality of care on our inpatient units.

How we will track performance, share lessons learned, good practice and improvements

We report all breaches using the National Unify System. We will share lessons learned from the programme of works and the implementation plan as we roll out the work across the Trust.

How we will sustain quality

- By being regulatory compliance, and reporting any breaches
- Including in the Trusts Quality and Safety inspections

Learning from Deaths

Why we consider this is important

National guidance was published in March 2017; Learning from Deaths, A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care. Pennine Care NHS Foundation Trust have to meet the National expectations and deliver on the actions.

What we aim to achieve

We aim to be compliant with the following:

- Publish a Learning from Deaths policy
- Have processes in place for responding to the death of an individual with a learning disability, severe mental illness, an infant or child death, a still birth or maternal death
- Establish an evidence based approach to undertaking case record reviews
- Identify the categories and selection of deaths in scope for case records review and how the organisation will determine whether a full investigation is needed
- Identify how the Trust engages with bereaved families and carers
- Establish process for supporting staff affected by the death of patients

What are the benefits of the initiative

The Trust will be compliant with National Guidance and meet expectations in relation to Learning from Deaths.

The Board will receive reports and data informing them of the numbers of deaths plus an assurance of the model of structured judgement reviews introduced across the Trust. The reporting arrangement will identify any themes and issues arising from the reviewing process, including examples of good practice and how the findings from the reviews and investigations have been used to inform and support quality improvement activity and any

actions taken; plus progress on implementation.

How we plan to do it

We will have:

- Reporting arrangements
- An identified Non-Executive Director
- Process for selection and reviewing
- Training for Staff
- A score will be given to the care received

How we will track performance

- Production of a Board report as per guidance.
- Adherence to an internal escalation process (via an agreed algorithm).
- Production of reports to the Quality Committee.

How we will share lessons learned, good practice and improvements

- By sharing the reports through the governance architecture
- Ward to Board approach
- Using the algorithm for escalation
- We can identify any areas for managerial action / sharing of lessons.

How we will sustain quality

- By the reporting processes/reports
- Sharing evaluations/outcomes
- Routine monitoring.

2.2 Statements of Assurance from the Board

This section describes activity during 2017/18 on specific workstreams and uses the exact form of each statement specified by the Quality Accounts Regulations.

During 2017/18 Pennine Care NHS Foundation Trust provided and/or sub contracted 4 relevant health services:

- Mental Health Services
- Community Services
- Specialist Services
- Dental Services

Pennine Care NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 4 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Pennine Care NHS Foundation Trust for 2017/18.

Participation in National Clinical Audits and Confidential Enquiries

During 2017/18 eight national clinical audits and four national confidential enquiries covered relevant health services that Pennine Care NHS Foundation Trust provides.

During that period Pennine Care NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

Assessment of side effects of depot LA antipsychotic medication (POMH-UK Topic 17a)

National clinical audit of psychosis

National chronic obstructive pulmonary disease (COPD) audit programme: pulmonary rehabilitation

National diabetes footcare audit

National audit of intermediate care

Prescribing valproate for bipolar disorder (POMH-UK Topic 15b)

Sentinel stroke national audit programme (SSNAP)

UK Parkinson's audit

Learning disability mortality review programme (LeDeR programme)

Maternal, newborn and infant clinical outcome review programme (MBRRACE-UK)

Child health clinical outcome review programme – young people's mental health

National confidential inquiry into suicide and homicide

The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust participated in during 2017/18 are as follows:

Assessment of side effects of depot and LA antipsychotic medication (POMH-UK Topic 17a)

National clinical audit of psychosis

National chronic obstructive pulmonary disease (COPD) audit programme: pulmonary rehabilitation

National diabetes footcare audit

National audit of intermediate care

Prescribing valproate for bipolar disorder (POMH-UK Topic 15b)

Sentinel stroke national audit programme (SSNAP)

UK Parkinson's audit
Learning disability mortality review programme (LeDeR programme)
Maternal, newborn and infant clinical outcome review programme (MBRRACE-UK)
Child health clinical outcome review programme: young people's mental health
National confidential inquiry into suicide and homicide

The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Title of Audit		Percentage of cases submitted
Assessment of side effects of depot and LA antipsychotic medication (POMH-UK Topic 17a)		100%
National clinical audit of psychosis		100%
National chronic obstructive pulmonary disease (COPD) audit programme – pulmonary rehabilitation		100%
National diabetes footcare audit		100%
National audit of intermediate care		100%
Prescribing valproate for bipolar disorder (POMH –UK Topic 15b)		100%
Sentinel stroke national audit programme (SSNAP)		61%
UK Parkinson's audit		100%
Learning disability mortality review programme (LeDeR programme)		100%
Maternal, newborn and infant clinical outcome review programme (MBRRACE-UK)		100%
Child health clinical outcome review programme – young people's mental health		100%
National confidential inquiry into suicide and homicide	Homicide	100%
	Suicide	62%

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

National Diabetes Footcare audit (NDFA)

Key Findings

- 45.5% of patients met their NICE recommended treatment target for HbA1c.
- 71 (48.6%) of the ulcer episodes were self-presented to the specialist foot care service, compared to 27.1% nationally. Patients who self-present are seen and assessed on presentation.
- 75 (51.4%) of the ulcer episodes were referred to the specialist foot care service by other professionals; of which 41.8% were seen by the foot care service within 2 weeks, 8.9% were not seen by the foot care service after two weeks following the first healthcare contact for their ulcer, and 0.7% were seen more than two months following first contact.
- 118 (80.8%) ulcer episodes seen, had a 12 week outcome recorded; of which 39.8% were reported to be alive and ulcer free at 12 weeks.

Key Actions

- The Clinical Effectiveness and Quality Improvement Team is working with services to review local outputs and develop action plans to address any areas for improvement.
- Some of the services have introduced drop-in clinics that enables patients to self-present, and for initial assessment to be carried out at that presentation.

National Audit of Inpatient Falls

Key Findings (nationally)

- 72% of patients could reach for an appropriate mobility aid such as a walking aid
- 81% of patients had a call bell in sight and were able to reach this
- 40% of patients were assessed for the presence or absence of delirium
- 67% had a continence care plan if this was required
- 46% of patients did have a vision assessment
- 48% had an assessment for medications, to identify drugs which could increase the risk of falls
- 19% had their blood pressure measured when lying and standing

Key Actions

- This national audit was carried out in acute hospital settings only; however, the key findings may be used for local learning.
- The Clinical Effectiveness and Quality Improvement Team plan to meet with the Trust's Falls Group to review the results and discuss monitoring against the national standards within relevant Trust inpatient settings.

National COPD – Pulmonary Rehabilitation Audit

Key Findings (nationally)

Local hospital level reports are with NHS England and pending before they are disseminated to each Trust.

- Nearly 30% of patients who were assessed for Pulmonary Rehabilitation, had at least one hospital admission within 180 days, and of those patients, 27% had completed Pulmonary Rehabilitation programme.

- The mean number of days spent in hospital within 180 days post Pulmonary Rehabilitation was just over 7 days, with 4.8% of patients completing Pulmonary Rehabilitation programme.
- Overall mortality following assessment for Pulmonary Rehabilitation was 0.7% within 90 days of assessment and 1.6% within 180 days of assessment.
- 8% of patients who died within 90 days and 19% who died within 180 days had completed Pulmonary rehabilitation programme.

Key Actions

- The Clinical Effectiveness and Quality Improvement Team plan to meet with the Trafford Team who provide the service to review the results at both national and local level, and discuss any actions for improvement.

National Audit of Intermediate Care

Key Findings

- 100% of referrals have an assessment done by the Crisis response service, with an average response time from referral to assessment of less than two hours.
- Over 60% of service users are discharged to their own home from the Crisis response service and less than 20% are discharge to acute care.
- The average waiting time from referral to commencement of Intermediate Care services is under two days, and less than 10% of patients were waiting more than two days.
- The average length of stay was less than 27 days.
- On average, 65% of patients were discharged from Intermediate care service to their own home and under 20% were discharge to an acute hospital.

Key Actions

- The Clinical Effectiveness and Quality Improvement Team plan to meet with Intermediate Care Teams to review both national and local level results and discuss actions for improvement.

Assessment of side effects of depot and LA antipsychotic medication (POMH-UK Topic 17a)

Key Findings

- 85% of patients care plans were accessible in clinical health records, and 94% of patients were involved in their care planning.
- Patients relapse ‘signature’ signs and symptoms were recorded in 92% of cases.
- 95% of patients care plans included a crisis plan.
- 84% of patients had a clinical plan, which addressed follow up action for if a patient failed to attend an appointment for administration of the depot injection or declined.
- 93% of patients had an annual review of their medication, which included a therapeutic response.
- 100% cases included a clear rationale for initiating a depot/long acting antipsychotic medication.
- 85% of cases recorded the side effects of the medication.

Key Actions

- The results were presented and discussed at the Drugs and Therapeutic Committee in March 2018.
- The Clinical Effectiveness and Quality Improvement Team are scheduled to meet with participating teams to review the results at both national and local level and discuss actions to be implemented.

The reports of 23 local clinical audits were reviewed by the provider in 2017/18 and Pennine Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Titles of Clinical Audits reviewed in 2017/18 by driver for the audit

Driver	Clinical Audit Title
Trust Concern	Antimicrobial prescribing (community residential) Q1, Q2, Q3
	Antimicrobial prescribing (non-medical prescribers) Q1, Q2, Q3,
	Antimicrobial prescribing (dental) Q2
	Antimicrobial prescribing (inpatients) Q2
	Omitted and delayed medicines doses Q1, Q2, Q3
	Individual Care Planning for End of Life Patients Q2
	Safe and Secure Handling of Medicines (Mental Health) Q3
	Safe and Secure Handling of Medicines (Community Services) Q3
	Healthy Young Minds Safeguarding Documentation Q2
	Therapeutic Activity Risk Assessments Q2
	Female Genital Mutilation (Q1)
Trust Policy	Infection prevention and control (IP&C), hand hygiene Q1, Q2, Q3
	Infection prevention and control (IP&C) environmental inpatient areas Q2
	Infection prevention and control (IP&C) environmental community buildings Q3
	Infection prevention and control (IP&C), dental environmental Q2

Key Actions of Clinical Audits reviewed in 2017/18

Clinical Audit Title	Key Actions	Alignment to Quality Governance
Individualised Care Planning (ICP) for End of Life Patients Q2	The results of this clinical audit have been shared with the Trust Lead for end of life care, nursing, palliative and end of life care teams, to ensure Individualised Care Plans are in place for all patients nearing the end of their life. Local protocols are in place to ensure that where multi-disciplinary discussions cannot take place, there is an alternative means of providing relevant information about the patient and this is documented in the individualised care plan. Further work has been undertaken to ensure the use of the end of life protocol and the 5 Priorities of Care are embedded into everyday practice.	Clinical effectiveness Patient safety Patient experience
Female Genital Mutilation (FGM) Q1	The results of this clinical audit have been shared with the Trust Lead for Safeguarding, and the safeguarding teams, and local summary reports have been provided so any improvements can be implemented at team level. Local protocols are in place for handling cases where FGM is alleged or known about, or where a potential risk of FGM is identified. Work is underway to ensure services providing clinical care to children and young people are aware of the duty and action to be taken whenever there is any identified known risk to the child or young person.	Clinical Effectiveness Patient safety
Healthy Young Minds Safeguarding documentation audit	The results of this clinical audit have been shared with the Service Manager and an action plan has been developed to address areas for improvement. Work is underway to ensure general documentation is improved, and that relevant assessments and care plans are in place. This includes ensuring all cases with safeguarding issues have an up to date chronology of significant events, and that practitioners access 3-monthly supervision. A further cycle of clinical audit is planned to measure improvements.	Clinical effectiveness Patient safety

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Pennine Care NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee is 524.

During 2017/18, Pennine Care NHS Foundation Trust was involved in the conduct of 44 clinical research studies.

Participation in clinical research demonstrates Pennine Care NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay informed of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

For 2017/18 Pennine Care NHS Foundation Trust is anticipating they will achieve all clinical research targets (700) set by the National Institute of Health Research (NIHR). Results against these targets are published on both the Trust and the NIHR website, which shows our commitment to transparency and desire to improve patient outcomes and experiences across the NHS.

Our engagement with clinical research also demonstrates Pennine Care NHS Foundation Trust's dedication to continue to promote a culture of continuous quality improvement and encourages our staff to innovate and adopt 'best practice' in order to deliver the highest standard of care to our patients.

Improving service delivery and patient care through high quality research and innovation

"The NHS aspires to the highest standards of excellence and professionalism…through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population." (NHS Constitution).

Pennine Care NHS Foundation Trust is committed to supporting all elements of the constitution and to contributing to the local and national evidence-base to drive service improvements and support the delivery of patient-centred, whole person care.

The aim of the Research and Innovation Department is to promote evidence-based practice through supporting clinical research within the Trust. Improving patient care through high quality research and innovation is central to everything we do, enabling us to deliver better care and more advanced treatments and services to our patients and communities.

We believe technology, research and innovation are critical to helping support changes within the NHS and wider health and social care economy. As such, the Trust is keen to embark on innovative projects, including those incorporating technology to improve the quality of service provision, whilst generating an evidence-base of what works.

During 2017/18 Research and Innovation Department have approved 21 new studies, 17 of which are National Institute for Health Research (NIHR) portfolio.

New Portfolio Projects 2017/18

BN29552 A Study of Crenezumab in Patients with Prodromal to Mild Alzheimer's Disease (CREAD)

This Phase III, multi-centre, randomised, double-blind, placebo-controlled, parallel-group study aims to evaluate the safety and efficacy of crenezumab in patients with prodromal to mild AD.

Clinical Effectiveness

Examining the experiences of resilience to suicidal thoughts and behaviours in people with psychosis

Schizophrenia is a severe mental health problem which affects approximately 800,000 people worldwide (World Health Organisation, 2016). Having a schizophrenia diagnosis increases the risk of premature mortality (Walker, McGee, & Druss, 2015). The estimated lifetime risk of suicide is between 5% and 10% in people diagnosed with schizophrenia spectrum disorders (Hor & Taylor, 2010). This shows that suicide in this diagnostic group represents a major health concern.

Clinical Effectiveness
Patient Experience

A psychological intervention for suicide applied to patients with psychosis: the CARMS trial (Cognitive AppRoaches to coMbatting Suicidality

Around 6% of people with psychosis die by suicide. Many more think about suicide. Talking therapies for people with psychosis focus on symptoms which does not stop people from having suicidal thoughts or making suicide attempts. We have designed a psychological therapy (called CARMS, Cognitive AppRoaches to coMbatting Suicidality) which specifically targets suicidal thoughts and behaviours. Many people with psychosis feel isolated, unable to cope emotionally, nor able to deal with their problems. Feelings of being hopeless, trapped and defeated may ensue which are precursors to suicidality. CARMS aims to help people find ways of dealing with these sorts of negative perceptions and feelings.

Patient safety
Clinical Effectiveness
Patient Experience

Pragmatic RAndomised controlled trial of a Trauma-Focused Guided Self Help Programme versus InDividual Trauma-Focused Cognitive Behavioural Therapy for Post-Traumatic Stress Disorder (RAPID)

The aim of this research is to determine if trauma-focused guided self-help (GSH) using a web-based programme provides a faster and cheaper treatment for post-traumatic stress disorder (PTSD) than trauma-focused cognitive behavioural therapy (TFCBT), whilst being equally effective.

Clinical Effectiveness
Patient Experience

Children and Adolescents with Parental Mental illness: Measuring Vocal Brain Development in Babies of Mothers who have Experienced Serious Mental Illness (CAPRI-Voc)

Improving the social and academic outcomes of children and adolescents with parental mental illness is an urgent political and public health concern for the UK and EU. Parental mental illness is believed to affect cohesion of the family, yet social care and healthcare interventions are poorly targeted and

Patient Safety
Patient Experience
Clinical Effectiveness

non-specific. This study forms part of a wider European Research Council funded programme CAPRI ' Children and Adolescents with PaRental mental Illness: Understanding the 'who and 'how' of targeting interventions. CAPRI's aims are to provide the missing evidence needed so health and social care services can understand better 'who' to target and 'how' to target so we can prevent long term problems for these children.

Developing an activity pacing framework for the management of chronic pain/fatigue

Activity pacing is frequently advised in the management of chronic pain/fatigue, including chronic low back pain, chronic widespread pain/fibromyalgia and chronic fatigue syndrome/myalgic encephalomyelitis, (CFS/ME). However, there is no agreed definition of activity pacing and it is instructed in various ways by different healthcare professionals. For some, pacing involves adapting/limiting activities (for example, breaking down tasks/using rest breaks); whilst for others, pacing involves having consistent activity levels/gradually increasing activities. Furthermore, previous research has found pacing to be associated with both improved symptoms (decreased fatigue, anxiety and depression) and worsened symptoms (increased pain and disability). Due to the frequent referral of patients with chronic pain/fatigue (20% of those frequently attending healthcare appointments/investigations), together with the cost of chronic pain/fatigue on patients quality of life and financial burden on the NHS/society.

Clinical Effectiveness

Aphasia Therapeutic Alliance Measure (ATAM): Development and preliminary psychometric evaluation

The development and psychometric evaluation of a therapeutic alliance measure for language (aphasia) rehabilitation post stroke. Aphasia is an acquired language deficit, usually caused by stroke, which can affect talking, understanding, writing and reading to varying degrees. The role of the speech and language therapist is not only to assess and treat the linguistic deficit but also to assist in providing help in the necessary adjustment to aphasia. Therapeutic alliance is a term used, commonly in the field of psychotherapy, to describe both the collaborative bond between the client and therapist and the agreement negotiated between the client and therapist in relation to the goals and purpose of therapy. Although therapeutic alliance is an established concept in the field of psychotherapy, research to date, has yet to explore this concept in aphasia rehabilitation. This concept is in fact highly relevant to aphasia rehabilitation since establishment of a common purpose and a shared commitment to engage in therapeutic activities, within a context of mutual respect, empathy and warmth are essential ingredients in purposeful aphasia rehabilitation. The development of a robust measure of therapeutic alliance will enable us to determine whether therapeutic alliance is a variable component of language (aphasia) therapy and will enable us to tap into this, as yet unexplored phenomenon in stroke rehabilitation, to ensure that patients reach their full potential.

Clinical Effectiveness

Investigating healthy brain ageing with multiple biomarkers in cognitively normal advanced elderly participants

Dementing diseases of old age are an expanding problem in developed countries as their populations get older. Advanced age (over 65 years) is associated with many changes that occur within the human brain. These brain

Clinical effectiveness

changes can often affect an individual's ability to function normally in daily life, an individual's behaviour and thinking can be seriously altered. Although dementia is on the increase, many people reach old age and still have normal everyday function, including behaviour and thinking ability. These people, as "successful" brain agers, can potentially provide vital clues about what is required to sustain brain health into the eighth, ninth and tenth decades of life.

The Angela Project: Improving diagnosis and post-diagnostic support for younger people living with dementia and their family members/ supporters

Dementia in younger people affects up to 42,000 people in the UK. The first signs of young onset dementia often differ from later onset. The average time to diagnosis is over 4 years, as clinicians often do not immediately recognise the symptoms. In addition, in some areas of the country specialist treatment, care and support is limited or not available. This 3 year project aims to develop guidelines that will improve the diagnosis of dementia in younger people and improve the experience of receiving a diagnosis. It will gather good examples of post-diagnostic age-appropriate and condition-appropriate support that will help spread good practice more evenly across the UK. To develop the best practice guidelines, two panels will be asked for their opinions. One will be a panel of leading experts and the other will consist of younger people with dementia and their family members/supporters. Examples of clinical case notes of young people with Dementia (YPD) diagnosed in the last year will be compared to a 'quality indicators' template. This will show where there are gaps in the way younger people with dementia are currently diagnosed.

Clinical Effectiveness

Patient Experience

The effect of cannabis use on brain function in early psychosis

Schizophrenia is a devastating psychotic disorder, accounting for over 1% of the worldwide burden of disability. Use of cannabis makes both developing and relapsing into psychotic illness more likely. We do not quite know why this is. Psychosis is normally associated with abnormal levels of a brain chemical called dopamine. However, cannabis does not appear to cause substantial changes in the dopamine system that fully explain this. Another explanation could be related to a brain chemical called glutamate. This study will therefore investigate brain glutamate in a group of patients with psychosis who use cannabis and compare them to patients who do not and another group of healthy volunteers. We will undertake a brain scan known as magnetic resonance spectroscopy for this. We will also compare groups to see if their brains function differently inside the scanner. This is because cannabis use is known to affect brain function and regions of the brain associated with memory and emotions. This may guide us in future as to what type of treatments might work in patients with psychosis who continue to use cannabis. This is particularly important as the current treatments do not work well in this group.

Clinical Effectiveness

Developing personalised psychological intervention for patients with non-affective psychosis: patient preferences for psychological help.

Clinical Effectiveness

Multiple factors contribute to the occurrence of psychotic experiences, and these can also vary in the individual instance. Hence we have been developing and evaluating modular (psychological) interventions for each major contributory cause that can then be combined for a patient in a personalised treatment. The aims of the current study are to determine: the proportion of patients that may benefit from each of the treatment modules developed by our clinical psychology research group (i.e. in what proportion a key contributory cause is present) the degree of patient preference for each of the modular interventions and patient preferences for future module development. A cross sectional, self-report questionnaire study will be conducted in collaboration with NIHR Clinical Research Networks. Questionnaires will be completed by up to 1000 patients with diagnoses of non-affective psychosis (i.e. schizophrenia, schizo-affective disorder, delusional disorder, psychosis not otherwise specified) attending psychiatric services. The patients will complete brief questionnaires assessing: worry, sleep problems, self-esteem, avoidance, reasoning style, paranoid thinking, voice hearing, psychological well-being and preferences for treatment targets. There has been no similar study. It will inform services of the types of targeted psychological interventions that should be provided for patients with non-affective psychosis.

DemPower: Living Life and Doing Things Together couple-management guide for couples living at home in which one partner has dementia- A Feasibility Study

This project is one of eight work programmes within the Neighbourhoods and Dementia study developed in response to the former Prime Ministers Challenge on Dementia (DH, 2012) and is led by a team in Sweden. The key focus of the study is to develop a Living Life and doing things together couple-management guide for couples where one partner has a diagnosis of dementia and to assess the acceptability of the guide. Colleagues in Sweden compiled a paper based manual by looking at what had been done before and by analysing interview data to identify common issues raised by couples. This was later translated into English. Discussions with couples in England identified a need to make the guide more user friendly; e.g. using visual material rather than just written. This study is adapting the guide into an app form and we are aiming to determine how much support couples need to engage with this app and whether they make use of it in their day-to-day lives. If there is support for the app, a future study will assess whether it is superior to usual care.

Clinical Effectiveness

Patient Experience

A pragmatic, multi-centre, double-blind, placebo controlled randomised trial to assess the safety, clinical and cost effectiveness of mirtazapine or carbamazepine in patients with Alzheimer's Disease (AD) and agitated behaviours

This study is designed to establish the best treatment for the management of agitation and/or aggression in people with dementia. Agitation and aggression

Clinical Effectiveness

are common in people who suffer from dementia and can cause problems for the patients, families and the people caring for them. There are medicines available to treat agitation, but it is not clear which treatments work best for people with dementia. This study will compare 2 medicines with a placebo (a tablet designed to look like a medicine but that has no active component) to see if either are suitable for treating agitation in dementia.

Partners At Care Transitions (PACT): Understanding excellence at care transitions from a secondary care perspective.

The transition of care as patients move from hospital to home can be a risky period, particularly for older patients with complex needs. Previous research exploring health professionals perceptions of care transitions has predominantly taken a deficit based approach. It has focused on understanding what goes wrong in order to provide guidance on potential solutions. In contrast, this study takes an asset based approach which involves identifying healthcare teams that provide exceptional care during transitions and undertaking qualitative work to understand what staff do differently to succeed.

Patient Safety
Clinical Effectiveness

Evaluating the impact of minimum unit pricing in Scotland on harmful drinkers

What impact does the introduction of Minimum Unit Pricing (MUP) for alcohol in Scotland have on people who are alcohol dependent? The research examines the effects of MUP on how much and what people drink, how much they spend, whether or not they seek treatment, and any other effects of MUP on their lives.

Patient Experience

Active Assistance for Psychological Therapy 2.0 (Actissist 2.0): Digital Intervention for Co- producing care in psychosis.

Onset of psychosis typically occurs in early adulthood. Up to 80% relapse within 5-years, resulting in unscheduled acute care and adverse effects on psychosocial development. The main treatment for psychosis is medication and psychosocial interventions. Currently, the delivery of psychosocial interventions for psychosis by scheduled appointment can result in psychosis relapse indicators either being missed or treated too late. The NHS has a clear digital agenda for addressing mental health challenges, aiming to fully harness the information technology revolution. Smartphones offer an unprecedented opportunity to drive improvements in treatment quality, efficiency, cost, access and facilitate self-management. Supported by the Medical Research Council (MRC), Developmental Pathway Funding Scheme (DPFS) funding (MR/L005301/1), we have developed a user-informed, personalised, smartphone app, Actissist, that delivers a theory-driven psychological intervention over 12 weeks that is unconstrained by traditional service settings. We have shown that patients complete the intervention swiftly in the course of daily life over 12-weeks and that this technology is feasible, safe and acceptable. The primary aim of the current proposal,

Clinical Effectiveness
Patient Experience

Actissist 2.0, is to refine the software and conduct an efficacy study in an psychosis group. The randomized controlled trial will be carried out over 36 months and involves an initial period of app refinement, followed by an evaluation of the efficacy and usability of the app in a randomized controlled trial.

Improving Access to Psychological Therapy on Acute Mental Health Wards: Intervention Development Study

Between 2014 and 2015, 103,840 people with severe mental illness spent time as inpatients because they were at risk of harming themselves or others. NICE recommend psychological therapies, like cognitive behaviour therapy, for severe mental illness. People want psychological therapies on inpatient wards, but they are not offered them. Mental Health Trusts prioritise spending money for therapy on outpatient services and ward staff often think that inpatients are too unwell to benefit from talking-based treatments like psychological therapy, so don't refer them. Therapy needs to be delivered differently in inpatient settings compared to the community due to the different nature of the setting and patients' mental states. The overall aim of this programme of work is to increase access to psychological therapy on mental health inpatient wards. The first part of this project will work alongside service users and other stakeholders, such as inpatient staff to adapt existing psychological therapy for inpatient settings.

Clinical Effectiveness
Patient Experience

The CQUIN Framework

A proportion of Pennine Care NHS Foundation Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Pennine Care 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 2017/18 and for the following 12 month period are available electronically at **https://www.penninecare.nhs.uk/quality/performance/** and from Pennine Care NHS Foundation Trust, 225 Old Street, Ashton-Under-Lyne, OL6 7SR.

In 2017/18, £5,088,903 was conditional upon achieving a range of national, regional and local goals. The associated payment in 2016/17 was £4,846,254.

The following information provides a list of the national, regional and local CQUINs the Trust have worked towards.

CQUIN	Contract	CQUIN Title
National	Mental Health	NHS Staff Health & Well-being a) Staff Health & Wellbeing b) Healthy Food for NHS staff, visitors and patients c) Improving uptake of Flu Vaccinations for frontline staff
National	Mental Health	Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI): a) Cardio Metabolic Assessment and treatment for Patients with Psychosis b) Collaboration with Primary Care clinicians
National	Mental Health	Improving services for people with mental health needs who present to A&E
National	Mental Health	Child & Adolescent Mental Health Services (CAMHS)/ Healthy Young Minds (HYM)
National	Mental Health	Preventing ill health by risky behaviours
Local	Mental Health	Sustainability and Transformation Plan Engagement
Local	Mental Health	Risk Reserve
Local	Mental Health	Quality Outcomes Framework
Specialist Commissioning	NHS England	Recovery Colleges
Specialist Commissioning	NHS England	Reducing restrictive practices
Specialist Commissioning	NHS England	Discharge and Resettlement
Specialist Commissioning	NHS England	CAMHS Inpatient Transitions
National	Bury Community Services	NHS Staff Health & Well-being a) Staff Health & Wellbeing c) Improving uptake of Flu Vaccinations for frontline staff
National	Bury Community Services	Improving the assessment of wounds
National	Bury Community Services	Personalised care and support planning
National	Oldham Community Services	NHS Staff Health & Well-being a) Staff Health & Wellbeing c) Improving uptake of Flu Vaccinations for frontline staff
National	Oldham Community	Improving the assessment of wounds

	Services	
		Personalised care and support planning
Local	Oldham Community Services	Pennine Care NHS Foundation Trust involvement and engagement in care and extended primary care programme
		NHS Staff Health & Well-being a) Staff Health & Wellbeing c) Improving uptake of Flu Vaccinations for frontline staff
National	HMR Community Services	Personalised care and support planning
		Podiatry – Implementation of podiatry direct
Local	HMR Community Services	Referral Booking Management Service – Implementation of a paperless referral system
		Audiology – Patient/service feedback to improve patient/service experience
National	Trafford Community Services	NHS Staff Health & Well-being a) Staff Health & Wellbeing c) Improving uptake of Flu Vaccinations for frontline staff)
		Improving the assessment of wounds
National	Trafford Community Services	Personalised care and support planning
		Preventing ill health by risky behaviours
National	Trafford Community Services	Supporting proactive and safe discharge
		Nutrition and Hydration

CQC Registration, Reviews and Investigations

Pennine Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is Registered. Pennine Care NHS Foundation Trust has the following conditions on registration; no conditions.

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

Pennine Care NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC Ratings Grid

The CQC ratings grid is illustrated on the next page.

Service	Overall rating	Safe rating	Effective rating	Caring rating	Responsive rating	Well-led rating
Cambeck Close	Good	Good	Good	Good	Outstanding	Good
Older Peoples Wards	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement
CAMHS inpatient	Outstanding	Outstanding	Good	Outstanding	Outstanding	Outstanding
Older Peoples CMHTs	Good	Good	Good	Good	Good	Good
Community LD	Good	Requires improvement	Good	Good	Good	Good
Forensic inpatient/secure wards	Good	Good	Good	Good	Good	Good
Adult CMHTs	Requires improvement	Requires improvement	Requires improvement	Good	Good	Good
Community CAMHS	Good	Good	Good	Good	Requires improvement	Good
Children's Community Services	Good	Requires improvement	Good	Good	Good	Good
Intermediate Care	Good	Good	Good	Good	Good	Good
RHSD Wards	Good	Good	Good	Good	Good	Good
Drug and Alcohol	Good	Good	Good	Good	Good	Good
Acute Wards and PICU	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Crisis Services and Health Based Places of Safety	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement
End of Life	Requires improvement	Requires improvement	Requires improvement	Not rated	Requires improvement	Requires improvement
Adult Community Services	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Pennine Care Overall	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement

Hospital Episode Statistics

Pennine Care NHS Foundation Trust did not submit records during 2017/2018 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

At the end of the 2015/16 financial year, following discussions with other Mental Health Providers, the Trust stopped submitting data to Secondary Uses Service for inclusion in the Hospital Episode Statistics. Data in Secondary Uses Service is primarily focussed on acute Trusts and acute Payment by Results and of limited relevance to Mental Health Trusts.

In addition, the inpatient and outpatient data formerly submitted to Secondary Uses Services is included, alongside a wealth of additional data, in the Mental Health Dataset.

Information Governance

Pennine Care NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 71% and was graded Red.

Whilst continuing to provide expert advice and support to the Mental Health and Community Divisions of the organisation in the areas of Information Governance; Data Protection (including Subject Access Request); Confidentiality; Freedom of Information; Information Risk; Information Risk Management; Records Management; Integrated Care; and Privacy assessments, in 2018/19 the Information Governance Department will be looking to maintain and improve on the assessment score achieved in 2017/18, in the IG Toolkit replacement – the Data Security and Protection Toolkit.

The Trust will also continue with its implementation plan for the introduction of the new European General Data Protection Regulations from 25 May 2018, and any requirements from the National Data Guardian Review and NHS Cyber Security programme.

The Information Governance function will continue to support the integration programmes both at locality level and in support of the Greater Manchester Health and Social Care Partnership. This will internally involve working closely with key areas of Information Technology; Business Planning and Procurement; Performance and Information; Human Resources and Risk Management to review processes and Information Governance, including embedding the new Information Risk Management processes throughout the Trust, and externally working with partner agencies, Commissioners and other external bodies.

Payment by Results and Clinical Coding

For the past eight years the Payment by Results (PbR) data assurance framework has provided assurance over the quality of data that underpins payments as part of PbR, promoting improvement in data quality and supporting the accuracy of payment within the NHS.

The focus of this work is to improve the quality of data which underpins payments, but the data reviewed is also of wider importance to the NHS as it is used to plan and oversee healthcare provision.

Pennine Care NHS Foundation Trust was subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary diagnosis 4%
- Secondary diagnosis (treatment coding) 9%

The sample size for the audit was 100 records out of a total of 3,027 discharges in the reporting period. The coders code from the discharge proforma or discharge summary whilst the auditors have the benefit of the full set of notes relating to the inpatient spell. This in itself identified issues with information not being available to the coders.

Pennine Care NHS Foundation Trust is not subject to Payment by Results for inpatient spells as an Acute Trust would be. The audit is held to comply with Information Governance requirements that an annual audit by an external provider is undertaken and a sample of records across our Mental Health Inpatient Services is used, including Adult Mental Illness; Old Age Psychiatry; Child and Adolescent Mental Health Services and Forensic Psychiatry. The scores above relate only to the actual audit sample and should not be extrapolated further. The audit was undertaken at the beginning of February 2018 and currently this report is in draft status only.

Data Quality

Pennine Care NHS Foundation Trust will be taking the following actions to improve data quality:

The Trust will continue to focus on improving data quality throughout its operational services by providing interactive tools such as the Data Quality Management Tool (DQMT) to help staff manage their data and ensure it is complete, accurate and recorded in a timely fashion.

The on-going development of the 'Tableau' reporting and data visualisation tool across the Trust will also continue to support the improvement of data quality by giving clinical and operational staff even greater access to their own data and enabling them to proactively highlight and address a range of data quality issues. Tableau is available and is used by service and team managers across Mental Health and Community Services and a pilot is underway in our Heywood, Middleton and Rochdale Services to make it available at individual practitioner level with the intention of giving clinical staff a dashboard to enable them to identify both clinical and data quality issues which need to be addressed. Following evaluation of the pilot the intention is to roll out across the Trust.

The Performance and Information Teams will continue to work closely with operational services to ensure that all staff take responsibility for the quality of the data they record on their clinical systems. They will engage and encourage teams to improve both the coverage and quality of information recorded and ensure that all staff understand the importance of data quality.

The Trust is also working collaboratively with its commissioners to prioritise and address data quality issues via a monthly Mental Health Data Quality Sub-Group and an action plan to address key issues has been developed and signed-off by the group. The action plan is a live document which is updated on a monthly basis by the group to monitor progress against agreed deadlines and for 2018/19 will include data quality work on data for several services; RAID, Children and Young People's Access and Waiting Times and Dementia.

As part of the Trust's Health Informatics Strategy a project is underway to establish an Information Culture across the Trust. The purpose of the project is to make Pennine Care NHS Foundation Trust an organisation where all staff understand the value of information, the organisation has a high level of confidence in its data and data is the basis for all decision-making. There are three workstreams which form part of this project, one of which is dedicated to Data Quality. The workstream will cut across all systems (clinical and corporate) and will develop frameworks and standards, develop and maintain data quality policies and develop, manage and maintain data quality tools.

Learning from Deaths

During 2017/18 477 of Pennine Care NHS Foundation Trusts patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 116 in the first quarter;
- 93 in the second quarter;
- 144 in the third quarter;
- 124 in the fourth quarter.

By 21 March 2018, 3 case record reviews and 67 investigations have been carried out in relation to 477 of the deaths included above.

In 0 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 16 investigations in the first quarter;
- 13 investigations in the second quarter;
- 22 investigations in the third quarter;
- 16 investigations and 3 case record reviews in the fourth quarter.

0 representing 100% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 0 representing 100% for the first quarter;
- 0 representing 100% for the second quarter;
- 0 representing 100% for the third quarter;
- 0 representing 100% for the fourth quarter.

These numbers have been estimated using the pilot structured judgement review process that the Trust Board agreed on the 18th December 2017 in preparation for the Nationally mandated tool coming on-line from April 2018 for Mental Health Trusts and the Royal College of Psychiatrists for which Pennine Care NHS Foundation Trust and other Greater Manchester Mental Health NHS Providers have agreed to be in the pilot (test and evaluate) phase (April 2018 – June 2018).

What have we learned from case record reviews and investigations

The Trust has established areas of significant learning in relation to the deaths reported in the period. The key area of learning continues to lie within the processes of communication that occur within services, between services and between the Trust and other agencies. A number of deaths continue to highlight the fact that communication could and should have been better.

The Trust continues to learn the importance of communication with families after a death has occurred and that through meaningful engagement after a death by inviting them to contribute to the terms of reference for investigations a more detailed, meaningful and richer account of the person's care and treatment is realised.

What actions have we taken and propose to take

The Trust has improved communication to GPs from Improving Access to Psychological Therapies (IAPT) services in the form of e-letters; the Trust continues to roll-out its electronic patient record to services enabling different services operating from different

sites and disciplines to access relevant clinical data in real-time. The Trust Patient Safety Improvement Group will routinely reject reports that have not included the family's views, questions or comments for an investigation report. The Trust continues to work with other providers within the Greater Manchester area to consider how to involve families in case record reviews (structured judgement reviews). The Trust has offered a family the opportunity to be involved in developing a training resource for in-patient services around communication with loved ones.

What impact do we envisage the actions will have

The impact of improving communication will be that other teams and agencies have an increased awareness of risks for patients and that a shared accountability is better evidenced (e.g. GP risk letters). The impact of teams within the Trust having better communication via a shared electronic record will have a bearing on the risk management for the patient by the Trust. The impact of involving families where undertaking an investigation will be that the Trust is able to evidence a shared perspective and that the report accurately reflects any concerns that the family may have had. This in turn will enable teams to understand the impact of their care for patients and to develop better approaches as understood from a carer-perspective.

0 case record reviews and 32 investigations completed after 31 March 2017 which related to deaths which took place before the start of the reporting period.

0 representing 100% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. (It is important to note that the Trust was not assessing using a mandated tool the avoidability of a death due to problems in care).

This number has been estimated using the pilot structured judgement review process that the Trust Board agreed on the 18 December 2017 in preparation for the Nationally mandated tool coming on-line from April 2018 for mental health trusts and the Royal College of Psychiatrists for which Pennine Care NHS Foundation Trust and other Greater Manchester mental health NHS Providers have agreed to be in the pilot (test and evaluate) phase (April 2018 – June 2018).

0 representing 100% of the patient deaths during 2016/2017 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting Against Core Indicators

Pennine Care NHS Foundation Trust have reviewed the Department of Health's mandatory set of core quality indicators detailed in Regulation 4, Schedule within the quality account regulations, and will now provide data and statements in relation to the Trust's position for those indicators which are relevant to Pennine Care NHS Foundation Trust.

The data included in the report are in line with our submission to NHS Digital and corresponds to the indicators and performance thresholds set out in the Single Oversight Framework.

Care Programme Approach (CPA)

The percentage of individuals on Care Programme Approach who were followed up within 7 days after discharge from Psychiatric Inpatient care during the reporting period: 97.6%

	2015/16	2016/17	Trust Actual 2017/18		National Average 2017/18		National Range 2017/18	Threshold 2017/18
Patients on CPA who were followed up within 7 days after discharge	98.1%	97.6%	Q1 Q2 Q3 Q4	99.3% 97.0% 96.8% 97.1%	Q1 Q2 Q3 Q4	96.7% 96.7% 95.4% **	69.2% - 100%	95%

**Quarter four national averages had not been published at the time of writing.

Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons:

- To show the percentage of patients on CPA who are followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.
- To show that the Trust is working to reduce the risk of suicide and any problems in the immediate post discharge period.
- To show that all inpatient members of staff recognise their responsibility in relation to the 7-day follow-up discharge policy.

Pennine Care NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by:

- The Trust has incorporated CPA follow up breaches into their new reporting tool, Tableau. Now fully functional the Trust is going to ensure that this is accessible to all Team Managers and Practitioners to ensure that the tool is used as part of monitoring team performance and also in individual practitioners' supervision sessions.
- The Trust is currently undertaking a comprehensive review of its inpatient provision. This will involve the implementation of a new skill mix on wards and also the

creation of a central bed management function. This will release time for ward staff to ensure that continuity is provided throughout the pathway including the 7 day discharge on discharge.

Crisis Resolution Home Treatment (CRHT)

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period: 99.6%

	2015/16	2016/17	Trust Actual 2017/18		National Average 2017/18		National Range 2017/18	Threshold 2017/18
Patients who were admitted to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.	100%	99.9%	Q1	100%	Q1	98.7 %	84.3% - 100%	95%
			Q2	99.5%	Q2	98.6 %		
			Q3	99.1%	Q3	98.5 %		
			Q4	99.8%	Q4	**		

**Quarter four national averages had not been published at the time of writing.

Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons:

- To show the percentage of admissions to acute wards for which the CRHT Team acted as a gatekeeper.
- To demonstrate the Trust is achieving the threshold for hospital admission.
- To show that all patients are screened and considered for crisis home treatment as an alternative to admission to an inpatient ward.

Pennine Care NHS Foundation Trust intends to take the following actions to maintain this percentage and so the quality of its services, by:

- The Trust is developing a new central bed management function which will provide consistency across all Pennine Care NHS Foundation Trust sites and one point of entry for inpatient support. This consistency will provide timely support for patients and will also support discharge processes, ultimately minimising the length of stay and reducing the number of delayed transfers of care.

Mental Health 28-day emergency readmission rates

		2015/16	2016/17	2017/18	National Range 2017/18	Threshold 2017/18
Patients aged between 0 and 15, and 16 and over, who have been readmitted to a hospital which forms part of Pennine Care NHS Foundation Trust within 28 days of being discharged from a hospital which forms part of Pennine Care NHS Foundation Trust	0 to 15	0%	0%	0%	n/a	n/a
	16 or over	10.0%	10.7%	10.7%	n/a	n/a

Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons:

- To show the percentage of patients aged 0 to 15, and 16 and over readmitted to hospital which forms part of the Trust within 28 days of discharge from a hospital which forms part of the Trust.
- To illustrate factors that could help identify people who are most at risk of readmission.
- To allow targeted intervention for people with a history of readmission.

Pennine Care NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:

- The Associate Director of Medicine will undertake a review of re-admission rates across the Trust footprint to determine areas of best practice and to ensure consistency of support.
- New Practitioner Forums are being launched with a focus on reviewing best practice and NICE guidance. This supports clinical engagement within our Mental Health Teams with a forum for working age adults and also one for older people. These forums will review processes and practice issues across Pennine Care NHS Foundation Trust's services.
- The Trust will complete a review of its current CMHT provision. This is a comprehensive review of systems and processes which will ensure a consistent CMHT offer across the Trust's footprint and a shared approach to support between in-patient and community services.

Patient Experience of Mental Health Services

	2015/16	2016/17	2017/18	National Average 2017/18
Patients experience of Community Mental Health Services with regards to contact with a health or social care worker	7.9	8.0	7.7	"about the same"**
Listening		8.4	8.2	"about the same"
Time		7.8	7.7	"about the same"
Understanding		7.8	7.2	"about the same"

* The Community Mental Health Services survey was redeveloped in 2014 and therefore the scores for years previous to 2014/15 are not comparable.

** There is no data to indicate the national average; however, information received from the CQC indicate that Pennine Care NHS Foundation Trust compares "about the same" as other Trust's.

Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons:

- To show that our patients feel they are listened to carefully
- To show that our patients feel they are given enough time to discuss their needs and treatment
- To show that our patients feel that how their mental health needs affect other areas of their lives are understood.

Pennine Care NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services, by:

- Continue to review at local Triangle of Care Groups to reflect local need, and at the Trust Wide Triangle of Care Steering Group
- Continuing to review and monitor data through the Tier 4 group
- Continuing to collect FFT data and promote service areas to continue to remind service users to complete
- A commissioned CMHT work stream is being undertaken that includes a section on carer and family support
- Safer staffing has identified CMHTs are working at increased demand and this is expected to continue going forward. The modelling work which has been commissioned will assist the Organisation with the development of the CMHT 'offer' which will assist further discussions with commissioners.

Patient Safety Incidents

Local Rate				National Rate			
				Total No of incidents reported within the 54 Mental Health Trusts**			
Patient Safety Incidents*		**2016/17 Q1 & Q2**	**2016/17 Q3 & Q4**	**2016/17 Q1 & Q2**	**2016/17 Q3 & Q4**	**Median**	**Mean**
Number of Incidents		4378	3570	162,954	157,141	-	3017.66 2910.02
Rate per 1000 bed days**		49.73	43.01	-	-	46	-
Number resulting in:	Severe Harm	0 (0.0%)	4 (0.1%)	562 (0.3%)	538 (0.3%)	-	10.41 9.96
	Death	35 (0.8%)	30 (0.8%)	1240 (0.8%)	1233 (0.8%)	-	22.96 22.83
Total No incidents resulting in severe harm or death		35 (0.8%)	34 (0.9%)	1802 (1.1%)	1771 (1.1%)	-	33.37 32.80

* 2016/17 data reflects six monthly reporting periods quarter one and quarter two (April to September) and quarter three and quarter four (October to March) which is currently available via the National Reporting and Learning System (NRLS) via NHS Improvement.

** Differences in reporting culture could be reflective of the type of services provided and/or patients cared for.

Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons:

- Taken from the NRLS Reporting dataset of incidents reported to the NRLS between 1 April 2016 and 30 September 2016, and 1 October 2016 and 31 March 2017
- To show the number and, where available, rate of patient safety incidents reported to national reporting rates within the Trust during the reporting period, (compared with reporting rates of all Mental Health Trusts)
- To show the number and percentage of such patient safety incidents that resulted in severe harm or death
- Generally it is felt that organisations that report more incidents usually have a better and more effective safety culture.

Pennine Care NHS Foundation Trust has taken the following actions to improve incident reporting procedures and learning and so the quality of its services by:

- Continued review of the Risk Department National Reporting and Learning System (NRLS) reporting procedures against the NRLS Incident Type Coding List for Dataset, to ensure that all patient safety incident reported within the Trust are appropriately reported
- Networking with local Mental Health Trusts to identify any further strategies to improve incident management and investigation processes
- An extensive programme of investigation training and awareness sessions delivered by Consequence UK from July to December 2016

- Hosting the Making Families Count conference, with support from NHS England in October 2017. This innovative event, held for the first time in the North West, looked at how NHS Organisations can improve the ways in which families are included in, and become integral to investigations within Mental Health Services
- Further commissioning of Consequence UK to work with the Trust to streamline investigation procedures via the use of a case assessment approach
- The developments of a learning from deaths policy and procedures, including the commencement of structured judgement reviews, in response to the national Learning from Deaths programme
- The continued use of learning strategies such as continuous learning forums and 7 minute briefings to share lessons learned from serious incidents
- Agreed liaison processes with the CQC and NHS Improvement to highlight patient safety incidents and respond to information requests.
- The value of this work is evidenced by:
    - The continued position of the Trust within the middle 50% of reporters during the period.

During 2017/18 a total of 6554 incidents have been uploaded to date (9 April 2018) on the National Reporting Learning System. The details of these patient safety incidents will be reported in the 2018/19 Quality Account and the table below is for information only.

Month	Total
Apr-17	626
May-17	673
Jun-17	567
Jul-17	663
Aug-17	553
Sep-17	469
Oct-17	521
Nov-17	543
Dec-17	452
Jan-18	518
Feb-18	458
Mar-18	511 (9 April 2018)
TOTALS	**6554**

Part Three

This section provides an overview of care offered by Pennine Care NHS Foundation Trust based on performance in 2017/18 against indicators selected by the Board in consultation with a panel representing all key stakeholder groups; patients and carers, staff and Council of Governors.

Performance data are compared with historical data and benchmarked data where available; this will allow our readers to understand progress over time as well as compare Pennine Care NHS Foundation Trust's performance to other providers.

Reference is given to the data sources and whether the data are governed by standard national definitions. Indicators which have changed since 2016/17 are signposted and the rationale for the change is explained. Any inconsistencies between the data provided in this report and that reported in 2016/17 are signposted and explained.

3.1 Performance (2017/18)

Performance is illustrated along with an explanation for selection and are aligned to the three domains of quality:

- Patient safety
- Clinical effectiveness and
- Patient experience

Reducing Restrictive Practices (Patient Experience)

Involving: Dil Jauffur, Directorate Manager and CQUIN sponsor; Fiona Christopher and Lindsey Baucutt, Clinical Services Managers; Gemma Kirk, Transformation Lead, all ward managers, staff and patients from across the Rehabilitation and High Support Services Directorate (RHSD)

Aim of the initiative

The aim of the initiative is to develop a culture in which people using our services are able to fully participate in formulating plans for their well-being, risk management and care in a collaborative manner, promoting recovery and reducing the need for restrictive interventions.

We aim to achieve this by developing, implementing and evaluating a framework for the reduction of restrictive practices within Rehabilitation and High Support Services (RHSD) to improve service user experience whilst maintaining safety on the units.

Definitions to support understanding of the initiative

Restrictive interventions are defined as deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken

- End or reduce significantly the danger to the person or others
- Contain or limit the person's freedom for no longer than is necessary

Examples of restrictive interventions include:

- Physical restraint (PMVA – physical management of violence and aggression)
- Mechanical restraint
- Chemical restraint
- Seclusion
- Long term segregation

Restrictive practices are those practices that limit an individual's movement, liberty and/or freedom to act independently in order to maintain the safety and security of the site, patients and staff.

Examples of restrictive practices include:

- Environmental restriction: often concerned with the modification of an environment in an attempt to manage risk
- Psycho-social restriction: often concerned with the attempt to manipulate behaviours through the alteration of their consequences.

Blanket restrictions, both environmental and psychosocial restriction can result in the use of 'blanket restrictions' which are rules or policies that restrict a patients' liberty and/or other rights, which are routinely applied without an individual risk assessment to justify their application.

The Mental Health Act Code of Practice (2015) allows for the use of blanket restrictions only in very specific circumstances.

Why we did it

In 2016 NHS England established a CQUIN (Commissioning for Quality and Innovation) target for low secure services to develop and implement a framework to reduce restrictive practices nationally. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for service users. Whilst the CQUIN was specific to Prospect Place and Tatton Unit, RHSD recognised that a number of important national documents had made recommendations associated with the issue of restrictive practices in mental health care.

These documents include Department of Health guidance: *Positive and Proactive Care: reducing the need for physical interventions (2014),* a CQC (Care Quality Commission) report: *The state of care in mental health services 2014 -2017*; the revised Mental Health Act Code of Practice (2015) and recent NICE (National Institute for Clinical Excellence) guidance (NG10) *Violence and Aggression: Short Term Management in mental health, health and community settings* (2015).

All of the aforementioned documents highlight the need for services to review and reduce restrictive practices used across services and therefore the project plan was developed to address practice across all units in RHSD.

The Mental Health Act Code of Practice (2015) provides legal guidance for all staff on the application of the Mental Health Act (1983). When the code of practice was reviewed in 2015, one of the new guiding principles was to provide the least restrictive treatment and care for all whilst maximising independence and promoting recovery where possible.

The units within the RHSD aim to keep people safe and free from harm whilst enhancing

life skills and community functioning, supporting people to effectively manage any risky behaviours and reduce relapses, with the aim of enabling them to maximise their independence and move on from our services.

Central to achieving this aim is the delivery of high quality care that is purposeful, respectful and safe and takes into account individual needs and preferences supporting a culture in which the people using our services are able to fully participate in formulating plans for their well-being, risk management and care in a collaborative manner, which promotes recovery and self-management in partnership with their care teams.

People are often admitted to our units to help address challenges around their view of their illness and the vulnerabilities and risks to themselves and others that may result from this. The challenge for staff in Mental Health Services generally is the increasing complexity of the patients admitted to the service and the ongoing need to balance positive risk taking and collaborative, individualised care and treatment with the need to maintain safety on the units for staff and patients.

In the CQC report (*State of care in mental health services 2014-2017),* it was found that there is variation in the way staff are using restrictive practices when responding to challenging behaviour. They found best practice was in areas where there was specialist staff training and skills and involvement of patients in decisions about their care and treatment.

The reducing restrictive practices project was established to ensure that our units in RHSD are in line with national recommendations as well as to ensure they are compliant with their regulated activities as monitored by the Care Quality Commission and NHS England.

We want to empower staff and the people using our services with the knowledge and skills to make decisions about appropriate interventions and the reasonable, proportionate and justifiable use of any restrictive practices, protecting people's human rights at all times.

What we did

We recognise that any changes to culture and practice are anxiety provoking for staff working on the frontline of services and that before asking teams to consider different ways of working there is a need to engage with and educate teams.

We commenced the project by establishing a Reducing Restrictive Practices project group and an action plan was developed.

To determine a baseline of 'how restrictive our wards feel' we completed the 15 Steps Challenge with staff, carers and service users on the low secure units. We then generated a 7 minute briefing, a communication tool to share with teams.

A workshop training package was developed for staff and training was delivered across the directorate through workshops. The workshops were evaluated to identify changes in knowledge, understanding and likelihood of changing practice as a result of attending.

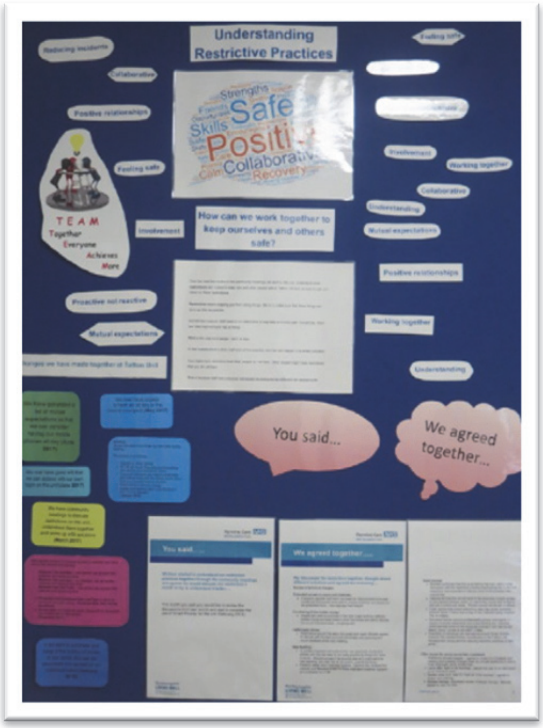
Following delivery of the workshops a framework for reducing restrictive practices was developed to support teams with making decisions and developing a culture where service users could participate in making decisions about their risk management and care and the safety of the wards.

Posters were produced for ward areas to support staff and service users in understanding the objectives of the reducing restrictive practices framework.

Monthly reducing restrictive practices meetings were established for staff and service users across the directorate to increase understanding of restrictive practices and to identify

blanket restrictions in place on the units.

Blanket restrictions identified on the units are reviewed on a monthly basis with service users and staff and processes reviewed and where necessary new protocols developed to maintain safety but also to protect the human rights of service users.



Noticeboard displays were developed for the units in communal areas to remind staff and service users of changes that have been made to promote independence and recovery.

Care planning training was established with the support of Manchester University's EQUIP team to support staff in developing collaborative care plans with service users.

We developed a course to be delivered at the Health and Wellbeing College in collaboration with service users from Prospect Place entitled 'Working in Partnership: Collaborative Care Planning' with the aim to support service user confidence in developing care plans for their recovery.

We completed an audit in two service areas on reducing restrictive practices to determine progress and identify further actions.

We identified a need for face to face "See Think Act" training which is now in progress.

We developed a process for monitoring and reviewing changes in practice and non-negotiable boundaries through the Reducing Restrictive Practices project group.

We developed a patient experience questionnaire which includes questions around safety.

We have established a patient council to support involvement and good governance of a number of directorate projects including restrictive practices.

Members of the project team attended a reducing restrictive practices conference at the Royal College of Nursing to support learning and development.

We shared good practice with CAMHS services, adult services and older peoples services.

How we did it

The implementation, learning, development and evaluation is ongoing and RHSD will maintain a focus on reducing restrictive practices in all of its services. The success to date however has been dependent on a project lead to develop a clear action plan and reporting process and to monitor progress towards key actions.

The Reducing Restrictive Practices project group has also been fundamental to the planning, monitoring and review of the framework and attendance by key stakeholders including ward managers, clinical services managers, transformation lead and project support.

The project support officer has provided considerable administrative support in planning workshops sessions, Health and Wellbeing College sessions, planning and arranging meetings, providing noticeboard displays and minuting meetings.

How we monitored progress

Progress has been monitored via the reducing restrictive practices project group and action plans. Information Governance meetings have supported the review of restrictive practices and identified learning from incidents where restrictions have been used.

Monthly reducing restrictive practices meetings with staff and service users has identified blanket restrictions on each unit that require review and enabled review of progress and feedback from service users where changes identified have either not happened or are progressing well.

The patient council has provided a clear voice and opportunity for service users to communicate with senior managers.

NHS England have monitored the success of the CQUIN (Commissioning for Quality and Innovation) targets for reducing restrictive practices on two low secure units. CQUIN outcomes have been fully achieved.

The measures used

The project team used a variety of measures at various stages of the project, including:

- 15 Steps Challenge was used as a baseline across two services.
- An audit tool was developed and used during a pilot across two services. The tool we be used again as we roll out across all service areas and monitor progress and identify further actions.
- Patient experience questionnaires were developed and information is collected every 6 months which include questions on safety.
- Qualitative feedback and patient narratives are also collected.

How we evaluated the impact upon service, patients, staff and carers

Evaluation of the impact on the service, patients, staff and carers has been through the collection of qualitative feedback from staff and students, workshop evaluations, supervision and the patient council. We have also been able to review the impact through reducing restrictive practices project groups and ward meetings and there has been clear evidence recorded and minutes of changes made to improve patient and staff experiences.

In October 2017 we presented progress and outcomes at the RHSD Quality Afternoon.

The Outcome

Around 60 staff attended the workshops and whilst most staff had some understanding of the topic prior to the workshop 88% of staff said their understanding increased as a result of attending the session.

86% of attendees said they would change the way they worked as a result of attending the session and here is a selection of how they will do that:

"Put myself in the patients shoes!"

"Be mindful of individual needs"

"Look for opportunities to work with patients on an individual basis rather than use blanket restrictions"

"Review blanket restrictions on a regular basis"

"Encourage the review of restrictive practices with clear timeframes"

"Question routines on the unit, think about what we do as a team and how this can be improved"
"Helped me realise this is for the benefit of the patients and not the staff"
"Encourage other staff to have an open mind"
"To have more regular discussions as a staff group to ensure everyone knows why decisions have been made"

The outcomes have led a number of key changes to practice on the wards, these have included but are not limited to:

Access to fresh air all day following reviews of locked courtyards/gardens (All units)
The development of a keypad system to enable access to the garden for patients (Heathfield House)
Development of a fob system to allow movement around the unit for service users (Bevan Place)
Access to ceramic mugs (Bevan Place)
The collaborative development of a protocol to allow the use of mobile phones and tablets/laptops without camera devices (Tatton Unit)
Implementation of protocol to allow use of mobile phones/tablet and laptops (without camera devices) (Tatton Unit)
Implementation of protocol to allow increased access to toiletries from 7am to 11pm (Tatton Unit)
Access to better bedding and linen (Tatton Unit)
Agreement around individualised use of leave and access to personal items (Tatton Unit)
Later access to razors to allow shaving before bedtime (Prospect Place)
Later access to the unit kitchen for supper preparation (Prospect Place)
A review and implementation of guest Wi-Fi (All units)
Agreement of one deodorant per patient in bedrooms to support self-care (Prospect Place)
Agreement that shower gels and shampoos (without alcohol content) can be stored in bedrooms (E&A and Prospect Place)
More individualised access to personal items, caffeine, food and toiletries (All units)
Access to Smart phones (Prospect Place)
Access to laundry anytime, access to all communal areas at any time (Stansfield Place, Hurst Place and Rhodes Place)
More individualised risk assessment and leave plans (Beckett Place and Bevan Place)

Positively three recent unannounced CQC mental health act visits stated that there were no unjustified restrictions in place.

Managing Demands Creatively (Patient Safety)

This section provides excellent examples of how services are responding and managing demands to their service using creative methods.

Our Waiting List

Involving: Caroline McCann, Associate Director Mental Health and Specialist Services, Heywood, Middleton and Rochdale; Sophie Marshall, Access & Crisis and Home Treatment Team Manager; Lynne Croston, Access & Crisis Team Administrator, Lesley Williams, North Division Crisis Services Manager, and Liaqat Ali and Sally Knight, Bank staff

Aim of the initiative

The aim of our project was to reduce the waiting time for patients who have been offered an appointment for a full Mental Health Assessment with Access & Crisis to determine if secondary care mental health services were indicated.

Why we did it

It is acknowledged that the waiting list time of approximately 4 months is not acceptable for patients to be waiting. The impact of the high waiting list time can result in patient relapse, multiple presentations to RAID and high 'did-not-attend' (DNA) rates.

What we did and how we did it

Approximately 200 patients were on the initial waiting list. We examined all files waiting for an appointment to determine if the patient had already been assessed whilst on the list by another team. If a patient had been re-referred to Access we examined the reason for referral and offered screening appointments where appropriate.

Screening appointments consisted of a 1 hour session with a patient, where a Mental Health Needs Assessment (MHSE) was undertaken, an assessment of risk, management of risk, and signposting on to relevant services to meet future needs.

The project life-cycle lasted approximately 4 to 5 weeks. By the end of the project all patients on the waiting list had been reviewed, contacted and signposted on

How we monitored progress and the measures we used

Progress was monitored throughout the project life using a variety of methods, including:

- Reduction of the length of the waiting list
- DNA rates
- Reviewing length of time taken to see new referrals, compared with length of time taken to see previous referrals
- Patient satisfaction including a reduction in verbal disappointment received from patients and referrers

How we evaluated the impact upon service, patients, staff and carers

We used several methods to evaluate the impact of the project on our service, including:

- Feedback from patients
- Feedback from referrers
- Improvement from joint working with other agencies (Adult Care)
- Improved referrals out from Access

The Outcome

Upon evaluation of our project, we can see that we improved waiting times for an appointment with Access. We developed a quicker patient journey through the Access Pathway and we received positive patient feedback. We found the DNAs decreased from this exercise and one reason for this was through the introduction of an opt-in appointment process, whereby patients can chose an appropriate time and date which suits them rather than being informed of a date and time.

Winter Pressures in Stockport

Involving: Karen Maneely, Locality Manager Mental Health Services Tameside; Nick Towell, Home Treatment Team Manager; all staff working within RAID

Aim of the initiative

An additional resource was provided for the NHS in 2017/18 to address winter pressures. The focus of the investment is to secure improvements in A&E performance and patient care over the winter. The key aims of our initiative were to:

- Reduce the number of psychiatric breaches within 4 hours
- Increased number of patients assessed within 1 hours of attendance at the Emergency Department
- Increased number of patients assessed within 2 hours of attendance at the Emergency Department
- Reduce in the number of patients who leave the department without being seen
- Improvement in Patient experience survey.

Why we did it

The increased demands are a result of a higher number of people presenting to the Emergency Department during winter. This increase leads to greater pressure on the pre-existing workforce, often resulting in prolonged waiting times due to staff already undertaking assessment. This leads to breaches in Emergency Department and may lead to patients who are referred from medical wards blocking beds due to pending assessment from the RAID service, due to the increased levels of referrals.

There are identified significant pressures in the Stockport Urgent Care system and by having an additional member of staff will prove the effectiveness of a mental health practitioner working at the front end of the Emergency Department.

The aim is to pilot a new approach to test the effectiveness of a Mental Health Accident

and Emergency Triage/ front end function, alongside reducing patient waiting times and breach times within Emergency Department.

What we did

A review took place which identified the busiest times for RAID which are late and night shifts from Thursday through to Sunday. Funding for an additional staff member was granted in order to meet the increased demand placed on the service.

How we did it

The regular member of staff received the referral via a bleep process and has triaged the referral and directed this appropriately. We have been allocated an office in the Emergency Department and we are currently awaiting equipment to utilise this office. Once this is complete a RAID practitioner will be based in the Emergency Department, assisting with the triage systems, determining if a patient requires a full assessment by RAID; for example, frequent flyers will be seen, screened and signposted effectivity, reducing the waiting times for patients.

How we monitored progress

All referrals into the RAID service are recorded into PARIS, our clinical information system. This takes into consideration how they came to the RAID service, what care was received while in service and what pathway was chosen when discharging from RAID. Operationally the RAID service is monitored closely by the Team Manager and Service Manager. The Mental Health Practitioners record all activity within the service and feed this back to senior management.

Data analysis is undertaken by the Performance Department, and qualitative feedback is received and analysed using an electronic survey.

The measures used

All the following measures are recorded within PARIS which is directly interpreted using the Tableau system:

- Number of psychiatric breaches within 4 hours
- Number of patients assessed within 1 hour of attendance at the Emergency Department (key performance indicator)
- Number of patients assessed within 2 hours of attendance at the Emergency Department (key performance indicator)
- Number of patients who leave the department without being seen

How we are evaluating the outcome of the project and the impact upon service, patients, staff and carers

A report of this project is currently being formulated showing the first 6 weeks of activity. The findings will influence the remainder of the project and its success.

Data analysis is undertaken by the Performance Department, as well as receiving qualitative feedback through the use of an electronic survey.

This project is set to finish on 31 March 2018.

Our Patient Flow

Involving: Dr. Sarmad Nadeem, Senior Psychiatrist, Bury Mental Health Outpatient; Dr. David Low, Knowledge and Innovation Programme Manager; Dr. Neil Crossley (CT3); Dr. Shauna How Sou Cheong (FY1); Carol Shaw (Receptionist, Bury Mental Health Outpatient)

Aim of the initiative

To introduce patient flow in Bury Mental Health Outpatient Unit through a whole system value-streamed approach using established Quality Improvement (QI) method (Six Sigma and Lean).

Why we did it

Due to high variation that currently exists within the Bury Mental Health Adult Outpatient Unit, a project was initiated to decrease variation across the entire system through introducing patient and information flow. This is envisaged to greatly reduce patient waiting times, DNAs as well as a standardised method of working, all targeted to increase a high quality patient experience and outputs. This project will also target to utilise existing digital means to aid this transformation.

What we did and how we did it

The project approach is to use the structured Define, Measure, Analyse, Improve and Control (DMAIC) method from the established QI method known as Six Sigma. Some Lean approach was also utilised to identify inherent wastes.

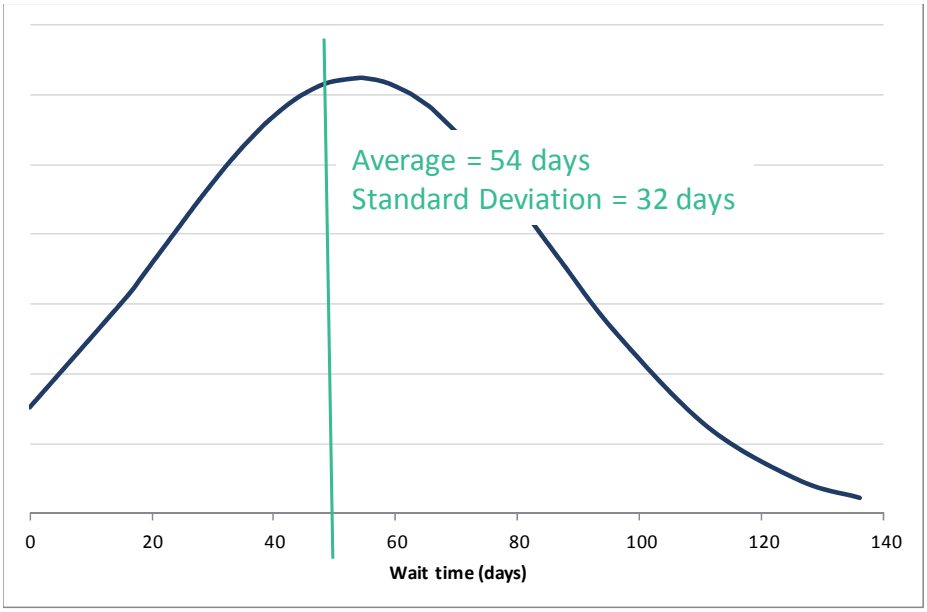


Fig. 1 Gaussian distribution of the 40 patient journeys (in days) from referral to appointment, including the average and standard deviation (in days)

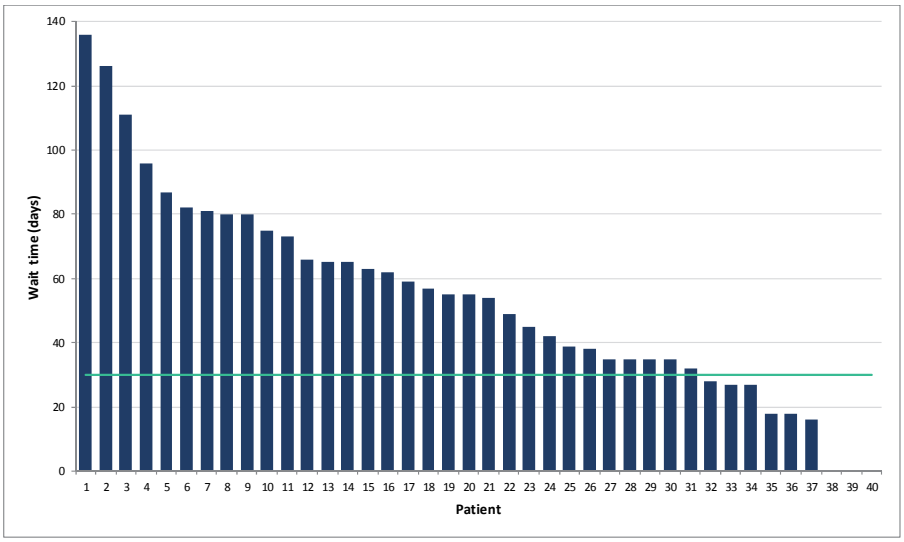


Fig. 2 Graphical representation of the 40 patient journeys (in days), depicting 80% of the patients were waiting over 30 days for an appointment (green line)

40 patient journeys were baselined, from Upstream (point of referral from GP) to Downstream (attending the appointment). An average of 54 days wait was calculated, with a standard deviation of 32 days. [Fig 1] Worryingly, 80% of the recorded journeys were experiencing waiting over 30 days. [Fig 2]

A top level process mapping was conducted as well as detailed ('walk the process') diagrams to understand what was occurring within the Bury system. The identified issues were then segregated into short term (quick wins, maximum impact), medium term and long term projects.

The 'quick wins' project consisted of understanding the current bottle necks caused by batching up of patient referrals through the weekly Multi Disciplinary Team (MDT) meeting, resulting in high waiting time for up to 18 days through a multi-step cyclic process, with each meeting consisting of 2 hours encompassing all 9 senior psychiatrists. [Fig. 3]

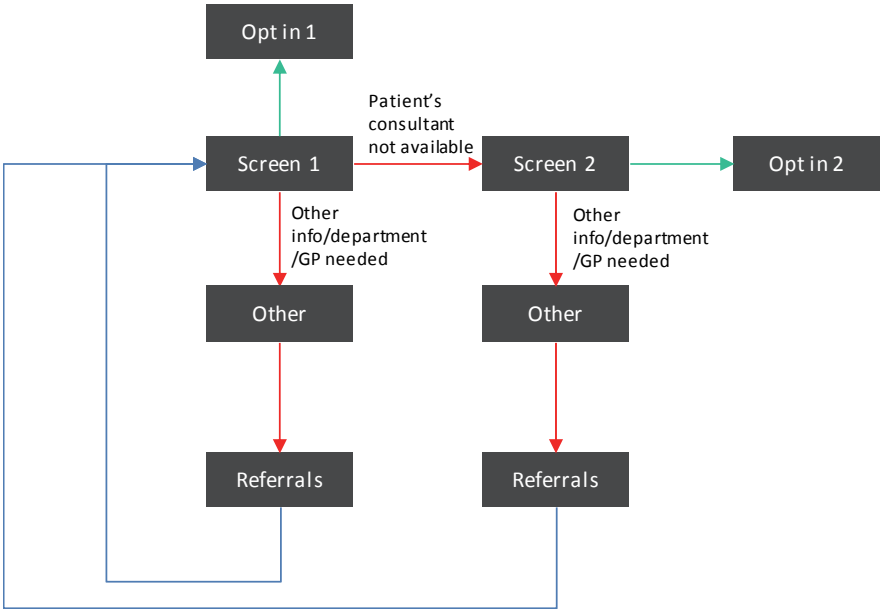
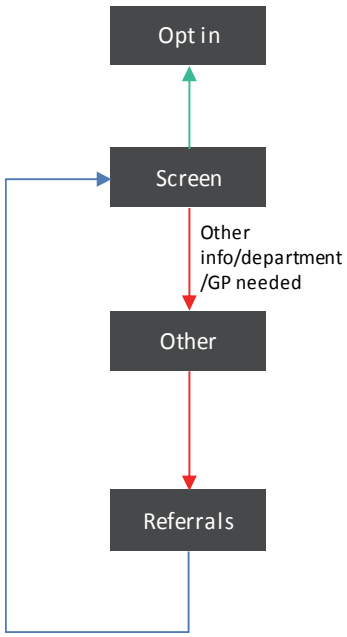


Fig. 3 Current MDT (screening) patient process



A redesign of the process to remove unnecessary cyclic process (duplication of second screening) in addition to a reallocation, individual screening rotas in an allocated weekly timeslot. The two hours MDT meeting was reduced to just 30 minutes, and each psychiatrist was allocated with their individual patients. [Fig. 4]

How we monitored progress and the measures we used

The implementation was monitored in regular monthly development meetings that took place between Dr. Sarmad Nadeem and specialists from the process.

The project team gained an understanding of the 'cycle' time and of the 'takt' time of the system; we undertook extensive process mapping of the system (top level and detail) and gained a thorough understanding of Specialist rotas, resources and time.

Fig. 4 Redesigned MDT (screening) patient process now implemented in Bury

How we evaluated the impact upon service, patients, staff and carers

A two-hour meeting per week per person was reduced to 30 minutes. Validation through a real-time capture of the meeting resulted in an actual meeting time to be only 10 minutes per person. This is an incredible 92% increase in productivity (per person). The process steps also shows an increase of 75% in efficiencies, a testament of removing non-value added steps through identifying bottle-necks and other wastes.

The Outcome

Several quick wins were seized, including a redesign of the multidisciplinary team (MDT) meeting schedule and rotas to remove batching of patient referrals, and introduce role specificity.

Further development Plan, Do, Study, Act (PDSA) cycles are scheduled to enhance the downstream process from MDT meeting to the Admin function. In addition, the Admin function has undergone a 'walk the process' exercise, resulting in Dr. Sarmad Nadeem and Dr. David Low looking to implement a two-way text appointment system to completely re-haul the historical opt-in/out process. The estimated time (induced by postal and admin transportation) will be reduced from 3 weeks to less than 5 seconds. Further benefits include reduction in costs associated with paper and inks, a massive decrease in manual working through automation and standardisation, as well as enhancing patient experience by removing cognitive triggers imparted by postal letters.

These works will be reported in due course.

A Rapid Access Clinic for Psychiatry

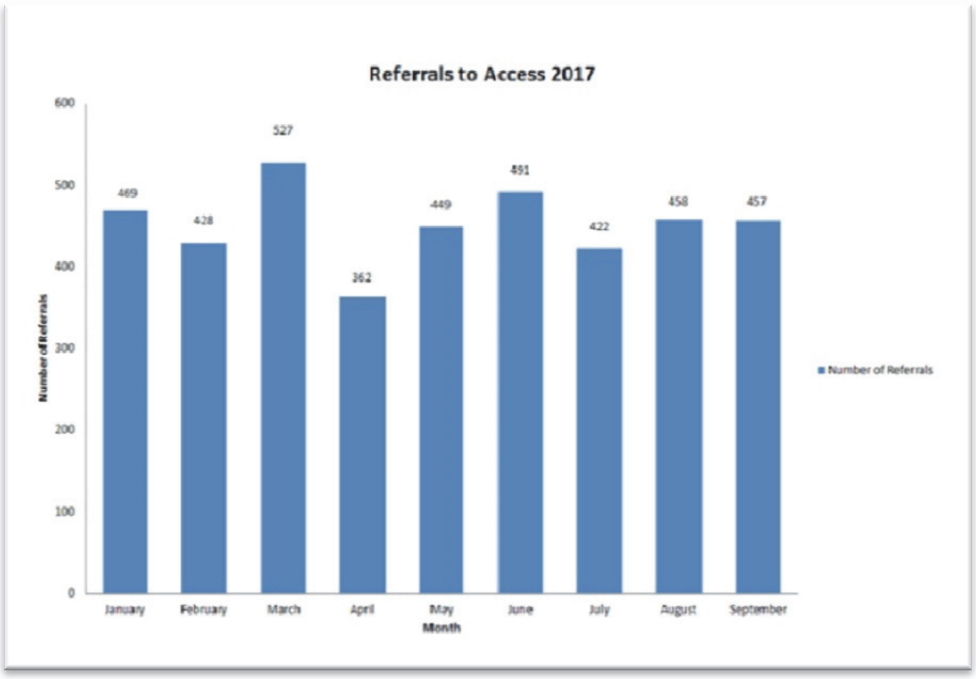
Involving: Dr A Mohan, Consultant Psychiatrist; Theresa Mooney, Acting Team Leader; Sarah Johnson, Jacky Burchill, Lucy Brooke, Jo Stucke, Jill Cashin, Access Team Nurse Practitioners; and Alli Bradfield and Demi Brennan, Access Team Administrators

Aim of the initiative

The aim of our initiative was to run a pilot project to demonstrate the need for a rapid response for new mental health patients requiring a consultant review. A Rapid Access Clinic (RAC) was identified by the Access Team as an option for providing a timely response for a one off consultation with a Consultant Psychiatrist following an initial assessment with a Senior Nurse Practitioner.

We wanted to evidence that by having a thorough quality assessment at the point of entry into Mental Health Services with the option of a rapid review by a consultant we could improve the patient journey, whether they were being referred back to their GP or into secondary care services.

The aim was also to demonstrate new ways of working and if funded appropriately could change Mental Health Services and allow for new ways of working to the benefit of patients and their carers, staff and other care providers.



Why we did it

Mental Health Services are stretched to capacity. As an Access Team we interface with every service both in the primary and secondary care sectors. The team recognises the need for change and the opportunity to drive change from a front door perspective.

The team had identified through patient feedback that a key indicator for satisfaction was the time taken to access a consultant review. The team recognised that the demand for a consultant review outstripped the availability of the current service provision. We recognised that more consultant time would allow for the rapid access option of no more

than a 4 week wait for a new patient to have a consultant review. This would allow for a timely diagnosis with a treatment plan for patients early on in the referral process which patients consistently identify as an important factor to enable them to make decisions about their care pathway and treatment options.

We also recognised an opportunity to engage with GP's to enable them to access timely advice from a Consultant Psychiatrist for patients who may only require prescribing advice initially.

A significant number of patients are in need of either a medication review or some clarity of diagnosis with a treatment plan for the GP. The only routine pathway currently for this is via the general adult consultants at Cherrywood Clinic. Many of these patients only require a one off review with a psychiatrist and yet due to the pressure on general adult psychiatry they may wait between 3 and 4 months for an out-patient psychiatric opinion. With this waiting time in mind, there is an unmet need for a rapid access to psychiatry to allow those who may only require a one off review to be seen at the initial point of contact and discharged back to their GP or other primary care service to continue their treatment in the least restrictive option.

What we did

The pilot clinic was made available between the weeks commencing 26 June and 30 August 2017; provided by the Access Team Consultant voluntarily and in addition to the funded time we already have.

The standard access clinic has run as per usual service delivery with the provision of 2 appointments per week with a waiting time of between 8 – 10 weeks. The Rapid Access Clinic has offered an additional 2 appointments with a waiting time of no more than 4 weeks. During this timeframe, a total of 35 patients have been offered an appointment, 15 in the regular clinic and 20 in the Rapid Access Pilot Clinic. Patients have received the same care and assessment process, the difference is the waiting time to be seen. Offering an additional clinic during this time obviously did have an impact on the length of time patients waited to be seen in the regular clinic and towards the end of the pilot, the wait had reduced to 6 weeks.

The majority of patients seen were directed back to primary care, however patients who subsequently did require secondary care service follow up were able to be commenced on treatment and directed to Cherrywood Clinic with a clear plan in place.

How we did it

Dr Mohan offered his time as a service development opportunity for the pilot period. Time to see the nurse practitioner was a week from date of referral and already factored into the current service provision.

We set a criteria:

- The Patients need to be between the ages of 16 – 65.
- Patients are experiencing symptoms/illness which are requiring a consultant review and would normally be passed to Cherrywood Clinic for an appointment in an out- patient clinic.
- Patients must reside within the Oldham area.

How we monitored progress and the measures used

We had already completed a 3 month audit of referrals between January and March 2017. This looked at Did not attend (DNA) rate, and also outcome to either Primary or Secondary

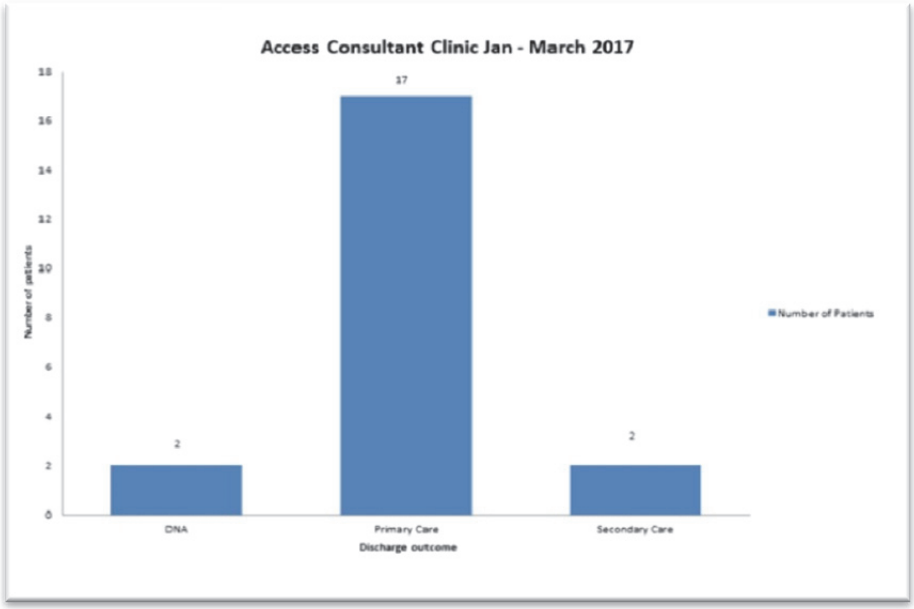
Care services. By looking at patterns in 3 month blocks this allowed the team to monitor patient need, outcome and general satisfaction.

Patient feedback was the driving force behind making changes and this was actively sought from patients.

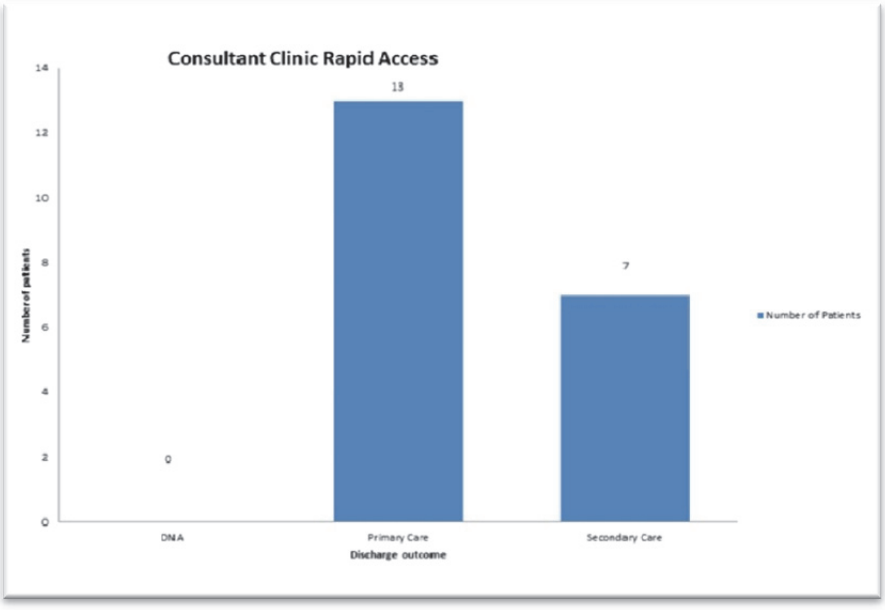
How we evaluated the impact upon service, patients, staff and carers

Evaluation was undertaken using patient feedback. We compared the RAC to our routine clinic during the pilot period. We also compared this to a previous 12 month clinic activity looking mainly at DNA rates.

Feedback was sought by colleagues outside of the service. The project evidenced that with a Rapid Access Clinic the DNA rate fell to zero. Patient satisfaction was high with clear treatment plans for GP/ Primary care staff. Patients were educated on diagnosis and those requiring secondary care services had a clear plan in place to reduce a need for reassessment at entry to appropriate service.



We were able to reduce the number of referrals being passed to secondary care consultants which alleviated an already identified pressure. The long term benefit should make the service more cost effective and start to address the revolving door cycle. It reduced the risk of patients deteriorating and patients reported better outcomes and experience.



As the pilot was delivered on a voluntary basis by staff there was no additional funding to allow for the time required which was a staff pressure but evaluated to be worth the time.

Risk management plans were able to be more robust due to the assertive nature of the clinics. The rapid access approach had a clear impact on team morale due to the positive patient experience evidenced by the patient satisfaction questionnaire.

The Outcome

Overall, between the dates the clinics were run, 35 appointments were offered. 15 patients were offered appointments in the Wednesday clinic and 20 patients were offered appointments in the Friday Rapid Access Clinic.

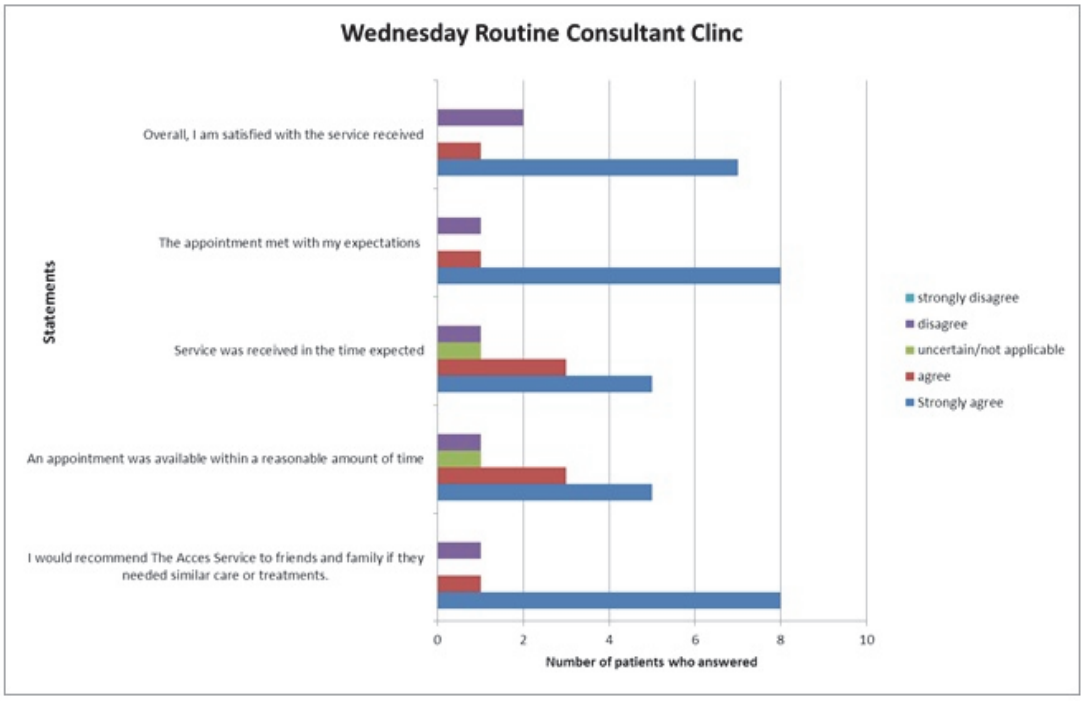
The Wednesday clinic, with a waiting time of 6 to 10 weeks, had 5 patients fail to attend. The Rapid Access Clinic had no DNA's with no more than a 4 week wait.

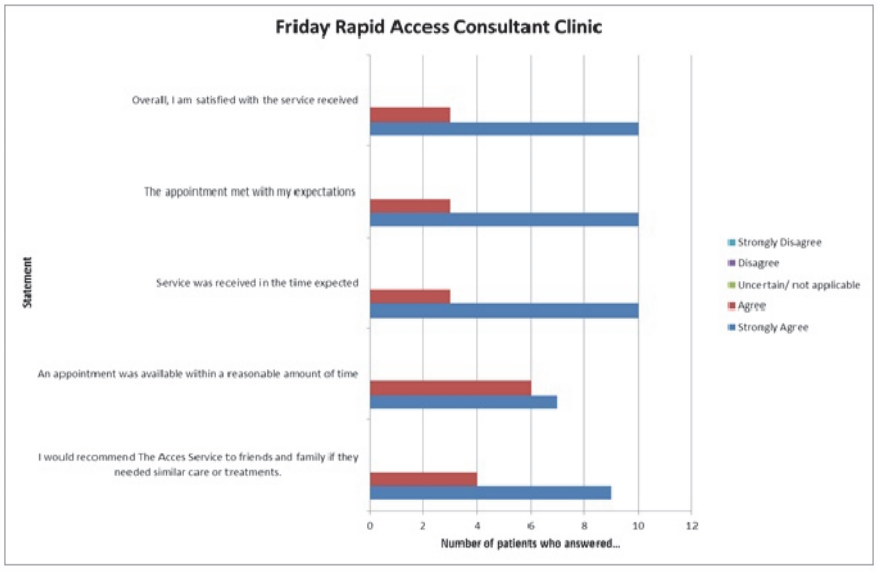
Cases referred to Cherrywood Clinic had a clear diagnosis which allows for the decision making timeframe to be evidenced when offering a follow up by consultant colleagues.

Patient satisfaction is high on receipt of timely services. Early diagnosis and treatment provides the opportunity for the patients GP to follow the plan and avoid repeated referrals into services with a poor response. Patient cooperation is improved with a clear treatment plan. Consistent prescribing rationale to GP's is helpful in terms of understanding re-referral back into service for cases of treatment resistant cases.

The project demonstrated that a Rapid Access Clinic is associated with:

- A lower DNA rate
- A significantly higher level of patient satisfaction
- Reduced waiting times from assessment to diagnosis
- Streamlined, efficient and clinically effective mental health assessments, and
- Reduced pressure on secondary care out-patient clinics.





Winter Pressures in Tameside

Involving: Nicholas Towell, Adult Inpatient/RAID Service Manager South Division; Jo Barratt, RAID Manager; Gerry Todd, Liaison Nurse; Senior Nurse Practitioners, seconded from RAID Team, Tameside; RAID Practitioners

Aim of the initiative

The key aim of the project is to gain rapid identification of individuals presenting with mental health difficulties, or those presenting with physical health problems where existing or suspected mental health needs may be a contributory factor.

Other aims of the project include:

- To promote supported community discharge and timely community interventions
- To reduce the time spent in the Emergency Department (ED)
- To prevent and reduce the duration of hospital admissions
- To promote and signpost to commissioned, voluntary and third sector community services
- To reduce demand on health services
- To provide a broad range of information and advice

Why we did it

We undertook this initiative to reduce seasonal pressures within the ED, to avoid unnecessary referrals to the RAID team and to reduce patient waiting time within the Accident and Emergency Department.

What we did

We provided a mental health triage nurse to work in close collaboration with the ED Triage Nurse/ North West Ambulance Service (NWAS) triage nurse offering support and advice to rapidly identify patients with mental health difficulties. Based on ED nurse triage, we then agreed which patients may be immediately mental health triaged, those who may be offered parallel triage with ED medics and those who required immediate medical intervention or observation prior to mental health triage.

We produced a guidance document to clarify what we expect as a basic ED triage before we would accept a patient. We also provided a liaison service for our ED colleagues. This including support, advice or joint review in cases where patients had presented for medical treatment with mental health problems later uncovered or suspected prior to discharge from ED.

We provided guidance and education to ED colleagues regarding common mental health problems and how to signpost access to appropriate services for those individual's not requiring referral to RAID team.

We organised rapid mental health admissions/ assessments under Mental Health Act (MHA) for patients known to Mental Health Services. Where possible, we organised rapid RAID assessments to take place within the Urgent RAID clinic, Mental Health Unit, to reduce ED waiting times, facilitate timely ED discharge and free up ED assessment rooms.

How we did it

We based ourselves in the Emergency Department, ensuring NWAS, triage, nursing and medical team leaders were aware of our role. Initial discussions took place to decide how we would effectively work together. We agreed with senior managers, nurses and ED consultants which patients we would accept directly from ED triage, and those who would require further medical checks. It was agreed that if the mental health triage nurse had concerns, the ED consultant would agree to discuss the patient prior to mental health triage acceptance. We agreed that, whilst the Mental Health Triage Nurse was on duty, the ED medics would not be required to complete mental health pro-forma or SAD PERSONS (SAD) scale. This relieved much pressure on medics, freeing them to attend to medical problems. This also significantly reduced length of time our patients spent within the ED.

At point of mental health triage a brief mental health review was completed, including risk review. Other aspects such as social and safeguarding issues were also triaged.

Based on triage outcome various pathways were then followed. These included rapid referral to RAID for full assessment, referral to other services including Hospital Alcohol Liaison, admissions avoidance, Older Person's Community Mental Health Teams. Each patient not referred for full RAID assessment would be provided with a care plan offering urgent contact numbers and signposting to appropriate agencies. A GP letter reporting patient presentation and a suggested management plan was also provided. Where a referral for full RAID assessment was indicated, the preliminary records check and triage process helped to reduce time between referral and assessment.

We fully integrated with our ED colleagues. Consultants, ED medics and nurses accessed the mental health triage practitioner with any queries. This avoided un-necessary referrals to RAID, equally individuals who may ordinarily have 'slipped through the net' had more chance of being identified.

Where patients already under the care of Mental Health Service/ CPA were triaged and it was apparent the patient required admission, in many cases the mental triage practitioner was able to rapidly contact Resident Medical Officer/ Care Coordinators and arrange admission to a Mental Health Unit without the requirement for referral to RAID team. When medical/ blood tests were also required, the mental health triage worker and ED medics worked alongside each other to prevent unnecessary waiting times.

In those cases where a Mental Health Act assessment was indicated, this was usually quickly organised within the ED by the Mental Health Triage Practitioner. This removed the requirement for the RAID team to be involved, freeing them up to assess other patients and

attend medical wards more quickly to complete post self-harm assessments. More rapid response to medical wards had the effect of reducing number of bed hours required.

Those patients indicating relapse of pre-existing mental health conditions were fast tracked to Care Coordinators for increased monitoring/ intervention/ Home Treatment Team referral, to prevent further deterioration/ hospitalisation. Again, Mental Health Triage Nurse was often able to expedite this rapidly, without the need for RAID team referral.

An updated mental health in-patient bed state was e-mailed to the Mental Health Triage Practitioner each morning.

How we monitored progress and the measures used

We measured several indicators to monitor progress, including:

- Waiting time from ED triage to mental health triage
- Number of patients able to completely bypass preliminary medical mental health screening
- Duration of patient time spent in ED prior to discharge
- Duration of time spent in ED prior to admission to mental health bed
- Duration of time from Mental Health Triage referral to patient assessment by RAID/psychiatric doctor
- Number of patients leaving ED without waiting for ED/mental health triage
- Number of repeat attenders
- Number of patients referred on to RAID team
- Number of patients assessed by RAID requiring admission, Home Treatment Team and RAID clinic follow up
- Number of patients directly referred to Older Person's Mental Health Services
- Number of inappropriate direct referrals to ED for mental health assessments
- ED breach times

We examined the following documentation:

- Discharge outcome forms
- Patient leaving ED without waiting forms
- Request for police welfare checks
- RAID referral forms

How we evaluated the impact upon service, patients, staff and carers

The impact of the initiative was evaluated using the following methods:

- Verbal feedback through regular brief meetings with senior ED nurses and consultants
- The number of un-necessary bloods tests, medical tests, referrals to ED medics
- The number of patients waiting longer than one hour from Mental Health Triage to full RAID assessment

Impact upon patients and carers was monitored by verbal feedback, in particular the reduction of time spent in ED, the number of patients deciding to leave prior to mental health assessments and the awareness of ED practitioners of where and how to access mental health support for patients not requiring onward referral to RAID

The Outcome

Measurement, evaluation and feedback provided us with the following outcomes:

- A reduction of ED referrals to RAID

- A reduction of ED medical time spent with patients presenting with primary/ secondary mental health problems
- A cost reduction due to fewer un-necessary blood and other medical screens
- Effective joint working between mental health triage/ ED medical practitioners
- The elimination of requirement for ED medics to complete SAD scores
- A reduction in the duration of patient time spent in ED prior to discharge home
- A reduced duration of patient time spent in ED prior to MHA assessment/ admission to mental health bed
- Improved professional relationships with ED colleagues, increased understanding of roles, mutual support and learning from each other
- ED practitioners, nursing and medical requested an ongoing presence of mental Health Triage Practitioner in core hours
- An easier identification of repeat inappropriate referrers
- A reduction of RAID time spent in ED, allowing faster response to post-self-harm referrals from medical wards, reduction of medical bed hours.

Stockport Team for Early Management (STEM)

Involving: Karen Maneely, Locality Manager Mental Health Services Tameside; Nicholas Towell, Adult Inpatient/RAID Service Manager South Division; Kevin Gordon, Stockport RAID, STEM, OOH AMHP Team Manager; Registered Mental Health Nurses, Social Workers and Support Workers at Stepping Hill Hospital in partnership with Big Life Group Sanctuary Self Help service

Aim of the initiative

The aim of the Stockport Team for Early Management (STEM) is to reduce the number of admissions to the acute inpatient mental health beds at Stepping Hill Hospital, while providing an out of hours service which offers therapeutic intervention and engagement for those experiencing mental health crisis.

Why we did it

An increase in the number of short term admissions to acute inpatient mental health beds within the Stockport Borough, particularly late at night and in the early morning had been identified. The length of stay for these admissions was typically between 3 to 5 days. It was identified that in the absence of any other service provision out of hours to care for those in mental health crisis, the only option to ensure the patients safety and offer engagement was to admit into hospital. Providing a service out of hours which offers therapeutic intervention and engagement for those experiencing mental health crisis was predicted to fill this gap in mental health service provision.

What we did

A space was located for the service to be operational; this is called the STEM room and is furnished comfortably and to a high standard with the décor designed to be warm and welcoming. The room is staffed by Mental Health Practitioners and support workers, ensuring there is always staff available to work with patients. Patients are offered refreshments whilst receiving care alongside various occupational activities.

How we did it

The provision of STEM is directly linked to the Emergency Department (ED) and takes all

referrals to mental health services in Stepping Hill Hospital between the hours of 2100 to 0900. STEM will then screen/ triage the patient and information received in order to ascertain what the best pathway would be to follow. In these cases the decision would be made to whether the patient is suitable to receive therapeutic interventions and engagement with STEM or is more suitable for a direct RAID assessment.

When a patient is screened to STEM they attend the STEM room which operates as a safe, clean and therapeutic environment for them to receive the care that is required. The service provision ranges from full mental state risk assessments to therapeutic engagement and care planning out of normal working hours. Following assessment or intervention a patient can either leave if appropriate to do so, be signposted or referred to other services, or in some instances admitted to an acute inpatient mental health ward if the need requires such provision.

How we monitored progress and the measures used

All referrals into the STEM service are recorded into PARIS. This takes into consideration how they enter the STEM service, what care is received whilst in the service and what pathway is chosen when discharging from STEM. Operationally the STEM service is monitored closely by the Team Manager and Service Manager. Mental Health Practitioners record all activity within the service and feed this back to senior management. Data analysis is undertaken by the Trust's Performance Department, as well as receiving qualitative feedback from an electronic survey developed locally.

All measures are recorded within PARIS, our clinical information system; data is made available and easy to understand through the use of Tableau, an online business intelligence and data visualisation tool.

We measured the following indicators:

- The number of psychiatric hour breaches within 4 hours
- The number of patients assessed within 1 hour of attendance at the Emergency Department
- The number of patients receiving an assessment within 2 hours of attendance at the Emergency Department
- The number of patients who leave the department without being seen

How we evaluated the impact upon service, patients, staff and carers

Data analysis, undertaken by the Trust's Performance Department and qualitative feedback received through the use of the locally developed survey supported evaluation of the project.

A report describing the first year of STEM has been produced and details an evaluation of the service over this time period.

The Outcome

It has been found that there was a reduction in short term admissions to the acute inpatient mental health wards and reductions in inappropriate referrals were seen alongside the patient waiting time being reduced in ED.

The STEM service is still operational and is hoping to secure further commissioning to continue to provide this excellent out of hours service.

Clinical Skills (Clinical Effectiveness)

Adult acute inpatient clinical skills course and Adult acute services collaborative care planning project

Involving: Gemma Mlambo, Modern Matron; Zoe Molyneux, Associate Director of Quality Governance; Service Managers; Service Users and Carers; Frontline Staff; External Subject Matter Experts

Aim of the initiative

The aim of the initiative is to improve the quality of mental health care planning with a focus on collaboration and patient centred care, and to improve the patient experience and quality of what is delivered within adult acute mental health care.

During the planning and piloting of the collaborative care planning, a training needs analysis was undertaken that identified a number of areas of development, and an adult acute inpatient clinical skills programme was identified as a need.

The programme provides important new opportunities for practitioners in this key service. It adopts a wide-ranging and flexible approach to working effectively with people who require acute in-patient care.

The overarching principle guiding the programme is that people with acute mental health problems have a right to effective treatment and support to assist them through the time of acute crisis. The programme acknowledges that provision of acute care is an essential component of a comprehensive and integrated service, and emphasises that patient-centred care should be the fundamental principle underpinning both the development and delivery of acute care.

These principles are reflected in the themes of user and carer collaboration, social inclusion, gender, sexuality and ethnicity which have been integrated and interwoven throughout the programme. Participants are expected to demonstrate sensitivity to, and awareness of, the major issues in these areas within each topic, from providing appropriate comprehensive client assessment to implementing culturally relevant and acceptable treatment.

Why we did it

We found that mental health staff working on adult acute mental health wards had access to very limited role specific development after formal nurse education.

Research has highlighted serious problems in acute inpatient care (SCMH 1997, 1998, 2005, MIND 2005 et al). Although service users acknowledge they left hospital in a ‘better mental state than when they came in’ many stated that their longer term needs were overlooked. Commonly service users reported they were bored; found therapeutic and recreational activities lacking, compounded by a limited focus on the principles of recovery. Some studies (SCMH 2005 et al) are beginning to suggest that with the introduction of acute care at home (HTT teams), many inpatient wards are seeing greater pressure on their resources from increased acuity, throughput and levels of risk.

The new developments in hospital, community, day and residential care and treatment have emphasised the need for a high level of skill and expertise. However, developments

in training and education had not kept pace with service changes and there remain very few training programmes for acute inpatient care practitioners (Clarke 2004)

Acute Care staff is one of the largest single staffing groups within Pennine Care NHS Foundation Trust. Developing this vital staffing group to meet the needs of service users has to date relied on education and training provision that does not always fully recognise the very specific challenges of practicing within such settings.

What we did and how we did it

We reviewed a range of care plan documents available nationally, and held several task and finish groups to develop and design a bespoke collaborative care planning document. We worked in collaboration with service users, carers, frontline staff and service managers, and developed and introduced a collaborative care planning document.

Once the document was developed; a pilot was carried out to test it in several services, and feedback from service users, carers and staff was sought. Following revisions to the document, full roll-out commenced.

A 10 day training programme was developed with front line staff, to equip staff with the underpinning knowledge and skills to use the collaborative care plan. The training programme included face to face learning, practical workshops, lived experience and knowledge and skill refreshers. Additionally, training delivered was co-facilitated with service users and carers.

Training was delivered in a way that supported shared learning and reflective practice, and included participants from each of the 10 adult acute wards which allowed for rich discussion about elements of best practice and opportunities for learning.

How we monitored progress and the measures used

During training and piloting of the collaborative care plan, feedback was sought from service users, carers and staff. Training sessions were evaluated, and audit measures were identified to allow audit of the use of the collaborative care plan.

How we evaluated the impact upon service, patients, staff and carers

The training programme was evaluated using feedback from staff attending the training sessions. Audit measures were identified to allow audit of the use of the collaborative care plan, and during the pilot and roll-out, feedback was sought from staff and managers.

What the outcome was

Audit has identified improved quality of written care plans, and a better skilled workforce. Feedback identifies staff feel valued and invested in.

Training (Patient Safety)

This section provides excellent examples of bespoke training programmes developed to meet service needs.

Our Clinical Supervision Special Interest Group

Involving: Garry Hodgkinson, Senior Paediatric Physiotherapist; Noel McLaughlin, Specialist Musculoskeletal Paediatric Physiotherapist; Trafford Children's Therapy Team; Paediatric Musculoskeletal Physiotherapy Service, Heywood, Middleton and Rochdale

(HMR) in liaison with Paediatric Physiotherapy Service Leads across Pennine Care

Aim of the initiative

The key aim of this initiative is to ensure adequate clinical supervision is provided for the Paediatric Musculoskeletal Physiotherapy Service. Other aims include:

- Sharing 'best practice' across practitioners in Pennine Care NHS Foundation Trust
- Developing a peer support network and maintaining professional relationships across the Trust
- Ensuring individual practitioners adhere to best evidence based practice reducing practitioner isolation whilst maintaining quality and safe practice
- Providing a financially efficient service.

Why we did it

As a Band 7 specialist physiotherapy practitioner, I am recognised as a source of expertise in my clinical area of practice, and therefore have to ensure that I continue to develop. My personal aspiration is to partake in a clinical journey, questioning and developing my practice, adding to my level of expertise rather than merely reinforce static practice, also ensuring that I don't repeat years of practice.

Through development of new services, individuals became increasingly isolated with regards to their specialist practice in that we moved away from traditional 'physiotherapy departments', incorporating all physiotherapy services in one place, to the new model of multi-disciplinary Children's Services. This ultimately provides an improved, joined up service for our patients but at the expense of peer support and supervision in specialist areas of practice.

This provided the need to develop partnerships across Pennine Care NHS Foundation Trust with peers in similar positions, thus creating the concept of the clinical supervision specialist interest group. The first supervision sessions were implemented in February 2017, and continues on a 3 monthly basis.

In HMR Paediatric Physiotherapy Service alone, in 2017 823 new patient referrals were received, of which approximately 600 were due to a musculoskeletal issue. Numbers from other areas of Pennine Care NHS Foundation Trust; i.e. Bury, Trafford and Oldham are unknown but similar figures may be represented. This is a significant patient group, requiring the right intervention at the right time; similarly when intervention is not indicated, following assessment, they are discharged in a timely manner.

In addition, effective supervision in this specialist area promotes efficiency of resources i.e. physiotherapy time, reduced impact on waiting lists and times, self-management strategies, patient empowerment to promote independence and activity based interventions, reducing professional reliance and 'bounce back' for the same conditions.

What we did and how we did it

Of utmost importance is the opportunity of self-reflection and feedback to the group with regards to topics discussed, current practice and actions required.

Liaising with all Paediatric Physiotherapy Service Leads we coordinated 3 monthly supervision meetings; developing the agenda and supervision recording documentation.

The supervision specialist interest group focuses on individual practitioners with regards to

their own professional development and reflective practice. More importantly, it provides evidence of practitioner supervision, using the agenda, minutes and individual supervision recording sheets.

One session, delivered by Garry, our Senior Paediatric Physiotherapist aimed at Goal Setting and Outcome Measures. In turn, there was interest from Service Leads in the model of care implemented in HMR; therefore a service development morning was held in Trafford; aimed at developing the service to improve service delivery, goal setting but more importantly measuring the effectiveness and outcome of our specialist interventions. Further training has been planned to support Trafford in their transformation.

Further topics discussed at sessions include:

- Management of children with hypermobility (hypermobility represents a significant number of referrals to our services and management models vary widely, potentially draining services of time and financial resources).
- Sharing clinical pathways.
- Sharing developments i.e. leaflet production, text messaging service reinforcing advice given (FLO).
- Band 5 competency framework within Musculoskeletal Physiotherapy Practice.

Following discussion of topics, there is an agreed outcome with regards to physiotherapy practice.

In addition, identification of conditions such as Temporomandibular pain, a rare paediatric condition, was the topic for discussion. This topic raised awareness and highlighted a training need for all physiotherapists, and therefore the appropriate expert in this area was approached to conduct further training for Pennine Care NHS Foundation Trust Paediatric Physiotherapists.

How we monitored progress

Progress is continually monitored through the development of the agenda, using a process to identify topics, including reflection and feedback in relation to changes in practice.

Progress is driven by the attending therapists ensuring professional topics raised and discussed meet individual practitioner needs.

How we evaluated the impact upon service, patients, staff and carers

Our discussion, reflection, sharing evidence based practice and clinical guidelines has had a positive impact upon the service, and patients are receiving an improved, up to date, timely, and efficient service from individual practitioners, across Pennine Care NHS Foundation Trust.

The Outcome

We have moved from individual practice with no shared learning, towards sharing practice and a collective learning environment.

Employing this model of supervision facilitates my practice and that of others in this clinical speciality. Interest has been further expressed in implementing this model of supervision across other speciality areas within Paediatric Physiotherapy.

District Nurses Medication Error Review

Involving: Kerry Briggs, Quality Lead, Oldham; Dr. David Low, Knowledge and Innovation Programme Manager; Alyson Wadsworth, Cluster Performance Lead; Sara Handley, District Nurse Team Leader; Emma Grainey, Senior Practitioner; Lorraine Jones, Governance Manager; Frances Branton, Senior Business Manager

Aim of the initiative

To prevent medication errors that could result in:

- Compromise of patient safety
- Compromise of effective use of nursing time

Why we did it

At the end of December 2016 Oldham Adult Community Nursing had 33 medication errors during 2016/17. A medication error review was requested to establish reasons for these errors and to provide assurance that appropriate actions were undertaken. For the full year 2016-17 the total number of medication errors increased to 41. It should be noted that two of these medication errors were non Pennine Care NHS Foundation Trust medication errors.

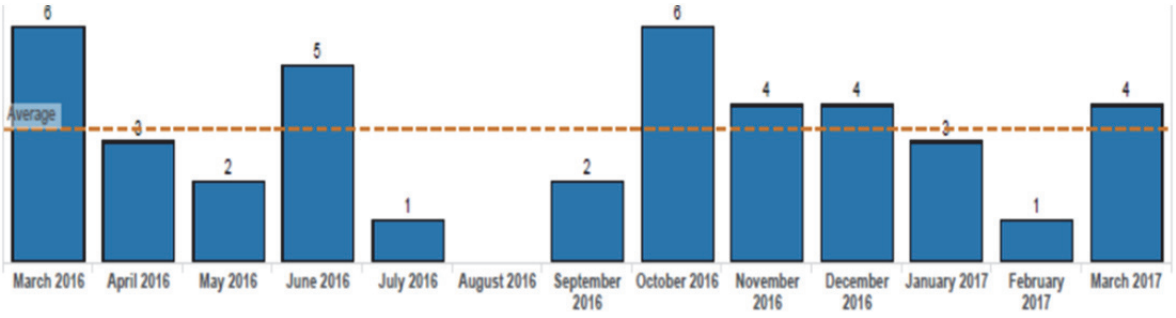


Figure 1: Medication Errors over time

What we did and how we did it

The team followed a systematic approach based upon established quality improvement (QI) method (Six Sigma, Lean) to establish the root causes and countermeasures to reduce medication errors.

We completed the following stages:

1. Collecting and collating of baseline data (medication errors)
2. Analysis of data through visual charts
3. Root cause analysis using Ishikawa (Fishbone Diagram) and 5 Whys, with the Oldham District Nursing Team
4. Determining countermeasures after establishing root causes
5. Quality checks, approval and dissemination of report

How we monitored progress

The original report was modified to include the use of the Ishikawa (Fishbone) root cause analysis (RCA) tool, in combination with 5 Whys questioning technique, encompassing the entire team. The reason for the amendment of the original report was:

- Inclusivity of all 'voices' from the process
- Knowledge interdependencies from all 'voices'
- Focussed areas to determine root cause
- Powerful combination of established RCA tools to use in one engagement session
- Showcase of the power of quality assurance with experts in their fields

How we evaluated the impact upon service, patients, staff and carers

The amended report, including new RCA methods and intelligence gained from a focus group were used to evaluate the impact of the initiative. Countermeasures were amended to reflect new RCA intelligence.

Further evaluation will take place to understand and quantify the effectiveness of the countermeasures.

The Outcome

The report was distributed and presented to Executives and the Trust Board.

On the basis of the report, Oldham are in the process of working with the Knowledge and Innovation Programme Manager to design a 'practical' workshop to coach and teach District Nurses on 3 vital QI tools used in any quality improvement and continuous improvement projects.

It is envisaged that this will increase the culture of speaking with data as well as embedding quality improvement and continuous improvement as part of their roles

Environmental Design and Dementia

Involving: Ruth Chaplin, Occupational therapist; Louise Stratton, Occupational therapist; Sarah Spencer, Therapy Support Worker; Claire, student of The University of Salford

Aim of the initiative

The aim of the project is to improve the service users experience by making the care home environment a positive place to be for both residents, family and staff and demonstrating to the care home staff the impact the environment and activity can have on the wellbeing and behaviours of service users with dementia and that this can be achieved in a cost effective way.

Why we did it

We receive many referrals from care homes due to staff having difficulties managing certain challenging behaviours and mood disorders. Often the environment and a lack of social stimulation play a big

part in the service users presentation. Working with care homes and educating them can help to improve wellbeing and enable staff to have the tools to better meet resident's needs.

What we did

Claire and Sarah ran an activity programme within the home for one week. It had been identified that lack of choice was a contributing factor to the residents participation so a residents meeting was run the week before for residents and family. Interest checklists were utilised to identify meaningful activities for the service users. The activities included a vintage afternoon tea where family got involved baking cakes and a 'movies for memories' afternoon was held.

Reminiscence was utilised to give the residents a sense of belonging to their environment. There were historical pictures of Stockport already in the home but these were not noticeable to the residents. Sarah and Claire decorated the frames to make them tactile and to draw attention to them and rehung them in places around the home where residents would walk and be able to interact with them. They also took the old meaningless canvases away and painted them, adding reminiscence artwork with the help of the residents.

Coloured doors were added to the frames on the resident's bedroom doors to make them distinctive and help orientate them.

It was identified that one of the barriers for staff with engaging with residents was time so Sarah and Claire made activity boxes with a mixture of sensory objects and activities that staff could easily use with residents. They also left pre-printed resident meeting sheets to make it easier for the weekly meetings to go ahead.

The project lasted six weeks and information was left with the home to move the project forward once Claire and Sarah finished visiting; this included information on dementia friendly signage and the use of contrasting colours.

How we did it

Claire identified a number of care homes to visit across the North West that had dementia specific environments, to gain ideas. On her visits she spoke to managers and staff to identify areas that worked well and not so well. She conducted a number of literature reviews which identified the areas that needed targeting, including looking at depth perception, colour contrasts, sensory overstimulation and sensory loss all of which can lead to increased agitation, confusion and social isolation.

Claire met with a civil engineer to look at the layout of the lounge environments to see if they could be rearranged in a better way and a walk through of the care home environment was conducted to identify areas for change.

Interest checklists were utilised to identify meaningful activities for the service users.

Sarah attended a conference on Dementia and the environment to ensure the most up to date knowledge.

How we monitored progress

Claire visited the home most days constantly gaining feedback from staff, residents and family. At the end of the project Louise spoke to the care home manager for feedback.

The measures used

We used the Model of Human Occupation (MOHO) Reis assessment tool, designed to specifically examine the environmental impact of residential facilities on the residents.

How we evaluated the impact upon service, patients, staff and carers

An interview was conducted with the Care Home Manager at the beginning and end of the project to understand the impact of the project and the changes to the environment and activities. This was supported by observations of service users engaging in activities and the environment and gaining feedback from family, staff and residents.

The Outcome

Changes meant the home was no longer purely staff led, we saw an increase in participation within activities and an improvement in the aesthetics of the home.

Staff in the home gained a greater understanding of the impact of the environment and activity on resident's wellbeing and their knowledge improved in relation to overcoming barriers; for example, the barriers of cost and time in providing activities and improving the environment.

Improving Care of Patients with Delirium

Involving: Dr. Seri Abraham, Consultant Psychiatrist; Wendy Kettleton, RAID Practitioner; Diane Wynne, Clinical Lead; Claire Warhurst, Teram Manager; Sam Houghton, Mental Health Practitioner; Belinda Gallacher, Senior RAID Practitioner; Matt Meredith, RAID Support Worker; Lisa Norton, Administrator

Aim of the initiative

Delirium forms a significant proportion of referrals to the Older People Liaison team at Oldham. The aim of the project is to improve the care received by patients with delirium and increase the awareness regarding management and prevention of delirium among staff working for the acute trust.

Why we did it

Delirium is sometimes called 'acute confusional state' and is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course (Inouye, 2006). Delirium is a medical emergency that is associated with poor outcomes. The mortality rates associated with delirium is comparable to myocardial infarction and sepsis; however, it can be prevented and treated if dealt with efficiently.

Older people and people with dementia, severe illness or a hip fracture are more at risk of delirium. The prevalence of delirium in people on medical wards in hospital is about 20% to 30%, and 10% to 50% of people having surgery develop delirium. In long-term care the prevalence is under 20% (Rudolph and Marcantonio, 2011). Reporting of delirium is poor in

the UK, indicating that awareness and reporting procedures need to be improved (NICE, 2010).

Delirium can be hypoactive or hyperactive but some people show signs of both (mixed). People with hyperactive delirium have heightened arousal and can be restless, agitated and aggressive. People with hypoactive delirium become withdrawn, quiet and sleepy. Hypoactive and mixed delirium can be more difficult to recognise (Siddiqi et al, 2006).

There were 128 referrals to the Older People's RAID team at Royal Oldham Hospital in September and 164 in October 2017 respectively. Having reviewed the presentation and interventions offered, 39 patients in September 2017 and 52 patients in October 2017 were assessed by the team and deemed to have fairly 'uncomplicated delirium' (patients without a history of a memory difficulty, presenting with acute onset confusion with any associated risks and confusion managed mainly with appropriate nursing intervention and treatment for underlying cause).

In 35% of the referrals, the patient was diagnosed with delirium prior to referral to the team. Patients with uncomplicated delirium could be managed by the medical team with advice and signposting from our psychiatric liaison service. Additionally, when patients present with delirium, other psychiatric co-morbidities such as depression, anxiety, background cognitive impairment (undiagnosed and pre-existing) tend to get clouded by delirium.

The team felt that devising a delirium pathway would be useful in helping medical staff manage patients with uncomplicated delirium.

What we did

The delirium pathway was implemented at the beginning of December 2017. It is designed to be a two pronged approach with triaging and training arms.

How we did it

Triaging, advising and signposting referrals

On receiving a referral which suggested acute confusion, the team would check the patient database for past psychiatric history. In absence of previous contacts by the team and secondary mental health services, the team would then proceed to ring the ward to gain further clinical details such as presenting circumstances, medical history and current presentation. The team would then ring the next of kin/ family to gain further collateral information. On being satisfied about the nature of difficulties, current presentation and risks; the team would then place the patient under the delirium management pathway. As part of the pathway; the ward, patient and family would receive a leaflet designed by the team. This would provide the team with an opportunity to engage the medical team in bedside teaching regarding delirium.

Appropriateness of placing individual patients under the pathway was reviewed on a weekly basis by the band 6 nurse working with the team. If a patient placed under the pathway was to be re-referred, the team would gain further information to see if there were any clinical changes and undertake a face to face assessment if required.

Training

The second approach was to provide an hour long teaching session on a monthly basis. This includes identifying, managing and preventing delirium for medical staff (all grades

and professions). This would be undertaken by the band 6 nurse working with the team with support from all other team members. So far, three 1-hour sessions have been delivered on 3 different medical wards at Royal Oldham Hospital. Additionally, an hour long teaching session on the management of delirium has been delivered to foundation year doctors by the team psychiatrist.

How we monitored progress

Towards the beginning of January 2018, the team noted an increase in referral letters implying that the patients had low mood. However, on further assessments, the patients were found to be presenting with delirium. It was then decided the team would complete the triage on the ward with face to face conversations with the medical team and family if present. This helped improve the quality of referrals, provide bedside teaching and focus on the preventative aspect of delirium.

The measures used

Confusion Assessment Method (CAM) was used to diagnose delirium based on the information available. Feedback for teaching sessions was collected using a locally designed and developed tool.

How we evaluated the impact upon service, patients, staff and carers

The care received by patients placed on the pathway was reviewed in February 2018. The team received 114 referrals in December 2017 and 170 referrals in January 2018. Out of the referrals received, 9 patients were placed under the pathway in December 2017 and 28 patients in January 2018. Over the 2 month period, 3 patients were re-referred and were reviewed by the team. 1 patient was inappropriately placed under the pathway; this was picked up the senior clinicians and the team subsequently dealt with it.

As mentioned earlier, we have delivered 3 sessions on 3 different medical wards at Royal Oldham Hospital. The feedback from staff who attended a session has been positive and some comments are illustrated here:

'I did learn a lot and it was good to learn new things about delirium'

'Was made aware of different types of delirium and causes of it'

'The leaflet would be very useful for the future'

'Good explanation of delirium'

'More delirium training please'

The training sessions are being very well supported by medical and senior nursing colleagues on the wards and monthly sessions have been organised for the remainder of the year.

The Outcome

The pathway has helped improve the awareness regarding management and prevention of delirium among acute trust staff. The future plan is to tie in the local work with ongoing work

across Greater Manchester in standardising the diagnosis and care received by patients with delirium from the point of entry to discharge and beyond.

Health and Wellbeing College – RHSD Units (Patient Experience)

Involving: Dil Jauffur, CQUIN sponsor; Gemma Kirk, Transformation Lead and RHSD Health and Wellbeing College Lead; Fiona Christopher, Clinical Services Manager and supervisor; Amanda Sweeney, Project Support Officer; Dan Connally and Neil Scott, Peer Co-facilitators; Staff from across the Rehabilitation and High Support Directorate, including Clinical Services Managers, Modern Matron, Governance Manager, Nursing staff, Occupational Therapy staff, Psychology staff and Ward Managers in partnership with Living Well Rochdale, Rugby League Cares and Transport for Greater Manchester.

Aim of the initiative

A recovery college is a college that offers a range of recovery focused educational courses and resources aimed at supporting people in recognising their potential, through self-management, to deal with the mental and physical health challenges they experience and to achieve the things they want in life.

Our Recovery College delivers peer-led education and training programmes within Mental Health Services. Courses are based on recovery principles and are co-devised and co-delivered by people with lived experience of mental illness and mental health professionals.

After two successful terms on our low secure units, the aim of this initiative is to expand the offer and establish a Recovery College to include all patients and carers and staff across the Rehabilitation and High Support Directorate (RHSD) and extend the offer to our Psychiatric Intensive Care Unit (PICU).

Why we did it

Traditionally implementing recovery-focused services and projects has been challenging in secure environments due to the tensions between managing and containing risk and helping individuals to move on with their life; challenges not necessarily present in community services. Many patients within RHSD, due to the nature and degree of their illness and often previous offending history, have been out of work and/ or education for significant periods. However, many patients will cite the desire to return to some kind of work or education as a future goal.

Many of our patients lack the confidence to pursue education or employment in the community therefore it is considered that providing them with a safe, supportive learning environment will provide a valuable means of developing skills and confidence that will help

patients achieve future goals, bridging the gap between hospital and community participation.

In addition we want to be able to offer people who may not be able to leave the units to access the main community based Health and Wellbeing College or who may not yet have the confidence to access mainstream opportunities to recognise their potential and learn self-management skills to deal with the mental and physical health challenges they may experience. We plan to establish a model which supports students to feel hopeful about the future and to think about the things they want to achieve in life.

The ethos of the college which is about bringing together professional experience and lived experience to co-produce, co-deliver and co-facilitate learning is fundamental to its success. The college promotes hope, control and opportunity for everyone. This has been a totally different experience for our secure patient group, who become students as soon as they enter the college - there to learn regardless of their previous experiences and risks.

What we did

In the first instance, key members of the project team attended training with Nottinghamshire NHS Trust's Recovery College. We then developed a clear model, values and aim, working alongside the Trust's Health and Wellbeing College.

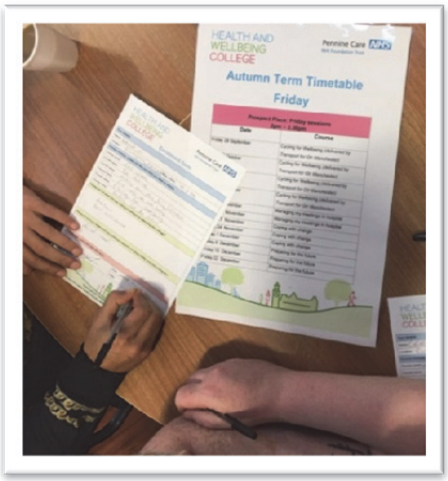
We established bi-monthly campus action groups to help shape the future of the college and working with patients from the two low secure units, we identified courses which would most benefit their health and wellbeing and worked collaboratively to co-produce courses to be delivered at the college.

Two classrooms were identified on the units at Prospect Place and Tatton Unit. We turned a meeting room into a learning environment, working with students to decide how best to 'decorate' the rooms.

The prospectus and enrolment process were then developed along with high quality course materials. We have since shared resources, learning and experiences with other recovery colleges in the North West and presented at a number of events including the RHSD Quality Afternoon, the Recovery and Outcomes North West group and a Pennine Care NHS Foundation Trust Consultants training day.

Established partnerships with external organisations to deliver courses and people with lived experience were supported to volunteer at the college and are now completing the peer navigator qualification.

Started delivering courses to low secure students in January 2017, expanded to include carers and all inpatients in RHSD in term 3, increased the number of college afternoons from 2 to 3 and are planning to take the model to Cobden Unit in May 2018.



How we did it

The success to date has been dependent on an identified college lead and project support; however, the sustainability of the college has relied on staff and service user evaluation of the college and input into development and delivery of courses.

In addition we identified two college classrooms that have been booked out and allocated to the college during term time. Staff from across RHSD have supported with facilitating breaks, providing 1:1 support to students where necessary, completing risk assessments where needed and encouraged and reminded students to attend.

We have promoted the college through community meetings, dedicated noticeboards, poster displays and timely delivery of prospectuses. We have supported students to enrol at any point in their recovery journey and have operated an open door policy.

Letters confirming enrolments and updates have been sent directly to the students and copied to their care teams and students have self-referred to courses they feel would most benefit their recovery journey.

Unit administrators and project support have supported with setting up of rooms and provision of resources each week, issued diary reminders and have supported external facilitators when accessing the units.

We have co-produced every course with people with lived experience and courses are co-reviewed each term to ensure they continue to meet the needs of students and have supported peer co-facilitators to increase their confidence in delivering courses.

How we monitored progress

Progress has been monitored by reviewing attendance figures across courses each term:

Term	Number of attendances
Winter 2017	28
Spring 2017	35
Autumn 2017	95
Winter 2018	Term not ended

NHS England has monitored the success of the Commissioning for Quality and Innovation (CQUIN) targets for the establishment of a Recovery College on two low secure units and

the outcomes have been fully achieved.

We have also monitored progress through Clinical Business Unit (CBU) meetings and the Trust's Quality Group as well as collecting feedback from staff and students on a regular basis.

The measures used

We have used co-produced course evaluations, termly evaluations and qualitative feedback from students to monitor progress.

How we evaluated the impact upon service, patients, staff and carers

Evaluation of the impact on the service, patients, staff and carers has been via course evaluations, termly evaluations and qualitative feedback from students and staff experiences.

In the future we hope to be able to compare length of stay figures for those who have attended the college as opposed to those who haven't.

The Outcome and our successes

The college has offered something different for our patients. Patients take on a new role through the college, that of student and learner and through the college there is a redefinition of the purpose of services from reducing symptoms to rebuilding lives; using an educational paradigm to complement traditional treatment approaches to help people on their recovery journey.

The students who attend the college all have complex mental health needs and are in long stay units. Many have been out of work or mainstream education for some time so to have attended the college and participated in courses each week has been a huge achievement.

The courses develop knowledge and skills to help people to live well outside of hospital. All of our courses are co-produced and co-delivered by people with lived experience of mental health difficulties and people with professional expertise. There is a recognition of the equal importance of both 'professional expertise' and 'lived experience'; a different kind of workforce that includes peer workers, founded on co-production and shared decision making.

We have one co-facilitator with lived experience from within RHSD who is currently working with Patient Advice and Liaison Service (PALS) to become a formal volunteer at the college and another who has been through RHSD services and is now living in the community. Their experiences and contributions have been invaluable. They are both currently completing the accredited peer navigator course and are working towards being able to facilitate courses independently.

We have increased the number of courses being delivered per term from 8 to 18 during the most recent term and the number of attendances from 28 to 95 by the third term. We now accept enrolments at any point during the term to allow for individual recovery journeys.

We have held three really well attended celebration events, one of which was featured in the Rochdale Herald.

Here is what some of our students have said:

Co- production at the college: *"I've enjoyed it, you get to have your say and come up with suggestions. You feel part of a group in the sessions. We brainstorm and come up with loads of ideas. People with lived experience have valuable input because they have experience of the system. During the sessions you get to share what you've been*

through which makes you realise you aren't alone and other people have been through similar things. It's helped me and I know I can help others."

Co- production at the college: *"I have been co-writing with other patients for the drug and alcohol abuse and living with psychosis courses. It's good to have a chance to tell people about my experiences. I have enjoyed this work and feel my opinion is valid."*

Attending the courses: *"It's been helpful learning about mental health and psychosis; I'll be able to use what I've learnt. I want to develop myself in the future and the college helps with that. I have learnt to love myself, just like it was the first 16 years of my life."*

Attending the courses: *"I went to the Health and Wellbeing college course on drugs and alcohol and it enlightened me. The reality of what drugs can do to you. It might be good taking them but the side effects are huge, like death, liver failure, heart attack and mental health issues. I won't touch them again. I did the relationships and psychosis courses too. It's brilliant I need more input and want to learn things I never knew before. My input is very good. I am intelligent. I'm learning at the same time and using my wisdom and my experiences to help others".*

Attending the courses: *"Between 6 and 18 months ago I was depressed very much and just roughly down in the dumps a lot and I could not cope. Since I have started doing the courses and sessions at Tatton ongoing I have felt better."*

Attending the courses: *"I learnt a lot about living with Psychosis and what triggers mean."*

Attending the courses: *"It has made me realise that being on the straight and narrow, both criminally and mentally, is totally important for me."*

Attending the courses: *"I learnt everything - about mental health and wellbeing individual for myself."*

Attending the courses: *"I have gained wisdom and knowledge. It will improve your thinking"*

Attending the courses: *"You get to learn things that will help you in the future. The courses are interactive and fun. There is light at the end of the tunnel."*

Attending the courses: *"The Health and Wellbeing College is helpful and uplifting. It offers future positive planning."*

Self-Management (Patient Experience)

This section provides excellent examples of how services are supporting patients in relation to self-management techniques.

Education Videos for Musculoskeletal

Involving: Paul Duthie, Project Manager; Waseem Munir, Clinical Improvement Facilitator; Caroline Poole, Clinical Improvement Lead; Sharon Williams, Clinical Project Lead; Staff from the Trafford MSK Service; in partnership with My Health My Community project team (website content)

Aim of the initiative

As part of the My Health My Community (MHMC) self-management website, the Trafford Musculoskeletal (MSK) Service developed a suite of 70 exercise videos which are available online, with the aim to reduce the number of face-to-face appointments required, both by acting as a memory aid for those who have been seen by the service and as an initial intervention, and potential deflection, before patients reach the service.

Why we did it

In July 2016, the Trafford MSK Service began introducing various service redesigns following successful tendering. Part of the service specification was concerned with the provision of self-management and having a digital offer for patients; this was in addition to the Trust's strategy of embedding self-management and a recognition that new patient pathways were necessary to ensure the quality and delivery of the service.

The expectation was that a series of videos detailing correct exercise techniques could be used both by patients within the service and newly referred patients to enable them to self-manage. This would reduce the number of appointments they required, if any, and hopefully reduce waiting times.

What we did

Working with the physiotherapists we agreed a core set of exercise videos covering a range of issues; e.g. knee, hip, back, neck. These were then filmed being undertaken correctly and edited to include a simple bullet point list of instructions to accompany the visual demonstration. The short videos were then put on the MHMC website alongside other self-management resources identified by the service.

The service introduced telephone triaging; part of which included an option to refer patients to the MHMC website whilst on the waiting list for an appointment. Additionally, GPs were made aware of the resource and can signpost patients there alongside a referral into service.

How we did it

A dedicated member of staff was employed on a year's contract and shared between the MSK Service and MHMC. They worked with the service to gather information, developed the webpages for the content and assisted in filming. Through regular meetings we progressed the project and the videos were launched in April 2017.

The MSK Service placed a list of the videos available by all phones in the department so

patients can be easily directed to the ones that are most appropriate to them.

How we monitored progress

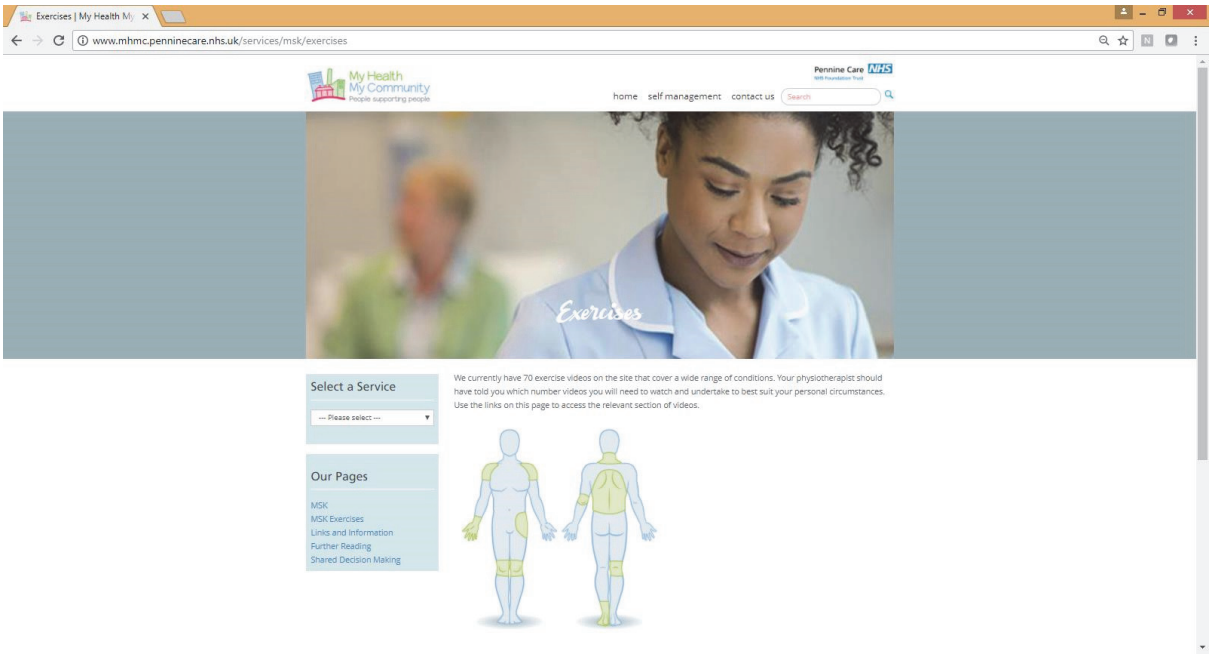
Video views were monitored on a weekly basis through web analytics to ensure patients were being directed and watching the videos.

Every quarter, data on numbers of appointments for individual patients has been reported on to assess whether a deflection is occurring.

The measures used

We used the following measures:

- Views per video
- Total video views
- Mean percentage of video viewed (to ensure people were watching the majority of the video)
- Number of appointments per discharged patient



How we evaluated the impact upon service, patients, staff and carers

The pathway was evaluated using the measures listed. In addition, a broader evaluation is being undertaken and that includes economic considerations as well as patient case studies.

The Outcome

In the first 11 months, the videos have been watched over 6,200 times in total; that's around 550 views per month. On average 81% of each video is viewed in its entirety; essentially everything to the end title.

The service has evidenced an 8% deflection. Half of this is patients who no longer have a single contact with the service after referral; i.e. are referred by their GP to the videos, then no longer need an appointment, and half who only have an initial telephone triage to self-management and no further care.

Shared Care Pathway

Involved: Kimberley Wilde, Wound Care Pathway Lead; Waseem Munir, Clinical Improvement Facilitator; Caroline Poole, Clinical Improvement Lead

Aim of the initiative

The Trust has embarked on a programme of work which aims to develop a new pathway to encourage a proportion of the population requiring community services to engage in shared care of their wound management, drawing on their own resources to self-manage more confidently and effectively whilst maximising independence.

Why we did it

In 2015, the District Nursing Team in Rochdale identified opportunities to promote self-management in wound care. Patients were supported and educated to enable them to self-manage. The team utilised 'Flo' personal text messaging service to provide support and guidance between appointments. 'Flo' is a text messaging system that sends patients reminders and health tips tailored to their individual needs. The results of this early pilot were very positive with 100% providing positive patient experience and stating that they would recommend 'Flo'. Service capacity was created by a 53% reduction in required nursing contacts for those patients supported via 'Flo', enabling the team to focus on more complex patients. No unplanned visits were required, supporting safe practice. Staff reported positively regarding the revised care pathway, appreciating the support that 'Flo' offered with improvements to the patient experience. Staff felt it released more time to care and improved their job satisfaction.

The positive work completed in Rochdale led to a plan to adopt the self-management work in all the adult community services provided by Pennine Care NHS Foundation Trust.

Who was involved

A project manager was appointed and a working group was formed with key stakeholders who included Tissue Viability Nurses, nursing leads, neighbourhood cluster leads and the service development and sustainability lead. An important element of the working group was that it included a patient representative as this type of collaborative working improves outcomes and is recommended by NHS England (2013).

What we did

The working group met on a monthly basis to develop the pathway. All aspects of the pathway work were overseen by the Nursing Strategy Group for governance purposes.

A project plan, risk register and stakeholder analysis was developed for the programme of work. The key elements of the pathway which were developed by the group were:

- A capacity evaluation
- Competency form
- Standard operating procedure
- Patient video and patient leaflet

The nursing staff all had to attend one and a half days training to support the self-management culture change within their practice.

How we did it

The development of the project involved four stages; researching current evidence and

practice in self-management of wound care; designing a pathway with support from key stakeholders such as patients, nursing teams and the governance team; implementation in the community nursing teams and evaluation.

How we monitored progress

Progress was monitored via highlight reports at the working group meetings. The project manager also reported regularly via Paris/EMIS how many patients had been 'signed up' to self-management. The 'Flo' Telehealth system also provided a monthly report of how many patients had been 'signed up' to regular text messages to support them with their wound care.

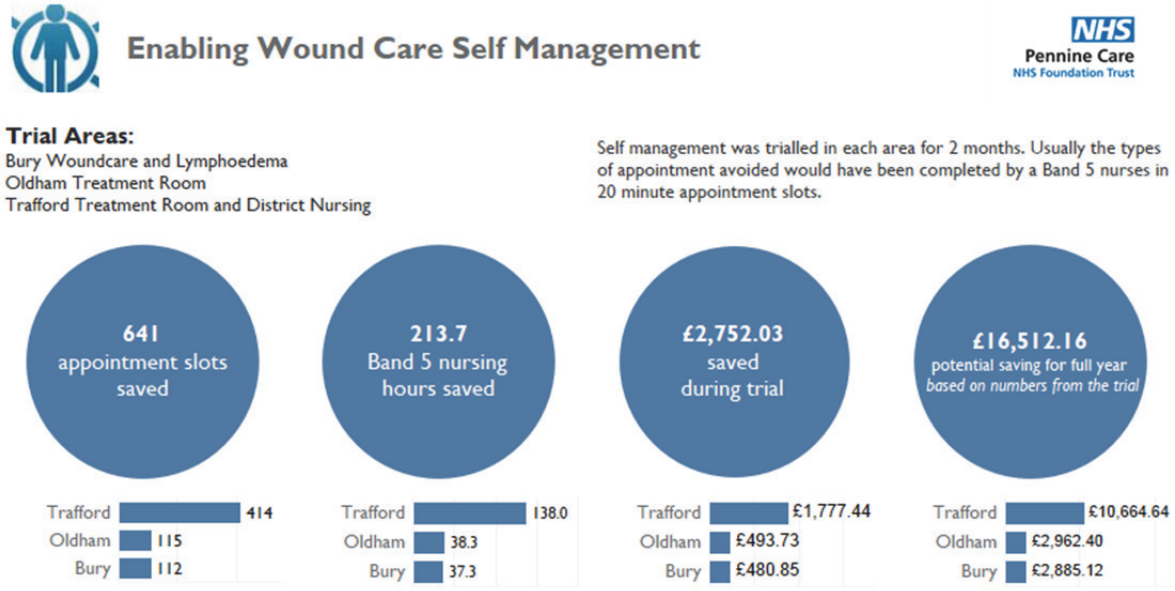
The measures used

'Flo': The percentage of patients using 'Flo' out of the total number of patients per month.

Paris/EMIS: The percentage of patients 'signed up' over the two month evaluation period out of the total number of patients.

Economic evaluation: The cost savings for appointments that were allocated to self-management

We also monitored the healing rates for wounds that were self-managed.



How we evaluated the impact upon service, patients, staff and carers

The pathway was evaluated using the following measures – patient experience, staff experience and service utilisation. Patient experience was to determine if self-management increases patient confidence, knowledge and competency. Staff experience questioned if staff feel safe and supported and if they have clear protocols and guidance in self-management in wound care. Service utilisation measured how many appointments were planned, how many were patients self-managing and how many were emergency appointments. This was to determine if there was a reduction in appointments, travel times and costs. Each nursing team undertook the evaluation for a two-month period following the introduction of the pathway.

The Outcome

The pathway roll-out is still ongoing within Pennine Care NHS Foundation Trust and to date

the results are extremely positive. Service utilisation is currently 5% with the view of a possible increase to 10% as the self-management culture is embedded.

The key challenge of the pathway was ensuring that there was a sustainability plan in place and that this included clear local leadership to embed the new culture into each team. The pathway has enabled existing variation in clinical practice to become standardised, ensuring staff involved in wound care are working to the same principles.

The patient video and leaflet has had excellent feedback from both patients and staff due to the clear and easy to follow format. The capacity evaluation form has enabled staff to feel more confident in assessing patients and carer's ability to self-manage wounds. Evaluation data demonstrates no emergency problems with the patients engaging in shared care, from this data we can conclude that this is a safe pathway that doesn't invoke any harm.

Feedback from patients and staff has demonstrated a positive experience that was well supported. This supports the NHS Five Year Forward View Plan of supporting patients to manage their health and avoiding complications.

Speech and Language Therapy Workshops

Involving: Beth Kilmartin, Highly Specialised Speech and Language Therapist; Lisa Hufton, Service Lead; Diane Ciapa, Professional Lead Paediatric Physiotherapist; Speech and Language Therapy team; School Special Educational Needs Coordinators (SENCOs)

Aim of the initiative

The aim if the initiative was to increase the effectiveness of therapy delivered to school aged children. By training school staff and parents we aim to increase the skills of adults who work with the child every day to carry out language activities that have been set by the Speech and Language Therapist as part of the child's care plan.

This approach ensures consistent shared working between therapists and schools for example in the uniformity of the training provided and supports the management of caseloads as skilling the adults around the child will facilitate timely discharge.

Why we did it

We had a large number of children on the caseload needing support in school. Therapists were having to provide the same information for various children and did not have time to demonstrate the activities to schools. Care plans were provided but school did not always feel fully supported to carry them out.

This resulted in children having to wait longer for therapy due to restricted time of therapists. Schools had inconsistent levels of experience and knowledge of carrying out therapy, leading to children having varying degrees of quality therapy.

What we did

We collected data around the most frequently targeted communication skills and created workshops around each area. We wanted these to contain practical information and demonstration alongside the theory, to instil confidence in those carrying out the therapy.

We booked a 'reflective learning session' 6 weeks after the course, to ensure the work is being carried out effectively, and that parents/staff can problem solve any difficulties with each other and a therapist.

We created an outcome tool to measure the effectiveness of the learning.

How we did it

We created a pathway for training workshops. After an assessment within the core service, any child needing therapy which is covered by a workshop was sent an invitation letter to parents and school. They were invited to book on to the workshop using 'Eventbrite'.

Following the workshop attendees were provided with resources to support individual or group work within their setting (home/school). Attendees were asked to complete a questionnaire prior to the workshop and at the end of the workshop.

Schools are able to book on to any workshop for a cost if they have not been recommended to attend by a therapist.

How we monitored progress

We collected a baseline number of children on the caseload being offered a 'care plan' to be carried out by school, which could be targeted in a workshop.

An outcome measure with quantitative and qualitative information was created to monitor the effectiveness of the workshops.

The measures used

Questionnaires were completed by all attendees. Quantitative information was collected using a Likert scale to measure change in knowledge and confidence. Qualitative information was collected to capture participants' feedback.

How we evaluated the impact upon service, patients, staff and carers

The impact on patients has been documented in the feedback collected.

We will monitor the number of children being signed up to the workshop to analyse the impact on therapist time and the impact upon patients' time within the service.

The Outcome

We received very positive qualitative feedback from parents and staff members and here are a few:

'Going to be really useful to help a lot of children and build their confidence'

'Found out lots more new ideas to help my child at home'

'Good ideas for use in class'

'Learnt about useful resources to help'

Positive quantitative feedback was collected showing an increase in understanding and confidence in providing therapy from prior to and after the workshop; which was found across all workshops. The level of knowledge in the area demonstrated an average increase of 4.125 (scale of 1-10). Confidence in supporting a child in the area demonstrated an average increase of 2.3 (scale 1-10) and confidence in carrying out the therapy increased by an average of 2.29 (scale 1-10).

Developing the HMR Paediatric Nurse Practitioner Team (Clinical Effectiveness)

Involving: Janine Parry, Paediatric Nurse Practitioner; Lisa Hufton, Service Lead

Aim of the initiative

The aim of the initiative was to improve patient and carers experience when their child is acutely unwell.

Why we did it

Heywood, Middleton and Rochdale (HMR) has extremely high rates of Accident & Emergency (A&E)/Urgent Care Centre (UCC) attendances. Most of the attendances are by HMR children aged 0-19, with 82% of all under 4 year olds in the borough presenting to these departments in a one year period. It was discovered that up to 70% of these children were discharged straight from A&E/UCC without any treatment or intervention.

Both the NHS's Five Year Forward View and the Rochdale Family Services Model had visions of delivering healthcare outside of acute hospitals. We identified that many of the children attending the hospitals A&E and UCC departments had conditions of a minor nature that could be dealt with more efficiently in a community setting, however we recognised that there was a lack of General Practitioner (GP) appointments to meet this demand. We identified potential for the Children's Community Nursing Team (CCNT) to get involved and help meet this demand. In providing this community based care we could ensure a higher standard of care was provided, reduced A&E, UCC attendances and reduced demand and cost to the acute services. It also had the potential to increase patient and carer satisfaction as it is acknowledged care closer to home is preferred and would also elevate some of the issues associated with attending these departments such as long waits and the risk of contracting more illness waiting with other unwell individuals.

Who was involved

Initially we liaised with our local commissioners and seven HMR GP surgeries. Three small trials were run involving two nurses from the CCNT who was already qualified as a Paediatric Nurse Practitioner (PNP) and had UCC experience. The trials were overwhelmingly successful and in November 2016 our first full time PNP was employed. Five months later a second full time PNP was employed. Since then a further 2 full time PNPs and 2 Healthcare support workers have joined the team (3 of the staff members are previous CCNT staff who have undertaken further training to progress into these roles). Throughout the development we have engaged with patients and carers, discussing the needs and wishes of the local community. We have also worked closely with our local commissioners throughout. The Children's Community Nursing Team manager was also heavily involved allowing establishment of the team as part of the current service. The team is now fully commissioned and all GP surgeries in HMR are on board.

What we did

We established a number of acute minor illness clinics for children aged 0-18 years living in the borough of HMR. The clinics offer appointments to patients with acute minor illnesses such as fevers, coughs, colds, rashes etc) when GPs have no available appointments for the day. The clinics are PNP led and operate in 3 locations across the borough Monday-Friday 10am-6pm. The Nurse practitioners are able to complete a comprehensive medical history, preform a clinical examination, provide a diagnosis and treat/prescribe or refer on. During the clinics we also take the opportunity to provide health promotion and education to

the patients and their families in a hope to encourage self-management and reduced presentations in the future where appropriate. To help us deliver this information we make use of the 'FLO' tele health service and have devised numerous patient information leaflets on a variety of conditions and self-care topics. We have also developed a very successful Facebook page on which we provide information on conditions, local services and self-care etc. One of our recent posts regarding hand foot and mouth disease reached 67,000 people and was published on the Manchester Evening News Website.

How we did it

Initial discussions were held with the commissioners and local GP's. We held joint patient engagement sessions with the commissioners to establish patient and carers views and wishes for the service. Once the idea of the clinics was established, work then started on sourcing appropriate locations and equipment. Staff from the CCNT started to develop their roles and gain the advanced skills needed to be competent in the PNP role. With staff and locations sourced clinic then opened. We participated in service promotion to inform the GP surgeries and make parents aware of our clinics. We visited local Sure Start Centres and surgeries to hand out leaflets and talk to families. We also made use of social media and began a team Facebook page which proved to be very popular.

How we monitored progress

To assess patient satisfaction across the PNP service we developed a small postcard type survey which we present to children and their parents/carers at the end of their clinic appointment whilst the experience is still fresh in their memory. The survey is anonymised and is offered to every family.

The information is collected by the patient experience team who produce a monthly summary of the findings.

The success of the clinic was also measured utilising the Tableau system. This system allows us to analyses data on the number of referrals we have received, patients seen, conditions diagnosed and these referred onto acute settings.

The measures used

The feedback form captures data on experience by collecting both quantitative and qualitative data. The questionnaire consists of 2 tick box rating questions, 2 free text questions and one multiple choice answer question. The questionnaires are also child friendly as they use faces with expressions with options ranging from extremely likely/happy to extremely unlikely/unhappy.

The first question asked on the questionnaire is the national friends and family test question, "How likely are you to recommend this service to your friends and family?"; the options given range between extremely likely to extremely unlikely. There is also a comment box underneath this for if they wish to expand on their answer.

The second question with a set range of responses is "how happy were you with the service today"; again the options given range between extremely likely to extremely unlikely.

We also thought it was important to capture some quality opinions of patients and service users, so we ask the question "Is there anything else you would like to tell us about the service provided to you and your child today?"

To establish if we were also meeting our goal of reducing hospital attendances the final question asked is "If this service wasn't available where would you have taken your child?";

options available are: Contacted Bury and Rochdale Doctors on Call (BARDOC), Attended A&E, attended the UCC, obtained a next day GP appointment or cared for my child at home.

How we evaluated the impact upon service, patients, staff and carers

We started to hand out the bespoke designed questionnaires in September 2017 and have continued with this to date. The questionnaires are sent to the patient experience team on a monthly basis and a report is compiled. The reports are analysed by the team at monthly team meetings.

The Outcome

Since September 2017 we have received 100% positive feedback in all areas. The friends and family tests displays that all of our patients/carers state that they would recommend us to friends and family with the vast majority answering extremely likely and adding positive comments. Again, pleasingly, 100% of patients are either happy or extremely happy with the service provided.

The feedback has been so overwhelmingly positive that as of April 2018 our clinics are expanding. We have also had a lot of interest from other areas (as far as Luton) wishing to discuss our service with a view of establishing a similar service in their area. We have been asked to present our service at a variety of events.

In terms of reducing hospital admissions the questionnaires indicate that our service has prevented 43% of our children seen from attending A&E/UCC.

Pharmacy-Led Clinics (Patient Safety)

Pharmacy Drop-in Clinics

Involving: Sarah Harris; Lead Clinical Pharmacist; Carl Hamilton, Occupational Therapist

Aim of the initiative

The aim of the initiative was to provide a pharmacy “drop in” service to inpatients on two acute admission wards at Birch Hill Hospital. This enabled patients to discuss their thoughts and concerns with respect to their medication with a pharmacist in a group setting or one to one if necessary.

Why we did it

To improve access to medication related information for all acute admissions to the adult wards at Birch Hill Hospital.

What we did

We allocated a time in the activities programme for the two acute wards (Hollingworth and Moorside). The session was held on Thursday at 1pm each week in the activity room on Moorside. Information relating to the session was advertised on the notice board on each ward plus an activity coordinator would approach patients throughout Thursday morning to ensure patients were aware that they could attend if they wished.

How we did it

The Pharmacist would come to the ward at 12.55pm and ensure the activity room was open for patients to take part. The Occupational Therapist (OT) or an Activity Coordinator

would bring patients from both wards to the activity room. The Pharmacist would explain the structure of the session and offer 1:1 support if anyone didn't want to speak in a group. Following the group an action plan is agreed with each patient if necessary and this is documented in the notes by the OT staff.

How we monitored progress and the measures we used

We asked for feedback through the community meetings facilitated by the OT team and monitored the number of individuals attending the sessions.

How we evaluated the impact upon service, patients, staff and carers

Feedback received through the community meetings was used to evaluate the impact the project had upon the service.

The Outcome

Patient satisfaction improved in relation to patients having the ability to ask questions of the Pharmacist during a facilitated session.

Physical Health Clinic on a Mental Health Ward

Involving: Lesley Smith, Chief Pharmacist; Maria Derrig, Pharmacy Technician; Firuja Khatun, Pharmacist; Gemma Simpson, Pharmacist; all ward staff, including Registered Mental Health Nurses, Occupational Therapist, Nursing Assistants, Ward Doctor

Aim of the initiative

The aim of the initiative is to put mental health on a par with physical health as per NHS England's objective (*Five Year Forward View for Mental Health*) and to meet NICE recommendations in relation to monitoring physical health in patients on antipsychotic treatment. The clinic facilitates appropriate interventions to in-patients identified as having abnormal results which can impact on morbidity and mortality. Additionally, we are now also able to provide physical health data to primary care colleagues at discharge to show what physical health checks had been undertaken for in-patients discharged on antipsychotics along with any resulting interventions.

Why we did it

People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population. They have higher rates of diabetes, respiratory and cardiovascular disorders as well as higher levels of obesity. Unfortunately the treatment for this cohort of patients, mainly antipsychotics, can further increase this risk.

'Parity of esteem' is defined as 'valuing mental health equally with physical health'. This term was first used in the mental health report (*No Health Without Mental Health 2011)* and following on from this, it was enshrined in the (*Health and Social Care Act 2012*). We wanted to ensure that our working practice incorporated the standards and vision to help put mental health on a par with physical health.

In 2014, the NICE guidelines were updated to include recommendations that General Practitioners (GPs) and other healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and subsequently at least annually. The health check should be

comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes.

By undertaking this project it would help achieve NICE recommendations and improve seamless transfer of care ensuring patients had baseline results for those initiated on treatment and bringing those already established on treatment up to date.

What we did

We liaised with the nursing team to discuss what physical health checks were currently being undertaken, how often and where the information was documented. We decided to work collaboratively to enable all the information to be pulled together so it was collated on one document for ease of use for primary care and to reduce duplication.

How we did it

We decided to run a pharmacy led physical health clinic weekly. The clinic allowed monitoring of patient's physical health checks during their inpatient journey. We checked all patients' newly commenced on antipsychotics every week for 6 weeks, then at 3 months, 6 months and 12 months for the following parameters whilst they remained an inpatient:

Weight	Height	BMI
Waist Circumference	BP	Pulse
ECG	Lipids	HbA1c
Plasma Blood Glucose	Prolactin	Thyroid Function Test
Liver Function Test	FBC	U&Es including Renal Function
Smoking Status	Lifestyle i.e. diet, drugs, alcohol, exercise	

The clinic consisted of the pharmacy technician identifying patients newly initiated on treatment on a weekly basis. This comprised of looking through medical notes and the pathology system to collate the necessary data and input into data sheets.

The nursing assistants helped undertake any duties that were needed or outstanding e.g. missing bloods, measurements. ECGs were requested online.

Any values that were out of range or had a notable change were highlighted to the ward pharmacist for their attention. The pharmacist then screened the results and if any interventions were necessary, a discussion was held with the patient and/or the ward doctor. Treatment would then be commenced or existing therapy adjusted to minimise risk.

Once the patient was discharged, their results and any recommendations were sent to their GP electronically, to be uploaded on to their primary care notes.

We also undertook the same monitoring for patients already established on antipsychotics to ensure they were receiving their annual check and forwarded this on to primary care as well.

How we monitored progress

We assessed the patients weekly to ensure all parameters were undertaken. If results were out of range we offered advice and/or discussed individual cases with the doctor or

nursing staff. For example, it was a common occurrence for patient's weight to steadily increase over the weeks. To prevent obesity and improve adherence to current medication, we would offer dietary and lifestyle advice and signpost to the onsite gym via the Occupational Therapist.

The measures used

- Ranges from the pathology department from Royal Oldham Hospital
- The parameters recommended from NICE guidance
- Follow up of intervention by initiation of treatment or documentation in notes.

How we evaluated the impact upon service, patients, staff and carers

We made several interventions that may have gone undetected without our interaction.

Feedback from the patients' appears positive as it gives them a chance to discuss their treatment and can voice any of their concerns regarding their medication or physical health matters.

It has also helped to integrate and strengthen relations between the pharmacy team and ward staff enhancing the multi-disciplinary approach at ward level.

To support us and provide data from those patients who may have initially refused or were not available, the nursing assistants have incorporated a physical health check day on a weekly basis.

The Outcome

By reviewing results, abnormalities were detected and interventions made that included:

- Several patients have commenced Statins
- One patient has been initiated on Metformin
- One patient has started a Beta Blocker
- Several patients have been offered smoking cessation advice and one patient stopped smoking
- Blood tests and ECGs up to date as certain tests that may have been forgotten or refused at admission had been identified through the physical health clinic
- A patient had very low iron during pregnancy but medical team wanted to wait till postpartum before starting intervention. This was overlooked and the medical team were reminded intervention was needed
- Abnormal results prior to admission have also been highlighted e.g. previous high prolactin levels.

The initiative has improved the collaboration of a multidisciplinary team approach to achieve parity of esteem and strengthened relationships between primary and secondary care. Staff have reported improved job satisfaction and have had the opportunity to develop new skills for example, interpreting results and have had increased opportunities to provide counselling. The development of the pharmacy technician role and educating new doctors on the parameters required for patients started on admission have also been instrumental in the success of the initiative. Importantly, outpatients who fail to attend follow up appointments for physical health monitoring are captured and offered interventions.

Cognitive Stimulation Therapy at Whittaker Day Hospital (Clinical Effectiveness)

Involving: Joanne Houghton, Staff Nurse and Project Lead; Amanda Egerton, Assistant Practitioner; Ellie Taylor, Psychology Assistant; Susan Slater, Support Worker; Christine Clegg, Nursing Assistant; Lynne Turton, Senior Occupational Therapist; Tracey Burgin, Team Manager; Donna Carr, Service Manager

Aim of the initiative

The group was established to provide Cognitive Stimulation Therapy (CST) for Clients with a diagnosis of Dementia.

Why we did it

Evidence demonstrates that a lack of cognitive stimulation hastens cognitive decline in normal ageing and also in dementia. Beruil, (1994) and Swaab, (1991) states that mental activity can lead to new learning and increased cognitive functioning in dementia and additionally to new neuronal pathways being formed. CST has been shown to be effective at improving concentration, mood and confidence (Spector et al 2011). Moreover, significant changes in verbal memory, language comprehension and orientation have been documented (Hall et al 2012). Evidence has also shown that following CST quality of life improves when measured at three and six months later (Orrell et al 2014). Therefore, the evidence suggests that cognitive stimulation would be useful for individuals with memory impairment. Informal cognitive stimulation and reminiscence has been offered at Whittaker Day Unit regularly, but given the evidence for formalised CST the decision was taken to run a pilot of a formalised CST therapy group for a period of 14 weeks. The multidisciplinary team also felt that there was a need for a treatment for individuals diagnosed with vascular dementia which also contributed to the decision to run this pilot.

What we did

Firstly staff planned and developed the material for the sessions based upon the 'Making a difference cognitive stimulation manual for group leaders' (Auguiree, Spector and Streater et al 2011).

We chose the sessions we believed would be most appropriate and interesting for clients from the 24 suggestions included in the manual. Some sessions were adapted to be appropriate for working with individuals with co-morbid mental health difficulties, for example the 'life history' session. Due to the practicalities of working within the day hospital environment, facilitators chose to run two sessions a day for 7 weeks and then one maintenance session a day for the following 7 weeks. The sessions were extended from 45 minutes to between 60 and 75 minutes, to ensure each client had appropriate time and opportunity to contribute. The group was held on Fridays for a total of 14 weeks from November 2017 – March 2018.

Sessions included recognising local scenes and categorising famous faces, tasting childhood food and comparing childhood toys to toys played with today, current affairs discussion and recognising and working with numbers.

How we did it

Multidisciplinary team members were provided with information sheets about the group to share with clients. The group was discussed on a 1:1 basis between the client and group facilitator to establish the suitability of the group for each client and to ascertain if they

wanted to participate. In total ten clients were referred. Two clients declined/could not attend, eight clients attended and seven clients completed the group. One client had to leave the group due to a decline in mental health.

How we monitored progress

Progress was monitored using several outcome measures which are discussed in more detail below. Additionally, an Assistant Psychologist observed each session noting the enjoyment, mood, communication and interest of each client. It was also noted how each session was facilitated. For example, was the amount of conversation around staff's own experiences appropriate? Were all clients encouraged to contribute? Was there an appropriate opening and closing to each session. Did each session run to time?

Furthermore after each session the team had a short debrief, reflecting upon how the session had gone overall, how clients had engaged within the session and if anything needed to be changed/ improved.

The measures used

Outcome measures were collected before the group commenced, at the 7 week point (the end of the main group, before the maintenance sessions began) and at 15 weeks (after the completion of the whole group).

The measures used were:

1) RAID – Rating Anxiety in Dementia' (Shankar, Walker & Frost et al 1999)
2) DEMQOL – Dementia Quality of Life' (Smith, Lamping & Banerjee et al 2005)
3) Cornel scale for Depression in Dementia' (Alexopoulos, Abrams & Young et al 1988)

The Outcome

The quantitative outcome measures demonstrated an improvement in quality of life and a reduction in anxiety and depression for the majority of clients. Three clients outcome measures are listed below (note the outcome measures for week 15 have not been included as this is yet to be scored).

Client	Pre-Group	7 Week point
1	2	0
2	3	1
3	18	9

(Anxiety in Dementia Score: Higher scores indicate greater level of anxiety)

Client	Pre-Group	7 Week point
1	95	103
2	88	106
3	78	84

(Quality of Life Measure: Higher scores indicate greater quality of life)

Client	Pre-Group	7 Week point
1	4	1
2	3	0
3	14	8

(Depression in Dementia: Higher scores indicate greater level of depression)

The qualitative feedback from clients was extremely positive. Some comments which were collected during the feedback session are listed below:

'I've seen a big change in us all…more alert, just getting people's names in your head is a bonus'
'That's really brought me out of myself.'
'I was a bit unsure at first, but soon settled in since then it's been great.''
'Can I just say thank you on behalf of us all for all the preparation you have put into this, finding us different things to do each week. I don't know about you lot but I really appreciate it.'

3.2 Performance against NHS Improvement Indicators and Thresholds

This section details performance against the indicators and performance thresholds which are relevant to Pennine Care NHS Foundation Trust and set out in NHS Improvements Single Oversight Framework (SOF).

The SOF includes the following indicators which are detailed earlier in this report (Part Two) and are not repeated here:

- Care Programme Approach: patients receiving follow-up contact within seven days of discharge
- Admission to inpatient services: access to Crisis Resolution/Home Treatment Teams

	Threshold	2015/16	2016/17	2017/18*				
					Q1	Q2	Q3	Q4
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	>92%	N/A	N/ A	100%	100%	99.95%	99.98%	99.97%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	>95%	99.82%	99.88%	99.99%	99.98%	100%	100%	99.99%
Maximum 6-week wait for diagnostic procedures	<1%	N/A	N/A	1.07%	1.17%	2.06%	0.26%	0.21%
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	>50%	N/A	72%	35.18%	42.1%	34.8%	31.8%	30.8%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:		44.90%	55.60%	NCAP *				
a) Inpatient wards		54%	N/A	N/A *				
b) Early intervention in psychosis services		N/A	89%	NCAP *				
c) Community mental health services (people on care programme approach)								
Improving access to psychological therapies (IAPT):								
a) proportion of people completing treatment who move to recovery (from IAPT dataset)	>50%	N/A	N/A	51.2%	51.51%	52.12%	49.01%	53.40%
b) waiting time to begin treatment (from IAPT minimum dataset)	>75%	58.6%	77.6%	86.5%	85.84%	85.45%	87.07%	88.50%
i. within 6 weeks of referral								
ii. within 18 weeks of referral	>95%	93.1%	96.6%	99.5%	99.57%	99.67%	99.52%	99.30%
Admission to adult facilities of patients under 16 years old	0	0	0	0	0	0	0	0
Inappropriate out-of-area placements for adult mental health services (Monthly Average Bed Days)	N/A	N/A	N/A	720				

*Data included in NCA Psychosis programme, report expected June 2018

Additional information

Grant Thornton performed limited assurance procedures on our Quality Account as required by the NHS foundation trust annual reporting manual 2017/18 and the 'Detailed requirements for external assurance for quality reports for 2017/18'. The Auditors developed a data quality testing strategy for the following indicators:

- Early intervention in psychosis: people experiencing a first episode of psychosis are treated with a NICE approved care package within 2 weeks of referral.
- Inappropriate out-of-area placements for adult mental health services.

The Auditors tested these 2 indicators substantively against supporting documentation and reported issues which came to their attention causing them to believe that these 2 mandated indicators have not been prepared in accordance with applicable criteria. Full details of the Auditors findings can be found at the end of this report.

It must be noted that the Auditors also undertook substantive testing of the Patient Safety Incidents (2016/17 published data) mandated incidents on behalf of the Council of Governors:

- The number and, where applicable, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

The result of the testing of this indicator is not reportable in the auditor's quality report opinion although it is worth noting that the Auditors found no issues.

However, due to the Auditors findings of the 2 indicators (EIA and OAP) Executive Directors have requested that the Trust's Clinical Effectiveness Department undertake testing of the remaining 2 mandated indicators:

- Improving access to psychological therapies: waiting time to begin treatment (from IAPT minimum dataset): within 6 weeks of referral.
- The percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care.

The testing strategy will be developed on par with those used by the Auditors and the results will be reported to the Executive Directors and Council of Governors.

Appendix 1: Glossary of Terms

BMI	Body Mass Index
BP	Blood Pressure
CAMHS	Child and Adolescent Mental Health Services
CARMS	Cognitive Approaches to combatting Suicidality
CCG	Clinical Commissioning Group
CCNT	Children's Community Nursing Team
CEST	Core and Essential Skills Training
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Framework
CRHT	Crisis Resolution Home Treatment
CST	Cognitive Stimulation Therapy
DNA	Did Not Attend
DTOC	Delayed Transfer of Care
ECG	Electrocardiogram
EMIS	Electronic Patient Records System
FBC	Full Blood Count
FGM	Female Genital Mutilation
FLO	Text Messaging System
GP	General Practitioner
HbA1c	Glycated Haemoglobin
HMR	Heywood, Middleton and Rochdale
HTT	Home Treatment Team
HYM	Healthy Young Minds
IAPT	Improving Access to Psychological Therapies
LD	Learning Disabilities
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
MHMC	My Health My Community
MSK	Musculoskeletal
MUP	Minimum Unit Pricing
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
NRLS	National Reporting and Learning System
NWAS	North West Ambulance Service
OT	Occupational Therapy
PARIS	Electronic Patient Records System

PbR	Payment by Results
PICU	Psychiatric Intensive Care Unit
PNP	Paediatric Nurse Practitioner
POMH-UK	Prescribing Observatory for Mental Health in the UK
PSIG	Patient Safety Improvement Group
QI	Quality Improvement
QS	Quality Standard
RAID	Rapid Access Interface and Discharge
RCA	Root Cause Analysis
RHSD	Rehabilitation and High Support Directorate
SOF	Single Oversight Framework
SPSH	Suicide Prevention and Self Harm
SSNAP	Sentinel Stroke National Audit Programme
STEM	Stockport Team for Early Management
UCC	Urgent Care Centre
U&E's	Urea and Electrolytes

Annex One: Statements

Statement from Joint Health Overview and Scrutiny Committee

Pennine Care NHS Foundation Trust shared the draft quality account with all stakeholders for 30-day consultation. On this occasion, the JHOSC did not accept the invitation to comment due to local elections.

Statement from Council of Governors

Statement has been prepared on behalf of the Council of Governors focusing on the Governors involvement and engagement in the Quality Account.

During the reporting year 2017/18 Governors have welcomed a new Chief Executive, Claire Molloy and Chair, Evelyn Asante-Mensah, and look forward to a future under the new leadership. The Governors were pleased to receive the communications from the Chief Executive on her views towards not compromising on quality, as this resonated to the Council's values, however they also recognised the challenges that balancing quality and finances would bring.

The Council of Governors welcome the Quality Account for 2017/18 and the opportunity to provide a statement.

Governors were invited to attend a development session regarding the Quality Account on 21 February 2018. During this session, Governors were provided with an overview of the aims of the Quality Account and informed of the process for selecting the locally selected indicator for audit by Grant Thornton, the Trust's external auditors. Governors voted on the area to be selected, the chosen indicator was 'patient safety incidents that resulted in severe harm or death'. This was the fourth year running that that Council had chosen the patient safety theme, the key reason was that the method and process used by the Trust to report deaths was changed significantly in recent years and this was the first year that the data would be reported, using that process, over the full reporting period.

The Governors are pleased to see the introduction of two new quality priorities focusing on Mixed Sex Accommodation and Learning from Deaths. The Council participated in a joint development session with the Board in December 2017 where they reviewed the Trust's CQC action plan in order to understand the position regarding Mixed Sex Accommodation. The Council looks forward to receiving further information regarding Learning from Deaths.

Governors have been involved in the Patient Experience Steering Group to consider how the Trust receives information from patients and how this can be used to make improvements.

Governors were included in the selection of Quality Improvement Initiatives to be showcased in the Quality Account for 2017/18.

Governor comments on the consultation document have been fed back to the Trust and responded to accordingly.

The Trust has continued to value, engage with, support and involve Governors throughout 2017/18 and have provided a variety of development sessions to enhance and maintain Governors' knowledge. Governors hope this high level of engagement continues into 2018/19 and will continue to seek assurance from the Trust that they are meeting their responsibilities to the local population.

Evelyn Asante-Mensah
Chair

On behalf of the Council of Governors
10 May 2018

Statement from Clinical Commissioning Groups

The annual production of the Quality Account is the opportunity afforded to the commissioners of Pennine Care NHS Foundation Trust services to comment upon the deliverance of quality services that aim to be clinically effective and well led, delivering good patient experience and outcomes. The Quality Account sets out a range of planned quality initiatives and evaluates the improvements achieved during 2017/18. The Quality Account seeks to provide assurance that the Trust is continually striving to meet the healthcare needs of the population that it serves.

The Trust has consulted with the key commissioners who make up the Pennine Care Footprint and the following is a collective response, co-ordinated by Heywood, Middleton and Rochdale CCG acting in its role as lead CCG for Quality:

- NHS Bury CCG
- NHS Oldham CCG
- NHS Heywood, Middleton and Rochdale CCG
- NHS Tameside and Glossop CCG
- NHS Stockport CCG
- NHS Trafford CCG

The quality and safety of services continues to be of paramount importance to the CCGs. As such we welcome the opportunity to comment on the Quality Account 2017/18 for Pennine Care NHS Foundation Trust.

We recognise the challenge to present the breadth of all quality improvements across both mental health and community services across the localities within one report.

We welcome the use of a clear and standardised format across all improvement areas that encapsulate the aim of the quality initiative. The Quality Account provides rich information around developing a learning and positive culture in the Trust and key areas where improvement needs to be made.

The CCGs believe this is a positive account of the key quality improvements delivered and that a detailed reflective account of the challenges experienced during 2017/18 has been provided.

In relation to progress against the priorities previously set for 2017/18 to improve quality, we recognise the continued success during the year to achieve these and positively acknowledge:

- The *Sign up to Safety* campaign has now been embedded within practice supported by the introduction of Safety plans.
- The *Falls* prevention priority with incidents being tracked via the Trust's Safeguard system and that analysis and learning is shared with staff. We would welcome the opportunity to review and comment upon the Trust's new Falls Prevention Policy.
- *Safe discharge, transfer and leave from inpatient facilities* support achieving better outcomes for patients.
- The *Reducing hospital and community acquired avoidable pressure ulcers* campaign and that the lessons learned are shared via the Quality Governance Forum and internal communication channels. We look forward to hearing of continuing progress throughout the coming year.
- *Reducing omitted and delayed medications*: We acknowledge the process of reporting performance, lessons learnt and good practice that has led to greater than 50% reduction.

The CCGs welcome the continued focus on suicide prevention as a key priority and its partnerships with other organisations such as Papyrus and the Samaritans to address this. We welcome seeing the Trust's trajectory demonstrating a reduction in the number of suicides. We value the emphasis that the Trust has placed on Safety Plans being an integral part of the risk assessment tools where services are assessing an immediate risk of suicide. We particularly welcome that all plans are produced in collaboration with patients and/or their carers

We welcome all quality, patient safety and performance improvement projects showcased in the report. We would particularly like to signal our approval of the Reducing Restrictive Practices (Patient Experience) results, which was a project recently implemented by the Trust.

The CCGs wish to acknowledge the cooperation from the Trust in working collectively with them to address the demanding mental health urgent care agenda, including examining the quality of acute and crisis care services, and addressing variances in pathway delivery between localities. We expect that this piece of work continues to be fully supported by the Trust in 2018/19.

The CCGs recognise the on-going challenges faced in adhering to the requirements set out by the CQC following their inspection in 2016. The CCGs support the

response of the Trust to address the CQC outcomes through its Quality Improvement Plan. We welcome the implementation of the Quality Improvement Plan during 2017/18.

The NHS Improvement Board established to oversee deliverance of the CQC Action Plan seeks to improve and transform services in line with National and Greater Manchester priorities, to consider areas which demand a wider system response to generate sustained improvement. The Trust continues to be a key partner working with CCGs and provider colleagues to deliver locality plans.

The CCGs also acknowledge the challenges that the Trust has faced as a result of the CQC requirement to address mixed sex accommodation breaches. The CCG's understand the Trust has introduced a Standard Operating Procedure (SOP) which includes an algorithm that provides guidance for the management of patients within a mixed sex environment including refusing admission where it is felt that patient safety may be compromised.

The Quality Account shows that the Trust continues to be an active participant in national and local research, clinical audit and confidential inquiries. This is an example of the innovative ways of working being adopted by the Trust, for example the 'blue' zimmer frame as a way of reducing falls. We commend the Trust and on its innovation in practice described in the Account. We look forward to further innovation and developing partnerships to deliver quality care in 2018/19:

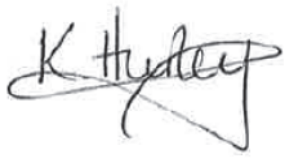
Commissioners note and confirm the Trust's achievements against the Commissioning for Quality and Innovation Schemes (CQUINs) for 2017/18. The considerable work undertaken by the Trust to reach this level of achievement is acknowledged. The Quarter 3a milestone relating to a shared care protocol between secondary care and primary care was not met. However, the CCGs would like to note that the requirement for improvements in this area have been acknowledged by the Trust and are linked to the informatics improvement work currently in progress.

The commissioners wish to note the continued positive partnership working that exists between the CCGs and the Trust and would like to express the desire to continue with this effective collaboration for the coming year. Overall we recognise that significant improvements in quality and safety that have been seen at the Trust during an evolving time within the NHS. We look forward to working together with the Trust to ensure continued improvement over the coming year. In 2018/19:

- We will continue to look for the outcomes of improved systems to capture patient experience effectively, through quality monitoring processes. We would also like to see how this information triangulates with complaints and serious incidents to inform service improvements.
- We anticipate the rollout of the developing outcomes CQUIN within mental health services. The project has sought the input of patients in identifying what outcomes are important to them. The CCGs now expect that this work be rolled out further across the Trust and the outcomes measured reported to the Trust.
- We would like to see evidence of the principles of the Mental Capacity Act embedded within everyday practice and that capacity assessments are clearly documented.
- We look forward to the role the Trust's new Quality Committee will play in

supporting the Trust's achievement of its primary goal to provide high quality, compassionate and continually improving services.
- We would like to see the work undertaken by the Trust to meet the Equality Standards.

Our response to Pennine Care NHS Foundation Trust's Quality Account 2017/18 is on behalf of the CCGs that make up the Pennine Care Footprint.



Karen Hurley
Deputy Chief Officer and Executive Nurse
NHS Heywood, Middleton and Rochdale Clinical Commissioning Group

11 May 2018

Statement from Trafford Council & Clinical Commissioning Group

The CCG considers the quality and safety of services to be of great importance. The CCG welcomes the opportunity to comment on the Quality Account 2017/18 for Pennine Care NHS Foundation Trust (PCFT) Community Services.

The CCG has worked closely with PCFT over the course of 2017/18, and have met regularly with the Trust to review the organisation's progress in implementing its quality improvement initiatives. We remain committed to engaging with the Trust in an inclusive and innovative manner to promote continued improvements in the quality of service provision. We are pleased with the level of engagement from the Trust and hope to continue to build on these relationships as we move forward into 2018/19.

Children's Community Services were rated as Good overall by CQC in their last CQC inspection, whilst Adult's Community Services were rates as Good in areas such as being effective; caring and responsive. The monthly Performance and Quality Improvement meetings have demonstrated PCFT's commitment to quality and innovations as well as trying to maintain and improve performance across the range of services provided. The CCG welcomes PCFT's continued commitment to meet regularly to monitor the quality and performance of their community services in 2018/19.

The PCFT Community Services has continued to meet the needs of local residents of Trafford. Services are meeting the quality targets and issues in service provision are raised and acted on to ensure good community provision of services designed to maintain and improve the health conditions of local residents.

The CCG have noted good practice in areas such as:

- Delayed Transfer of Care (DTOCs) where they have worked to minimise these by recruiting additional staff and supporting discharge to assess bed requirements.

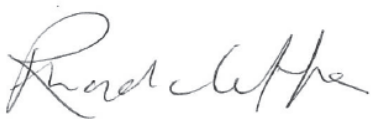
- Care of the dying:
  - a Pennine Care end of life (EOL) care forum meets bi-monthly and is chaired by the Trust's head of safeguarding
  - the implementation of a palliative EOL care competency framework for clinical staff and standardisation of individual care planning and relevant EOL care documentation
  - the service reported the development of EOL care peer support within Pennine Care and the development of a lessons learned dissemination process across the Trust

PCFT Community services have also been commended for:

- Leg ulcer service (tissue viability nursing) - which won the Trafford principles of care award and shortlisted for the Trust award
- School nursing service – in the wake of the Manchester Arena attack on 22 May 2017, the service was shortlisted for, and reached the final three of Trafford Council's employee recognition awards which took place on in October 2017
- Health visiting services are meeting their target for maternal mental health screening. This is an excellent initiative and demonstrates good integration of physical and mental health services

The CCG undertook a quality and safety walk-round of two community services in Trafford (Community Enhanced Care and the Community Children's Nursing Team) in 2017/18 which identified areas of good practice, opportunities for improved operational delivery, and potential connections to wider strategic developments across Trafford. We again commend the engagement of PCFT in the 2017/18 quality and safety walk-round programme.

The CCG support the quality improvements achieved and look forward to working with PCFT to further develop high quality services for our populations in 2018/19.



Sara Radcliffe
Corporate Director Commissioning
10 May 2018

Statement from Healthwatch

Response of Healthwatch Bury, Healthwatch Rochdale, Healthwatch Oldham, Healthwatch Tameside, Healthwatch Stockport and Healthwatch Trafford to the Trust's Quality Account 2017/18

This is the combined local Healthwatch response to Pennine Care NHS Foundation Trust's Quality Account 2017/18 consultation document. It must be noted that this is a response to the consultation document and the content may

not be exactly reflected in the Trust's published Quality Account.

Local Healthwatch have reviewed the Pennine Care Quality Account for 2017/18 and find that it is a fair reflection of the services provided by the Trust.

We have very much welcomed the ongoing liaison meetings of the six main Healthwatch associated with the Trust, namely, Rochdale, Oldham, Tameside, Stockport, Trafford and Bury. This has enabled us to feed in patient and carer views throughout the year to complement the work undertaken by the Trust.

We note that the Quality Account highlights positive work being undertaken by Pennine Care to improve the quality of the services it delivers. Many of the projects highlighted in the document help to show how the Trust is working to address many of the issues that have been raised by patients, services users and health professionals.

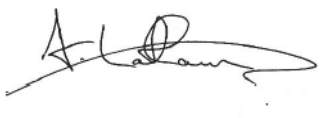
Having said this, we feel that the account presents Pennine Care as appearing to operate within a 'bubble' which doesn't seem to reflect the nature of any transitional processes with Primary Care and the Voluntary, Community and Social Enterprise sector. We would welcome greater recognition that Pennine Care is only part of the patient journey and that in order to be patient centred they need to actively engage with primary and other community-based services in order to treat the patient holistically and ensure sustainability of recovery and prevention of relapse/readmission.

Much of the work which has been done, or is part of 'Next steps', has come about due to breaches of regulations picked up by CQC and should have been happening anyway. Progress seems slow. Many of the items on the 'To-do' list on last year's Quality Account are still in progress, and re-iterated in this report as current work.

Complaints received by Healthwatch (as part of the NHS Complaints Advocacy function that some Healthwatch organisations deliver) relating to mental health care in the past have included elements noted throughout this report. If Pennine Care do everything they highlight in their plans in this Quality Account, we will hopefully see the number of complaints reduce.

We note that the Trust has some significant recent new appointments – including the Chief Executive and Director of Nursing. We look forward to working with these people as part of the Trust's improvement journey.

Andrew Latham
Chief Officer, Healthwatch Trafford



8 May 2018

Annex Two: Statement of Directors Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

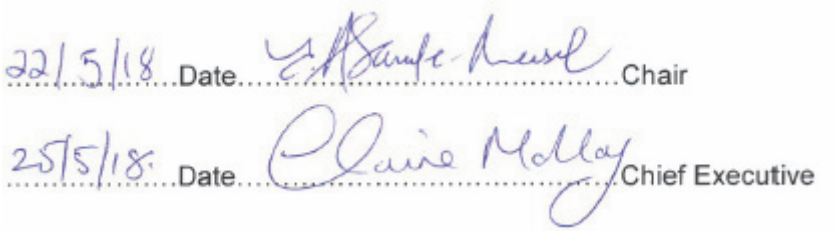
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2017 to the 25 May 2018
    - papers relating to quality reported to the Board over the period April 2017 to 25 May 2018
    - feedback from commissioners (Joint) dated 11 May 2018
    - feedback from commissioners (Trafford) dated 10 May 2018
    - feedback from governors dated 10 May 2018
    - feedback from local Healthwatch organisations dated 8 May 2018
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23 May 2018
    - the 2017 national patient survey, 1 December 2017
    - the 2017 national staff survey, 6 March 2018
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 24 May 2018
    - CQC inspection report dated 30 August 2017
- 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



External Auditors Opinion and Recommendations

Independent Practitioner's Limited Assurance Report to the Council of Governors of Pennine Care NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Pennine Care NHS Foundation Trust to perform an independent limited assurance engagement in respect of Pennine Care NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- inappropriate out-of-area placements for adult mental health services

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' 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 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2017 to 25 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 25 May 2018;
- feedback from joint commissioners dated 11 May 2018;
- feedback from Trafford commissioners dated 10 May 2018;
- feedback from governors dated 10 May 2018;
- feedback from local Healthwatch organisations dated 8 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated 23 May 2018;
- the national patient survey dated 1 December 2017;
- the national staff survey dated 6 March 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 24 May 2018; and
- the Care Quality Commission inspection report dated 30 August 2017.

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.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Pennine Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting Pennine Care NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the 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 Pennine Care NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance 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 that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Pennine Care NHS Foundation Trust.

Our audit work on the financial statements of Pennine Care NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Pennine Care NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Pennine Care NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Pennine Care NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Pennine Care NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Pennine Care NHS Foundation Trust and Pennine Care NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for adverse conclusion

The indicator reporting 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 did not meet he six dimensions of data quality in the following respects:

- Accuracy – Our testing identified seven errors in the ten cases tested where either the clock start or stop date was incorrectly set.
- Timeliness – Our testing identified one error in the ten cases tested where the data was recorded in the wrong month.
- Validity - Our testing identified one error in the ten cases tested which did not meet the criterion as an eligible patient.

The indicator reporting inappropriate out-of-area placements for adult mental health services did not meet the six dimensions of data quality in the following respects:

- Completeness – Our testing identified two errors in the twenty-four cases tested. These were patients that each had separate placements which were not recorded.
- Accuracy – Our testing identified three errors in the twenty-four cases tested. Two cases were tested where the placement discharge date was not recorded. This resulted in the placements being overstated by 172 and 206 days respectively. One case was incorrectly recorded twice in the population.
- Reliability - Our testing identified one error in the twenty-four cases tested. This arose due to a mismatch between the admission date per the data held by NHS Digital and the population spreadsheet used to calculate the indicator.

Adverse conclusion

Based on the results of our procedures, we conclude that:

- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the ‘NHS foundation trust annual reporting manual 2017/18’ and supporting guidance; and
- 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 2017/18’.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Manchester
25 May 2018

NHS
Pennine Care
NHS Foundation Trust

ANNUAL ACCOUNTS

2017/18

Foreword to the Accounts

Pennine Care NHS Foundation Trust is registered at 225 Old Street, Ashton-under-Lyne, Lancashire, OL6 7SR.

These accounts for the period ended 31 March 2018 have been prepared by Pennine Care NHS Foundation Trust in accordance with Schedule 7, paragraph 24 and 25 of the National Health Service Act 2006. They are in the form directed by NHS Improvement the Independent Regulator of NHS Foundation Trusts and approved by HM Treasury.

Claire Molloy
Chief Executive
25 May 2018

Statement of Comprehensive Income for year ended 31 March 2018

	NOTE	2017-18 £000	2016-17 £000
Income from patient care activities	3.1	**260,426**	**261,028**
Other operating income	3.2	**7,043**	**12,575**
Operating expenses	4.1	**(266,150)**	**(264,954)**
Operating surplus/(deficit)		**1,319**	**8,649**
Finance income	6.1	**38**	**30**
Finance costs	6.2	**(1,195)**	**(1,162)**
Surplus/(deficit) for the financial year		**162**	**7,517**
Public dividend capital dividends payable		**(2,371)**	**(2,337)**
Retained surplus/(deficit) for the year		**(2,209)**	**5,180**
Other Comprehensive Income			
Items that will not be reclassified to income and expenditure			
Impairments and reversals	SOCITE	**(1,961)**	**0**
Net gain on revaluation of property, plant & equipment	SOCITE	**4,574**	**0**
Total Other Comprehensive Income		**2,613**	**0**
Total Comprehensive Income for the year		**404**	**5,180**

The normalised financial position excluding exceptional items	2017-18 £000	2016-17 £000
Retained surplus/(deficit) for the year	**(2,209)**	**5,180**
Less exceptional Items:		
Impairment Reversal	**1,130**	**0**
Impairment Charge	**(3,106)**	**0**
Restructuring Cost*	**0**	**2,161**
Normalised surplus/(deficit) for the year excluding exceptional items	**(4,185)**	**7,341**

*Restructuring costs are no longer removed as an exceptional item when reporting a normalised financial position. For 2017/18 these costs total £964k.

Statement of Financial Position as at 31 March 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
Non-current assets:			
Intangible assets	8	**2,084**	**880**
Property, plant and equipment	9	**105,607**	**98,692**
PFI lifecycle prepayment	15	**1,453**	**1,267**
Total non-current assets		**109,144**	**100,839**
Current assets:			
Inventories	14	**88**	**88**
Trade and other receivables	15	**13,086**	**17,127**
Non-current assets held for sale	11	**660**	**0**
Cash and cash equivalents	16	**17,417**	**13,818**
Total current assets		**31,251**	**31,033**
Total assets		**140,395**	**131,872**
Current liabilities			
Trade and other payables	17	**(25,866)**	**(20,141)**
Other liabilities	18	**(5,867)**	**(4,461)**
Borrowings	19	**(1,500)**	**(1,500)**
Provisions	20	**(1,565)**	**(1,205)**
Total current liabilities		**(34,798)**	**(27,307)**
Non-current assets plus/less net current assets/liabilities		**105,597**	**104,565**
Non-current liabilities			
Borrowings	19	**(15,296)**	**(16,779)**
Provisions	20	**(27)**	**(78)**
Total non-current liabilities		**(15,323)**	**(16,857)**
Total Assets Employed:		**90,274**	**87,708**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital	SOCITE	**76,412**	**74,250**
Retained (losses)/earnings	SOCITE	**2,309**	**4,518**
Revaluation reserve	SOCITE	**11,553**	**8,940**
Total Taxpayers' Equity:		**90,274**	**87,708**

The accounts on pages 231 – 278 were approved by the Board of Directors on and signed on its behalf by:

Claire Molloy
Chief Executive
25 May 2018

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2018

	NOTE	Public Dividend capital	Retained earnings/ Accumulated losses	Revaluation reserve	Total equity
		£000	£000	£000	£000
Balance at 1 April 2017		**74,250**	**4,518**	**8,940**	**87,708**
Retained surplus/(deficit) for the year		**0**	**(2,209)**	**0**	**(2,209)**
Net gain on revaluation of property, plant, equipment	9	**0**	**0**	**4,574**	**4,574**
Impairments and reversals	9	**0**	**0**	**(1,961)**	**(1,961)**
New PDC Received		**2,162**	**0**	**0**	**2,162**
Balance at 31 March 2018		**76,412**	**2,309**	**11,553**	**90,274**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2017

	NOTE	Public Dividend capital	Retained earnings/ Accumulated losses	Revaluation reserve	Total equity
		£000	£000	£000	£000
Balance at 1 April 2016		**74,045**	**(662)**	**8,940**	**82,323**
Retained surplus for the year		0	5,180	0	**5,180**
New PDC Received		205	0	0	**205**
Balance at 31 March 2017		**74,250**	**4,518**	**8,940**	**87,708**

Statement of Cash Flows for the year ended 31 March 2018

	NOTE	2017-18 £000	2016-17 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Surplus/(deficit)	SOCI	**1,319**	**8,649**
Depreciation and amortisation	4.1	**2,956**	**3,190**
Impairments and reversals	7	**(1,976)**	**0**
(Increase) in inventories	14	**0**	**(1)**
Decrease in trade and other receivables	15	**4,170**	**(2,403)**
Increase in trade and other payables	17	**5,038**	**1,182**
Increase in other current liabilities	18	**1,406**	**342**
(Decrease)/Increase in provisions	20	**309**	**(3,729)**
Net Cash Inflow from Operating Activities		**13,222**	**7,230**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received	6.1	**38**	**30**
Payments for intangible assets	8	**(1,315)**	**(148)**
Payments for Property, Plant and Equipment	9	**(5,137)**	**(2,632)**
Prepayment of PFI capital contributions	15	**(186)**	**(182)**
Net Cash Outflow from Investing Activities		**(6,600)**	**(2,932)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital received	SOCITE	**2,162**	**205**
PDC dividends paid	SOCI	**(2,500)**	**(2,227)**
Loans repaid to DH - ITFF	19	**(1,250)**	**(1,250)**
Interest paid	6.2	**(56)**	**(80)**
Interest element of Private Finance Initiative obligations	6.2	**(1,146)**	**(1,082)**
Capital element of Private Finance Initiative obligations	19	**(233)**	**(241)**
Cash flows from other financing activities		**0**	**0**
Net Cash Outflow from Financing Activities		**(3,023)**	**(4,675)**
NET DECREASE IN CASH AND CASH EQUIVALENTS		**3,599**	**(377)**
Cash and Cash Equivalents at Beginning of the year		**13,818**	**14,195**
Cash and Cash Equivalents at year end	16	**17,417**	**13,818**

1 Accounting policies

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

1.1. Accounting standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

- IFRS 9 Financial Instruments, application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by FReM.
- IFRS 15 Revenue from Contracts with Customers, application required for accounting periods beginning on or after 1 January 2018 but not yet adopted by FReM.
- IFRS 16 Leases, application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by FReM.

The amendments to IFRS 15 have been assessed and are not considered to have a material impact on the recognition of either NHS contract income or other contract income in 2018/19.

The amendments to IFRS 9 have been assessed and are not considered to have a material impact on the classification and measurement of financial assets or financial liabilities in 2018/19. The change in impairment model for financial assets has also been assessed and is not considered to have a material impact in 2018/19.

The amendments to IFRS 16 are anticipated to have an impact on the disclosures contained with the financial statements. The impact of these changes will be assessed during 2018/19 in advance of the effective implementation date of 1 January 2019.

1.2.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2.2 Going concern

The Trust has prepared its accounts on a going concern basis. This is as directed by the 2017/18 Department of Health and Social Care Group Accounting Manual 2017/18, whereby, unless the trust expects that its services will cease to be provided to the public sector, the going concern basis for the preparation of the financial statements is assumed

The Trust recognises that there are operational and funding factors that represent material uncertainties with regard to the adoption of the going concern basis.The plan for 2018/19 to be submitted to NHSI on the 30th April is a deficit of £11.2m.

In preparing the plan for the Trust, key areas of potential risk have been reviewed and mitigated.

- Income - Contracts for 2018/19 with all commissioners have been signed.
- Cost Improvement Programmes - the Trust has a track record of delivering challenging efficiency programmes, with £5.0m delivered in 2017/18.
- The Trust has actively engaged in local strategic transformation planning with GM Health and Social Care and NHSI to develop models to deliver sustainable healthcare.

- The Trust has appropriate financial and operational risk management processes in place to support its operational plans.

However, it is recognised that the deficit plan will have a detrimental effect on the Trusts cash position and working capital support is anticipated to be required from the Department of Health during 2018/19. Informal discussions have taken place with NHSI and the Department of Health about the 2018/19 plan and the route for accessing appropriate funding to support the provision of the Trusts services. Following a detailed review NHSI have not raised any concerns about the integrity of the plan developed.

Therefore, although these factors represent material uncertainties that may affect the Trust's ability to continue as a going concern, the Board, having made appropriate enquiries, still have reasonable expectations that the Trust will have access to adequate resources to continue its operational existence for the foreseeable future, being a period of at least 12 months from the date of approval so the financial statements. On this basis, The Trust has adopted the going concern basis for preparing the financial statements.

1.3. Critical accounting judgment

In the application of the NHS Foundation 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.

1.4. Key sources of estimation uncertainty

The NHS Foundation Trust has made assumptions and estimates in the following areas in preparing the annual report and accounts:

- In making assumptions regarding restructuring costs (see note 20) the NHS Foundation Trust has utilised actual estimates provided by payroll where applicable; where this is not possible the NHS Foundation Trust has taken a prudent approach to estimating the likely costs of delivering the planned service re-design.
- The Trust has an estimation on the valuation of land and building assets and their lives, based on the information provided by the valuation company, currently Cushman and Wakefield as at the 31st March 2018. During 2017-18 a desktop valuation has been completed and the assets values have been adjusted in line with the revised valuation.

It is not considered that the degree of variability that could arise as a result of these assumptions would prove to be material, there is not therefore any significant risk of material adjustments being required to the carrying value of assets and liabilities within the next financial year as a result of these estimates.

1.5. Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the NHS Foundation Trust is contracts with Commissioners in respect of healthcare services.

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

Income from the sale of non-current assets is recognised upon completion.

1.6. Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment related payments are recognised in the period in which the service is received from employees.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

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

1.7. 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.

1.8. Property, Plant and Equipment

Recognition

Property, plant and equipment (PPE) is capitalised where:
• It is held for use in delivering service or for administrative purposes;
• It is probable that future economic benefits will flow to, or service potential be provided to, the NHS Foundation Trust;
• It is expected to be used for more than one financial year; and
• The cost of the item can be measured reliably

And meet the capitalisation threshold in that:
• Individually they have a cost of at least £5,000; or
• Form 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 or 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

Measurement – valuation

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

Land and buildings used for the NHS Foundation Trust's services or for administrative purposes are measured subsequently at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed by external independent valuers with sufficient regularity to ensure that carrying amounts are not

materially different from those that would be determined at the Statement of Financial Position date. Fair values are determined as follows:

• Land and non specialised buildings – market value for existing use
• Specialised buildings – depreciated replacement cost

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, as allowed by IAS23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use. Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

1.9. Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the NHS Foundation 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 NHS Foundation Trust and where the cost of the asset can be measured reliably.

Software

Software that 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 that 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. This includes directly attributable capitalised staff costs.

Subsequently, intangible assets are measured at fair value, with amortised historic cost being taken as fair value.

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

Amortisation

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

1.10. Inventories

Inventories are valued at the lower of cost and net realisable value, measured on a first-in, first-out (FIFO) basis.

1.11. Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS Foundation 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.

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

Derecognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the NHS Foundation Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as 'Fair Value through Income and Expenditure', Loans and receivables or 'Available-for-sale financial assets'.

Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The NHS Foundation Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

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

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

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

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

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

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis. This is not material for the Trust, therefore has not been applied to the annual accounts during 2017-18.

Impairment of financial assets

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows

discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.12. Leases

Finance leases
The NHS Foundation Trust does not have any finance leases.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenditure on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Lease of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.13. Provisions
The NHS Foundation 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 the money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. This is not material to the Trust and has not been applied during 2017-18 or in the prior year 2016-17.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 20.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Foundation Trust pays an annual contribution to the NHS Litigation Authority 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.

Legal costs
The NHS Foundation Trust will recognise the costs arising from legal cases that are not covered by risk pooling schemes with NHSLA. A provision for estimated costs where there is a probable outflow of economic benefit arising as a result of past events.

Restructuring and redundancy costs
Where the NHS Foundation Trust has committed to a course of action that will give rise to future restructuring or redundancy costs, the estimated value of such costs shall be recognised as a provision.

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 where an inflow of economic benefits are probable.

Contingent liabilities are not recognised but are disclosed 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.

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,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding any 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 (as the issuer) 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 report and accounts. The dividend thus calculated is not revised, should any adjustment to net assets occur as a result of the audit of the annual report and accounts.

1.16. Value Added Tax

Most of the activities of the NHS Foundation 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

The 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 specified activities of an NHS Foundation Trust (s519A[3] to [8] ICTA 1988). Accordingly, the NHS Foundation Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum.

1.18. Foreign exchange

The functional and presentation currencies of the NHS Foundation Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Any resulting exchange gains or losses are taken to the Statement of Comprehensive Income.

1.19. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the annual report and accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the annual report and accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.20. Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health services 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). The losses and special payments note is compiled on an accruals basis with the exception of provisions for future losses.

1.22. Consolidation of charitable funds

HM Treasury previously granted dispensation to the application of IAS 27 (revised) by NHS Foundation Trusts solely in relation to the consolidation of NHS Charitable Funds. From 2013-14 the Treasury dispensation is no longer available therefore the NHS Foundation Trust is required to consolidate any material NHS Charitable Funds. This represents a change in accounting policy and requires treatment in accordance with IAS 8, with prior year comparatives and opening balance sheet restated where applicable. In 2017-18 the NHS Foundation Trust does not have any material Charitable Funds, and did not have any in 2016-17.

1.23. Associates

Associate entities are those over which the NHS Foundation Trust has the power to exercise a significant influence, but not control. Associate entities are recognised in the NHS Foundation Trust's annual report and accounts using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the NHS Foundation Trust's share of the entity's profit or loss, or other gains and losses following acquisition. It is also reduced when any distribution (e.g. share dividends) are received by the NHS Foundation Trust from the associate. In 2017-18 and 2016-17 the NHS Foundation Trust does not have any associates.

2. Operating Segments

All activity at Pennine Care NHS Foundation Trust is healthcare related and a large majority of the NHS Foundation Trust's income is received from within UK Government departments. The main proportion of the operating expenses are payroll related and are for the staff directly involved in the provision of health care and the indirect and overhead costs associated with that provision. The NHS Foundation Trust operates in a limited geographic area, primarily Greater Manchester, with some services delivered across North West England. Therefore it is deemed that the business activities which earn the revenues for the NHS Foundation Trust and in turn incur the expenses are one provision, which it is deemed appropriate to identify as a single segment, namely 'healthcare'.

The NHS Foundation Trust identifies the NHS Foundation Trust's Board (which includes all Executive and Non-Executive Directors) as the Chief Operating Decision Maker (CODM) as defined by IFRS 8. Monthly operating results are reported to the NHS Foundation Trust's Board. The financial position of the NHS Foundation Trust in month and for the year to date are reported, along with projections for future performance and position, as a position for the whole NHS Foundation Trust, rather than as component parts making up a whole. The NHS Foundation Trust's Board does not have separate directors for particular service areas or divisions. The NHS Foundation Trust's external reporting to NHSI (the regulator) is on a whole NHS Foundation Trust basis, which also implies the NHS Foundation Trust is a single segment.

All decisions affecting the NHS Foundation Trust's future direction and viability are made based on the overall total segment, presented to the Board. The NHS Foundation Trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

3. Revenue

3.1 Operating income from patient care activities

	2017-18 £000	2016-17 £000
NHS trusts	1,634	1,521
Clinical Commissioning Groups and NHS England	233,388	229,409
Foundation trusts	557	246
Local authorities	23,386	24,745
NHS other	0	6
NHS Injury Scheme (was RTA)	25	18
Non-NHS: other	1,436	5,083
	260,426	261,028

3.2 Other operating income

	2017-18 £000	2016-17 £000
Education and training	4,008	3,891
Non-patient care services to other bodies	1,238	1,330
Research and development	809	977
Rental revenue from operating leases	170	268
Sustainability and Transformation Fund Income	520	3,230
Other revenue	298	2,879
	7,043	12,575
Total operating revenue	267,469	273,603

3.3 Private patient income

The NHS Foundation Trust does not receive any income related to private patient activity.

3.4 Operating lease income

	2017-18 £000	2016-17 £000
Operating lease income	170	268
	170	268

3.5 Revenue from Commissioner Requested Services

Pennine Care NHS Foundation Trust's Provider License specifies the following services as being Commissioner Requested Services, previously known as mandatory services.

Community services
Community sexual & reproductive health
Community medicine
Community dental
Rehabilitation (community & inpatient)
Palliative medicine
Nursing episode
Allied Health Profession episode

Mental Health
Adult mental illness
Old age psychiatry
Child & adolescent psychiatry
Forensic psychiatry
Learning disability

	2017-18 £000	2016-17 £000
Mental health		
Cost and volume contract income	**8,253**	**8,592**
Block contract income	**133,897**	**139,346**
Other clinical income	**2,112**	**2,326**
Community Services		
Block contract income	**88,961**	**87,674**
Total commissioner requested services revenue	**233,223**	**237,938**
Other non-commissioner revenue from patient care	**27,203**	**23,090**
Total Income from Patient Care Activities	**260,426**	**261,028**
Other operating income (see note 3.2 for breakdown)	**7,043**	**12,575**
Total Income	**267,469**	**273,603**

4.1 Operating expenses

	2017-18 £000	2016-17 £000
Services from foundation trusts	**2,869**	**2,385**
Services from other NHS trusts	**2,769**	**3,111**
Services from CCGs and NHS England	**255**	**255**
Purchase of healthcare from non NHS bodies	**2,569**	**659**
Employee expenses - directors' emoluments	**1,100**	**1,130**
NHS Foundation Trust chair and non executive directors	**166**	**177**
Employee expenses - staff costs	**206,087**	**207,041**
Supplies and services - clinical (excluding drugs)	**5,599**	**6,021**
Supplies and services - general	**2,073**	**2,508**
Establishment	**3,736**	**4,043**
Research and development (including staff costs)	**484**	**555**
Transport including business travel	**2,821**	**2,796**
Rates	**1,295**	**1,201**
Premises	**13,223**	**12,195**
Increase/(decrease) in provision for the impairments of receivables	**560**	**329**
Increase/(decrease) in other provisions		**0**
Drugs costs	**2,763**	**2,287**
Rentals under operating leases	**11,517**	**11,247**
Depreciation	**2,705**	**2,827**
Amortisation	**251**	**363**
Impairments and reversals of property, plant and equipment	**(1,976)**	**0**
Audit fees - statutory audit (Note 27)***	**46**	**47**
Audit fees - Quality Accounts (Note 27)***	**7**	**7**
Audit fees - internal audit	**88**	**107**
Clinical negligence	**1,248**	**1,134**
Legal fees**	**252**	**(3,499)**
Consultancy services	**370**	**915**
Education and Training (including staff costs)*	**1,184**	**1,351**
Redundancy	**964**	**2,161**
Other	**1,125**	**1,601**
	266,150	**264,954**

*In line with Department of Health and Social Care guidance, Education and Training expenditure for 2016/17 has been restated to include £394k of staff costs which were previously shown within Employee expenses - staff costs.

**Legal fees has negative expenditure during 2016/17 resulting from a provision which was overcharged in 2015/16. The Trust had anticipated a charge of £4m in 2015/16. Following the court hearing with the Health and Safety Executive the outcome to the Trust was a charge of £80k. Therefore the charge previously made has been reversed in 2016/17 resulting in the negative expenditure in the current financial period.

*** Audit fees are disclosed above including VAT where this cannot be recovered.

4.2 Operating leases

NHS Foundation Trust as a lessee Payments recognised as an expense	Land	Buildings	Other	2017-18 Total	2016-17
	£000	£000	£000	£000	£000
Minimum lease payments	0	11,161	356	**11,517**	11,247
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**11,161**	**356**	**11,517**	**11,247**
Payable:					
No later than one year	0	11,060	39	**11,099**	**10,806**
Between one and five years	0	25,548	58	**25,606**	**25,232**
After five years	0	42,714	0	**42,714**	**45,843**
Total	**0**	**79,322**	**97**	**79,419**	**81,881**
Total future sublease payments expected to be received:				**0**	0

The 2016-17 figures have been restated to include all commitments.

5 Employee benefits and staff numbers

5.1 Employee benefits

	2017-18			2016-17
	Total	**Permanently employed**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Employee Benefits - Gross Expenditure				
Salaries and wages	**165,039**	141,405	23,634	162,308
Social security costs	**13,826**	12,781	1,045	14,341
Apprenticeship levy	**808**	808	0	0
Employer contributions to NHS Pensions scheme	**20,388**	18,996	1,392	20,070
Agency/contract staff	**9,089**	0	9,089	12,370
Total gross employee benefits	**209,150**	**173,990**	**35,160**	**209,089**
Employee costs capitalised as part of assets	**1,106**	**1,106**	**0**	**0**
Total employee benefits are analysed as:				
Employee expenses - staff	**206,087**	170,927	35,160	207,041
Employee expenses - executive directors	**1,100**	1,100	0	1,130
Employee costs included in research and development	**473**	473	0	524
Employee costs included in education and training	**384**	384	0	394
Total employee benefits included in operating expenditure	**208,044**	**172,884**	**35,160**	**209,089**

5.2 Directors' remuneration

	2017-18 £000	2016-17 £000
Directors' remuneration	**976**	996
Employer contributions to the pension scheme	**124**	134
	1,100	**1,130**

The highest paid director in 2017-18 was the Medical Director, receiving a salary in the bracket £165k - £170k. The highest paid director in 2016-17 was the Chief Executive Officer, receiving a salary in the bracket £165k - £170k. Full disclosure is given in the remuneration report.

	Number 2017-18	Number 2016-17
Total number of directors to whom benefits are accruing under:		
Defined benefit schemes	8	8

5.3 Staff Numbers

	2017-18			2016-17
	Total	Permanently employed	Other	Total
	Number	Number	Number	Number
Average Staff Numbers				
Medical and dental	**221**	**121**	**100**	221
Administration and estates	**1,271**	**1,181**	**90**	1,379
Healthcare assistants and other support staff	**1,243**	**1,165**	**78**	1,267
Nursing, midwifery and health visiting staff	**1,692**	**1,611**	**81**	1,728
Nursing, midwifery and health visiting learners	**9**	**9**	**0**	12
Scientific, therapeutic and technical staff	**862**	**751**	**111**	752
Healthcare science staff	**0**	**0**	**0**	30
Social Care Staff	**1**	**1**	**0**	16
Other	**8**	**2**	**6**	9
Total	**5,307**	**4,841**	**466**	**5,414**

In line with Department of Health and Social Care guidance, the 2016/17 Staff Numbers figures have been restated with Agency and Contract Staff and Bank Staff now analysed across the relevant functional categories.

5.4 Exit Packages agreed in 2017-18

	2017-18			2016-17		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Less than £10,000	**3**	**3**	**6**	6	3	9
£10,001-£25,000	**0**	**3**	**3**	3	0	3
£25,001-£50,000	**5**	**2**	**7**	8	1	9
£50,001-£100,000	**1**	**0**	**1**	11	0	11
£100,001 - £150,000	**0**	**0**	**0**	0	0	0
£150,001 - £200,000	**0**	**1**	**1**	0	0	0
Total number of exit packages by type (total cost)	**9**	**9**	**18**	**28**	**4**	**32**
Total resource cost - £000	**330**	**302**	**632**	**1,173**	**50**	**1,223**

Where the NHS Foundation Trust has agreed early retirements, the additional costs are met by the NHS Foundation Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

*This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous year.

5.5 Early Retirements on ill health grounds

	2017-18	2016-17
	Number	**Number**
Number of persons retired early on ill health grounds	**8**	9
	£000	**£000**
Value of early retirement on the grounds of ill-health	**564**	497

5.6 Pension costs

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

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

6.1 Finance Income	2017-18 £000	2016-17 £000
Interest revenue		
Bank interest	**38**	30
Total investment income	**38**	**30**

6.2 Finance Costs	2017-18 £000	2016-17 £000
Interest		
Loans from the Independent Trust Financing facility	**49**	80
Interest on obligations under PFI contracts - Main finance Cost	**1,146**	1,082
Total interest expense	**1,195**	**1,162**

7. Impairment and reversals of impairment

7.1 Impairment of PPE charged to expenditure	2017-18 £000	2016-17 £000
Changes in market price	**1,130**	0
Total	**1,130**	**0**

7.2 Reversal of Impairment of PPE charged to expenditure	2017-18 £000	2016-17 £000
Changes in market price	**(3,106)**	0
Total	**(3,106)**	**0**

8. Intangible assets

8.1 Intangible non-current assets

2017-18	Software	Development expenditure (internally generated)	Assets under construction	Total
	£000	£000	£000	£000
At 1 April 2017	**1,708**	**79**	**305**	**2,092**
Additions - purchased	**39**	**0**	**1,416**	**1,455**
Disposals/derecognition*	**(958)**	**0**	**0**	**(958)**
Reclassifications	**0**	**0**	**0**	**0**
At 31 March 2018	**789**	**79**	**1,721**	**2,589**
Amortisation				
Accumulated at 1 April 2017	**1,180**	**32**	**0**	**1,212**
Provided during the year	**235**	**16**	**0**	**251**
Disposals/derecognition*	**(958)**	**0**	**0**	**(958)**
Reclassifications	**0**	**0**	**0**	**0**
Accumulated at 31 March 2018	**457**	**48**	**0**	**505**
Net Book Value at 31 March 2018	**332**	**31**	**1,721**	**2,084**
Net book value at 31 March 2018 comprises:				
Purchased	**332**	**31**	**1,721**	**2,084**
Total at 31 March 2018	**332**	**31**	**1,721**	**2,084**

Opening Assets Under Construction of £305k at 1st April 2017 relating to the Trust Child Health System have been re-categorised to Note 8 Intangible Assets from Note 9 Property, Plant & Equipment Assets Under Construction.

*Within the Disposals/derecognition lines are £958k of both cost and accumulated amortisation of assets which have a zero net book value on the fixed asset register but had not been recognised as disposals/derecognised in previous years. During 2017/18 these have been removed from the fixed asset register and therefore included in the Disposal/derecognition lines.

8.2 Intangible non-current assets

	Software	Development expenditure (internally generated)	Assets under construction	Total
2016-17				
	£000	**£000**	**£000**	**£000**
Cost or valuation:				
At 1 April 2016	1,560	79	115	**1,754**
Additions - purchased	148	0	190	**338**
Reclassifications	0	0	0	**0**
At 31 March 2017	**1,708**	**79**	**305**	**2,092**
Amortisation				
Accumulated at 1 April 2016	833	16	0	**849**
Provided during the year	347	16	0	**363**
Reclassifications	0	0	0	**0**
Accumulated at 31 March 2017	**1,180**	**32**	**0**	**1,212**
Net book value at 31 March 2017	**528**	**47**	**305**	**880**
Net book value at 31 March 2017 comprises:				
Purchased	528	47	305	880
Total at 31 March 2017	**528**	**47**	**305**	**880**

Opening Assets Under Construction of £115k at 1st April 2016 and Asset Under Construction additions of £190k during 2016/17 relating to the Trust Child Health System have been re-categorised to Note 8 Intangible Assets from Note 9 Property, Plant & Equipment Assets Under Construction.

9. Property, plant and equipment

9.1 Property, plant and equipment 2017-18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2017	**14,608**	**82,293**	**1,512**	**3,297**	**384**	**6,669**	**108,763**
Additions Purchased	**2**	**2,424**	**1,919**	**259**	**0**	**1,087**	**5,691**
Impairments charged to operating expenses	**0**	**(1,357)**	**0**	**0**	**0**	**0**	**(1,357)**
Impairments charged to the revaluation reserve	**(2)**	**(2,289)**	**0**	**0**	**0**	**0**	**(2,291)**
Reversal of impairments credited to operating expenses	**0**	**1,988**	**0**	**0**	**0**	**0**	**1,988**
Reversal of impairments credited to the revaluation reserve	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revaluations	**431**	**2,896**	**0**	**0**	**0**	**0**	**3,327**
Reclassifications	**0**	**3,021**	**(3,021)**	**0**	**0**	**0**	**0**
Transfers to/from assets held for sale	**(293)**	**(379)**	**0**	**0**	**0**	**0**	**(672)**
Disposals/derecognition*	**0**	**(1,818)**	**0**	**(1,302)**	**(278)**	**(3,024)**	**(6,422)**
At 31 March 2018	**14,746**	**86,779**	**410**	**2,254**	**106**	**4,732**	**109,027**
Depreciation							
Accumulated at 1 April 2017	**0**	**3,041**	**0**	**2,036**	**314**	**4,680**	**10,071**
Charged During the Year	**0**	**1,703**	**0**	**235**	**17**	**750**	**2,705**
Impairments charged to operating expenses	**0**	**(227)**	**0**	**0**	**0**	**0**	**(227)**
Impairments charged to the revaluation reserve	**0**	**(330)**	**0**	**0**	**0**	**0**	**(330)**
Reversal of impairments credited to operating expenses	**0**	**(1,118)**	**0**	**0**	**0**	**0**	**(1,118)**
Reversal of impairments credited to the revaluation reserve	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revaluations	**0**	**(1,247)**	**0**	**0**	**0**	**0**	**(1,247)**
Reclassifications	**0**	**334**	**0**	**0**	**0**	**(334)**	**0**

9.1 Property, plant and equipment 2017-18 (continued)

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Transfers to/from assets held for sale	0	(12)	0	0	0	0	(12)
Disposals/derecognition*	0	(1,818)	0	(1,302)	(278)	(3,024)	(6,422)
Accumulated at 31 March 2018	0	326	0	969	53	2,072	3,420
Net Book Value at 31 March 2018	14,746	86,453	410	1,285	53	2,660	105,607
Asset financing:							
Owned	14,746	77,767	410	1,285	53	2,660	96,921
On-SOFP PFI contracts - Note 10.1	0	8,686	0	0	0	0	8,686
Total at 31 March 2018	14,746	86,453	410	1,285	53	2,660	105,607

Opening Assets Under Construction of £305k at 1st April 2017 relating to the Trust Child Health System have been re-categorised to Note 8 Intangible Assets from Note 9 Property, Plant & Equipment Assets Under Construction.

*For the Plant & Machinery, Transport Equipment and Information Technology categories, within the Disposal/derecognition lines are £3,441k of both cost and accumulated depreciation of assets which have a zero net book value on the fixed asset register but had not been recognised as disposals/derecognised in previous years. During 2017/18 these have been removed from the fixed asset register and therefore included in the Disposal/derecognition lines. The residual movement in the Disposals/derecognition lines relates to a correction to historic balances. For these corrections there is no impact on the opening or closing net book values.

*For Buildings excluding dwellings, the Disposals/derecognition of £1,818k relates to a correction to historic balances. For these corrections there is no impact on the opening or closing net book values.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	**2,291**	**6,649**	**0**	**0**	**0**	**0**	**8,940**
Revaluation - impairment	**(2)**	**(1,959)**	**0**	**0**	**0**	**0**	**(1,961)**
Revaluation - increase in value	**431**	**4,143**	**0**	**0**	**0**	**0**	**4,574**
At 31 March 2018	**2,720**	**8,833**	**0**	**0**	**0**	**0**	**11,553**

Additions to Assets Under Construction in 2017-18

	£000
Buildings excl Dwellings	**1,916**
Plant & Machinery	**0**
Information Technology	**3**
Balance as at 31 March 2018	**1,919**

9.2 Property, plant and equipment 2016-17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2016	**14,608**	**81,407**	**1,112**	**2,834**	**384**	**6,122**	**106,467**
Additions Purchased	**0**	**19**	**1,982**	**268**	**0**	**27**	**2,296**
Reclassifications	**0**	**867**	**(1,582)**	**195**	**0**	**520**	**0**
At 31 March 2017	**14,608**	**82,293**	**1,512**	**3,297**	**384**	**6,669**	**108,763**
Depreciation							
Accumulated at 1 April 2016	**0**	**1,558**	**0**	**1,789**	**296**	**3,601**	**7,244**
Charged During the Year	**0**	**1,483**	**0**	**247**	**18**	**1,079**	**2,827**
Accumulated at 31 March 2017	**0**	**3,041**	**0**	**2,036**	**314**	**4,680**	**10,071**
Net Book Value at 31 March 2017	**14,608**	**79,252**	**1,512**	**1,261**	**70**	**1,989**	**98,692**
Asset financing:							
Owned	**14,608**	**71,589**	**1,512**	**1,261**	**70**	**1,989**	**91,029**
On-SOFP PFI contracts - Note 10.1	**0**	**7,663**	**0**	**0**	**0**	**0**	**7,663**
Total at 31 March 2017	**14,608**	**79,252**	**1,512**	**1,261**	**70**	**1,989**	**98,692**

Opening Assets Under Construction of £115k at 1st April 2016 and Asset Under Construction additions of £190k during 2016/17 relating to the Trust Child Health System have been re-categorised to Note 8 Intangible Assets from Note 9 Property, Plant & Equipment Assets Under Construction.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2016	**2,291**	**6,639**	**0**	**10**	**0**	**0**	**8,940**
At 31 March 2017	**2,291**	**6,639**	**0**	**10**	**0**	**0**	**8,940**

Additions to Assets Under Construction in 2016-17

	£000
Buildings excl Dwellings	**1,602**
Plant & Machinery	**49**
Information Technology	**331**
Balance as at 31 March 2017	**1,982**

9.3 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings excluding dwellings	25	80
Plant and machinery	7	25
Transport equipment	7	7
Information technology	3	10

9.4 Economic life of intangible assets

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Development Expenditure	3	7
Software - purchased	5	5

10.1 Property, plant and equipment On-SOFP PFI contracts 2017-18

	Buildings excluding dwellings	Total
	£000	£000
Cost or valuation:		
At 1 April 2017	7,857	**7,857**
Upward revaluation	829	**829**
At 31 March 2018	**8,686**	**8,686**
Depreciation		
Accumulated at 1 April 2017	194	**194**
Charged During the Year	98	**98**
Upward revaluation	(292)	**(292)**
Accumulated at 31 March 2018	**0**	**0**
Net Book Value at 31 March 2018	**8,686**	**8,686**

10.2 Property, plant and equipment On-SOFP PFI contracts 2016-17

	Buildings excluding dwellings	Total
	£000	£000
Cost or valuation:		
At 1 April 2016	7,857	**7,857**
At 31 March 2017	**7,857**	**7,857**
Depreciation		
Accumulated at 1 April 2016	97	**97**
Charged During the Year	97	**97**
Accumulated at 31 March 2017	**194**	**97**
Net Book Value at 31 March 2017	**7,663**	**7,760**

The above assets are included in the NHS Foundation Trust's total PPE disclosed in note 9.

11 Non-current assets held for sale

The Trust held £660k of non-current assets for sale at 31 March 2018 (£0k at 31 March 2017) relating to land and buildings.

These assets are no longer being held for their service potential and have been actively marketed. They have therefore been valued in accordance with IFRS 5 at the lower of their carrying amount and fair value less costs to sell.

12 Capital Commitments

Contracted capital commitments at 31 March not otherwise included in the annual report and accounts:

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	**2,551**	1,699
Information technology	**650**	0
Intangible assets	**2,246**	0
Total	**5,447**	**1,699**

13 Better Payment Practice Code

13.1 Measure of compliance

	2017-18 Number	2017-18 £000	2016-17 Number	2016-17 £000
Total Invoices Paid in the Year	**55,428**	**126,327**	63,820	115,844
Total Invoices Paid Within Target	**53,136**	**120,614**	62,146	112,024
Percentage of Invoices Paid Within Target	**95.86%**	**95.48%**	97.38%	96.70%

The Better Payment Practice Code requires the NHS Foundation Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

13.2 The Late Payment of Commercial Debts (Interest) Act 1998

The NHS Foundation has not made any payment during 2017-18 and 2016-17 relating to interest charges for Late Payment of Commercial Debts.

14. Inventories

	Drugs £000	Other £000	Total £000
Balance at 1 April 2017	87	1	**88**
Balance at 31 March 2018	**87**	**1**	**88**

15. Trade and other receivables

15.1 Trade and other receivables

	Current		Non-current	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Trade receivables	**9,805**	11,086	**0**	0
Other receivables	**19**	277	**0**	0
VAT receivables	**420**	861	**0**	0
Provision for the impairment of receivables	**(1,012)**	(452)	**0**	0
Prepayments	**1,486**	857	**0**	0
Accrued Income	**2,189**	4,448	**0**	0
PDC dividend receivable	**179**	50	**0**	0
PFI lifecycle prepayment	**0**	0	**1,453**	1,267
Total	**13,086**	**17,127**	**1,453**	**1,267**
Total current and non current	**14,539**	**18,394**		

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

15.2 Receivables past their due date but not impaired

	31 March 2018 £000	31 March 2017 £000
By up to three months	**5,827**	9,108
By three to six months	**855**	813
By more than six months	**981**	715
Total	**7,663**	**10,636**

The NHS Foundation Trust does not hold any collateral for its receivables.

15.3 Provision for impairment of receivables

	2017-18 £000	2016-17 £000
Balance at 1 April 2017	**452**	123
Amounts utilised	**0**	0
Unused amounts reversed	**(452)**	0
Increase in receivables impaired	**1,012**	329
Balance at 31 March 2018	**1,012**	**452**

16. Cash and Cash Equivalents

	31 March 2018 £000	31 March 2017 £000
Opening balance	**13,818**	14,195
Net change in year	**3,599**	(377)
Closing balance	**17,417**	**13,818**
Made up of		
Cash with Government Banking Service	**17,327**	13,732
Commercial banks and cash in hand	**90**	86
Cash and cash equivalents as in statement of financial position	**17,417**	**13,818**
Cash and cash equivalents as in statement of cash flows	**17,417**	**13,818**

17. Trade and other payables

	Current		Non-current	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Trade payables	**5,181**	4,638	**0**	0
Non-NHS payables - capital	**1,067**	373	**0**	0
Amount due to other related parties - Superannuation	**2,789**	2,711	**0**	0
Tax and social security costs	**3,710**	3,777	**0**	0
Accruals	**13,005**	8,616	**0**	0
Interest payable	**6**	13	**0**	0
Other	**108**	13	**0**	0
Total	**25,866**	**20,141**	**0**	**0**

18. Other liabilities

	Current		Non-current	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Other - deferred income	**5,867**	4,461	**0**	**0**
Total	**5,867**	**4,461**	**0**	**0**
Total other liabilities - current and non-current	**5,867**	4,461		

19. Borrowings

	Current		Non-current	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Loans from Independent Trust Financing Facility (ITFF)	**1,250**	1,250	**0**	1,250
PFI liabilities:				
Main liability	**250**	250	**15,296**	15,529
Total	**1,500**	**1,500**	**15,296**	**16,779**
Total other liabilities (current and non-current)	**16,796**	18,279		

Borrowings - repayment of principal falling due in:

	ITFF £000	PFI £000	Total £000
0-1 years	1,250	250	1,500
1 - 5 Years	0	1,195	1,195
Over 5 Years	0	14,101	14,101
TOTAL	**1,250**	**15,546**	**16,796**

20. Provisions

	Pensions Relating to Other Staff	Legal Claims	Restructuring/Redundancy	Other	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2017	**86**	**135**	**1,062**	**0**	**1,283**
Arising During the Year	5	157	1,413	0	**1,575**
Utilised During the Year	(4)	(33)	(263)	0	**(300)**
Reversed Unused	(58)	(109)	(799)	0	**(966)**
Unwinding of Discount	0	0	0	0	**0**
Balance at 31 March 2018	**29**	**150**	**1,413**	**0**	**1,592**
Expected Timing of Cash Flows:					
No Later than One Year	2	150	1,413	0	1,565
Later than One Year and not later than Five Years	8	0	0	0	8
Later than Five Years	19	0	0	0	19
	29	**150**	**1,413**	**0**	**1,592**
Balance at 1 April 2016	**99**	**4,152**	**711**	**50**	**5,012**
Arising During the Year	0	59	1,062	0	**1,121**
Utilised During the Year	(13)	(143)	(513)	(50)	**(719)**
Reversed Unused	0	(3,933)	(198)	0	**(4,131)**
Balance at 31 March 2017	**86**	**135**	**1,062**	**0**	**1,283**

£3,105k is included in the provisions of the NHS Litigation Authority at 31 March 2018 in respect of the clinical negligence liabilities of Pennine Care NHS Foundation Trust (31 March 2017 £1,487k).

Provisions made at 31 March 2018 include:

Pensions relating to other members of staff
These are commitments made to one former members of staff who receive Injury Benefits through NHS Litigation Authority. Payments are handled by NHSLA and recharged quarterly. It is expected the cash flows will continue annually for at least five years.

Legal claims
The legal claims provision includes the excess payable on Employer Liability and Public Liability claims being handled by the NHS Litigation Authority (NHSLA) where the cases have been notified to the NHS Foundation Trust as outstanding at 31 March 2018. It is expected that these balances will be settled within one year.

Restructuring/Redundancy
The restructuring/redundancy provision includes the costs associated with implementing service re-design and restructuring, which is partly due to changes in commissioning service, that the NHS Foundation Trust has committed to in 2017-18, but have not yet been fully implemented. These costs include the estimated redundancy costs for those areas where relevant. It is expected that all costs will be incurred within one year.

Other
The provision related to an estimate for a back pay claim which was settled during 2016/17, leaving no outstanding provision.

21. Private Finance Initiative contracts

21.1 PFI schemes off-Statement of Financial Position

The NHS Foundation Trust has no PFI schemes deemed to be off-Statement of Financial Position.

21.2 PFI schemes on-Statement of Financial Position

The Etherow Unit - This scheme is for the provision of specialist mental health care for the elderly population of Tameside and Glossop and forms part of (22%) the overall 'Health in Tameside' PFI scheme situated on the hospital site in Tameside.

At 31 March 2018 the current net liability of the scheme is £15,546k, and current unitary payments are £2,448k per annum.

The contract commenced in September 2009 and is due to expire in August 2041.

There are no deferred assets or residual interests associated with the NHS Foundation Trust's section of the PFI transaction.

Total obligations for on-statement of financial position PFI contracts due:

	31 March 2018 £000	31 March 2017 £000
Not later than one year	**1,379**	1,324
Later than one year, not later than five years	**5,514**	5,296
Later than five years	**27,064**	27,843
Gross PFI Liability	**33,957**	**34,463**
Less: Finance charges allocated to future periods	**(18,411)**	(18,684)
Net PFI obligation	**15,546**	**15,779**

21.3 Total on-SOFP PFI Commitments

	31 March 2018 £000	31 March 2017 £000
Not later than one year	**2,441**	2,362
Later than one year, not later than five years	**9,764**	9,449
Later than five years	**47,709**	49,056
Total future payments committed in respect of PFI arrangements	**59,914**	**60,867**

21.4 Charges to expenditure

The total charged in the year to operating expenditure in respect of on-statement of financial position PFI contracts for the service element of the PFI contract was £883k (prior year £834k).

The NHS Foundation Trust is committed to the following annual charges.

	31 March 2018 £000	31 March 2017 £000
PFI scheme expiry date:		
Not later than one year	**876**	857
Later than one year, not later than five years	**3,506**	3,426
Later than five years	**17,030**	17,500
Total	**21,412**	**21,783**

The 2016/17 figures above have been restated to exclude the capital lifecycle maintenance prepayment.

21.5 Analysis of amounts payable to service concession operator for the PFI scheme

	31 March 2018 £000	31 March 2017 £000
Interest Charge	**1,146**	1,082
Repayment of finance lease liability	**233**	241
Service Element	**883**	834
Capital lifecycle maintenance	**186**	182
Unitary payment payable to service concession operator	**2,448**	**2,339**

22. Financial Instruments

22.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with Commissioners and the way those Commissioners are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities, rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The NHS Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Foundation Trust's Standing Financial Instructions and policies, agreed by the board of directors. NHS Foundation Trust treasury activity is subject to review by the NHS Foundation Trust's internal auditors, KPMG.

Currency risk

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

Interest rate risk

The NHS Foundation Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The NHS Foundation Trust also has borrowing relating to the PFI building. The contract relating to the PFI building is inflated each year based on the Retail Price Index. The NHS Foundation Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the NHS Foundation Trust's income comes from contracts with other public sector bodies, the NHS Foundation Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

The NHS Foundation Trust's objective is to minimise credit risk, which it achieves by a programme of proactive credit control and internal controls.

Liquidity risk

The NHS Foundation Trust's operating costs are incurred under contracts with Commissioners, which are financed from resources voted annually by Parliament. The NHS Foundation Trust funds its capital expenditure from internally generated funds. The NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

22. Financial Instruments

22.2 Financial Assets

	31 March 2018	31 March 2017
	£000	£000
Trade and Other Receivables	**11,001**	15,359
Cash at bank and in hand	**17,417**	13,818
Total Financial Assets	**28,418**	**29,177**

Financial assets are classified as 'loans and receivables'.

22.3 Financial Liabilities

	31 March 2018	31 March 2017
	£000	£000
Payables	**19,367**	13,653
Other borrowings	**1,250**	2,500
PFI & finance lease obligations	**15,546**	15,779
Other provisions under contract	**1,563**	1,197
Total Financial Liabilities	**37,726**	**33,129**

Financial liabilities are classified as 'Other' and are not at 'fair value through profit and loss'.

Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
Liabilities falling due in:		
0-1 years	**22,430**	**16,350**
1-2 years	**268**	**1,500**
2-5 years	**927**	**977**
Over 5 years	**14,101**	**14,302**
Total	**37,726**	**33,129**

23 Related party transactions

23.1 Related party transactions with government bodies

Pennine Care NHS Foundation Trust is a public interest body authorised by NHSI, the Independent Regulator for Foundation Trusts.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Pennine Care NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year the NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income £000	Expenditure £000	Receivable £000	Payable £000
Bury CCG	41,401	0	974	106
NHS Manchester CCG	3,304	0	607	0
Heywood, Middleton & Rochdale CCG	35,089	0	721	52
Oldham CCG	52,763	331	644	148
Stockport CCG	27,968	0	305	14
Tameside & Glossop CCG	24,202	102	317	102
Trafford CCG	25,059	0	753	38
NHS England	21,067	0	1,890	106
Health Education England	3,464	17	0	94
NHS Property Services	79	2,251	103	319
Community Health Partnership	87	6,042	31	1,658
Pennine Acute NHS Trust	2,095	2,886	1,410	2,812
	236,578	**11,629**	**7,755**	**5,449**

In addition, the NHS Foundation 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 Local Authorities in respect of joint working arrangements. These entities are listed below:

	Income	Expenditure	Receivable	Payable
	£000	£000	£000	£000
Bury Metropolitan Borough Council	6,174	361	409	417
Rochdale Borough Council	7,076	126	738	130
Stockport Metropolitan Borough Council	3,019	30	509	139
Trafford Metropolitan Borough Council	5,820	1,662	202	470
	22,089	**2,179**	**1,858**	**1,156**

23.2 Related party transactions with key management personnel

IAS 24 requires disclosure of key management personnel. For this purpose we have included the Executive and Non Executive Directors i.e. those regularly attending Board level meetings with associated decision making autonomy. The 2016-17 figures have been amended below to reflect the same staff group.

	2017-18	2016-17
	£000	£000
Key management personnel compensation in total for:		
1. Short-term employment benefits	**1,145**	**1,222**
2. Post-employment benefits	**122**	**134**

1. Includes salary and NI contributions

2. Includes pension contributions

24 Use of Resources Rating

The five key financial performance measures are determined by NHS Improvement (NHSI), these are known as the Use of Resources Ratings (UoRR). The measures have been applicable to the Trust during 2017/18. The financial risk is rated from 1 to 4, where 4 equals the highest risk, and where 1 is considered the lowest risk with no regulatory concerns. The overall score is determined by a simple average, with the result rounded up.

These are designed to more thoroughly NHSI financial robustness and efficiency and is based on the following measures:

Capital Service Capacity - the degree to which the organisation's generated income covers its financing obligation.

Liquidity - days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.

Income and Expenditure (I&E) margin - the degree to which the organisation is operating at a surplus/deficit.

Variance from plan in relation to I&E margin - variance between a foundation trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year.

Agency Spend - measures the agency spend for the Trust against the NHSI target value, of £8.22m in 2017-18. The target set assumes a reduction in agency expenditure of approximately 33.5% compared to the 2016-17 agency outturn of £12.37m. The actual spend for the Trust was £9.09m which was 10.6% higher than the target, resulting in risk rating score of 2 detailed below.

The table below details the financial performance by the Trust against the plan submitted to NHSI in December 2016. The Trust submitted a revised plan to NHSI in March 2017 which reflected the financial challenges faced by the Trust. The actual performance in 2017/18 was broadly in line with the revised plan. The overall UoRR score for the Trust for the financial year 2017-18 is a score of 3.

	Capital Service Capacity	Liquidity	Income and Expenditure (I&E) margin	Variance from plan in relation to I&E margin	Agency Spend	Overall UoRR score with override
Plan for 2017-18	**2**	**2**	**1**	**1**	**3**	**2**
Achieved 2017-18	**4**	**2**	**4**	**4**	**2**	**3**

25. Third party assets

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

	31 March 2018	31 March 2017
	£000	£000
Patients monies held by the NHS Foundation Trust	**289**	286
Charitable Funds	**705**	535
Total	**994**	**821**

The NHS Foundation Trust Board does not consider the balances in the Pennine Care NHS Foundation Trust Charitable Funds to be a material balance in relation to the NHS Foundation Trust annual report and accounts and therefore they have not been consolidated into the NHS Foundation Trust annual report and accounts.

26. Losses and special payments

The total number of losses cases in 2017-18 and their total value was as follows:

	Total Value of Cases £000	Total Number of Cases
Losses		
Bad debts and claims abandoned (excluding NHS cases)	**0**	**0**
Special payments		
Personal Injury with advice	**49**	**41**
Ex-gratia payments	**1**	**4**
Total losses and special payments	**50**	**45**

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £000	Total Number of Cases
Losses		
Bad debts and claims abandoned (excluding NHS cases)	**0**	**0**
Special payments		
Personal Injury with advice	**57**	**16**
Ex-gratia payments	**1**	**3**
Total losses and special payments	**58**	**19**

Details of cases individually over £300,000
There were no cases individually over £300,000 in either year.

27 Auditors' remuneration and Liability Limitation Agreement

The NHS Foundation Trust's statutory external auditors are Grant Thornton UK LLP. Detailed below is a breakdown of the remuneration charged for both Statutory Audit charges and other auditors' remuneration.

	2017-18 £000	2016-17 £000
Remuneration for the Statutory Audit	**46**	47
Other auditors' remuneration is analysed:		
1. Remuneration for the Audit of the Quality Accounts	**7**	7
2. All other non-audit services	**0**	0
Total	**53**	**54**

These services were approved by the Executive and noted by the Audit Committee having assessed that appropriate safeguards to protect auditors independence were in place. The NHS Foundation Trust's contract with its auditors provides for a limitation of the auditors' liability of £2,000,000 as set out in the engagement letter.

28 Events after the reporting year

The NHS Foundation Trust has not identified any events that occurred after the reporting year that would require disclosure as non-adjusting events in accordance with IAS 10.

Independent auditor's report to the Council of Governors of Pennine Care NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Pennine Care NHS Foundation Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.2.2 in the financial statements, which indicates that the Trust's financial plan for 2018/19 forecasts an in-year deficit for that year of £11.2 million. In addition, the Directors are expecting that cash support from NHS Improvement will be required for 2018/19.

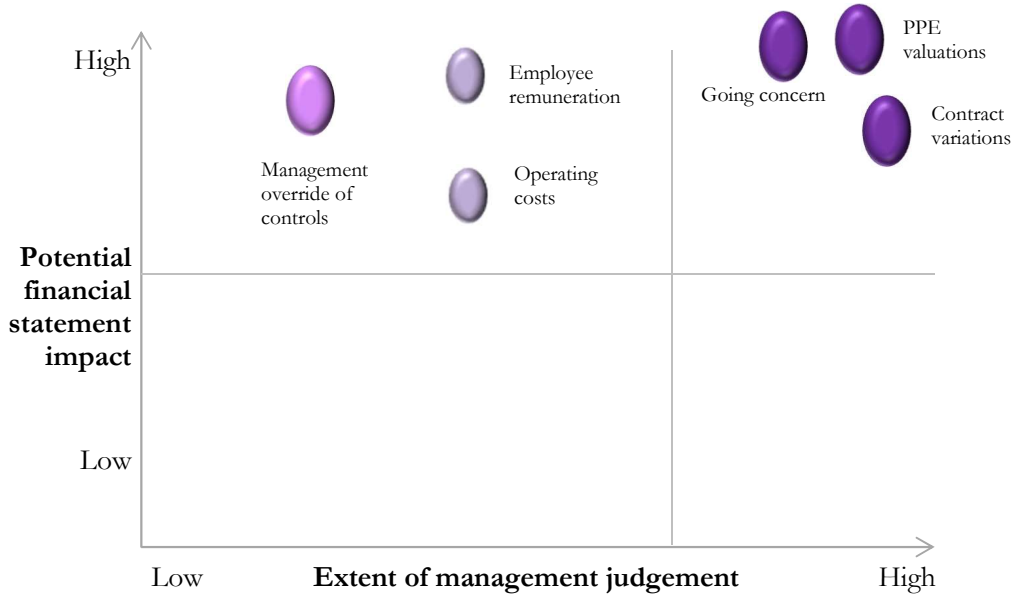
These events or conditions, along with the other matters explained in note 1.2.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Overview of our audit approach

- Overall materiality: £5,299,000, which represents 2% of the Trust's gross operating expenses;
- Key audit matters were identified as:
  - Valuation of land and buildings
  - Healthcare revenues contract variations
  - Going concern material uncertainty disclosures

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matter described in the *Material Uncertainty Related to Going Concern* section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 **Valuation of land and buildings** The Trust revalues its land and buildings on a five-yearly basis to ensure the carrying value in the Trust's financial statements is not materially different from fair value at the financial statements date. In the intervening years, such as	Our audit work included, but was not restricted to: • assessing the competence, objectivity and capabilities of the valuation expert used by the Trust; • evaluating management's processes and assumptions for the calculation of the estimate and the appropriateness of the instructions issued to the valuer, the basis of valuations and the scope of their work;

Key Audit Matter	How the matter was addressed in the audit
2017/18, the Trust requests a desktop valuation from their valuation expert. This valuation represents a significant estimate by management in the financial statements. We therefore identified valuation of land and buildings as a significant risk, which was one of the most significant assessed risks of material misstatement.	• on a sample basis, testing revaluations and impairments made during the year, per the valuation expert's report, to see if they had been input correctly into the Trust's asset register and financial statements; and • challenging the information and assumptions used by the valuer to ensure it was complete and accurate. The Trust's accounting policy on valuation of property, plant and equipment is shown in note 1.8 to the financial statements and related disclosures are included in note 9. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation was appropriate and the assumptions and processes used by management in determining the estimate were reasonable; • the valuation of land and buildings disclosed in the financial statements is reasonable.
Risk 2 **Healthcare revenues contract variations** 97% of the Trust's income is from patient care activities and contracts with NHS commissioners. These contracts include the rates for and the level of patient care activity to be undertaken by the Trust. Any patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the commissioners. We have identified the occurrence and accuracy of income from contract variations as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • gaining an understanding of the Trust's system for accounting for income from contract variations and evaluating the design of the associated controls; • evaluating the appropriateness of the Trust's accounting policy for recognition of income from patient care activities and assessing its compliance with the Department of Health and Social Care Group Accounting Manual 2017-18; and • on a sample basis agreeing amounts recognised as income in the financial statements to signed contracts, and agreeing contract variations to supporting documentation. The Trust's accounting policy on recognition of income from patient care activities is shown in note 1.5 to the financial statements and related disclosures are included in note 3. **Key observations** We obtained sufficient audit evidence to conclude that: • The Trust's accounting policy for income from patient activities is in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18 and has been properly applied • Contract variations income from healthcare revenues is not materially misstated.

Our application of materiality

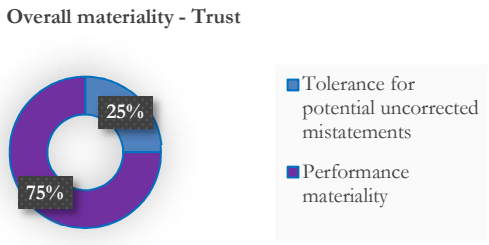
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use

materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£5,299,000 which is 2% of the Trust's 2016/17 gross operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue. Materiality for the current year is at the same percentage level of gross operating expenses as we determined for the year ended 31 March 2017 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	Disclosures of senior manager remuneration in the Remuneration Report: £25,320 based on 2% of the total executive and non-executive directors' remuneration. Disclosure of related party transactions: £296,200 based on 2% of total related party transactions expenditure. These items have a lower materiality than the financial statements as a whole because they are considered to be of particular interest to the reader of the accounts.
Communication of misstatements to the Audit Committee	£250,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business. It included an evaluation of the Trust's internal controls including relevant IT systems and controls over key financial systems.

Our work involved obtaining evidence about the amounts and disclosures in the financial statements to give us reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. The scope of our audit included:

- undertaking an interim audit visit where we:
    - obtained an understanding of and evaluated the Trust's overall control environment relevant to the preparation of the financial statements, including its IT systems
    - completed walk through tests of the Trust's controls operating in key financial systems where we consider that there is a risk of material misstatement to the financial statements
    - performed interim testing, on a sample basis of operating expenditure and non-healthcare income.
- performing year-end testing on the Trust's financial statements, which focussed on gaining assurance around the Trust's material income streams and operating costs, testing the Trust's employee remuneration costs and the notes to the accounts to ensure that they were compliant with the Department of Health and Social Care's Group Accounting Manual for 2017/18.
- We tested, on a sample basis of:
    - all of the Trust's material income streams
    - all of the Trust's operating expenses
    - land and buildings within property, plant and equipment , covering 95% of the total net book value.

Other information

The Accounting Officer is 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 of the Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- The Audit Committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matter described in the basis for qualified conclusion section of our report, we are satisfied that, in all significant respects, Pennine Care NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matter:

- The Trust incurred a retained deficit of £2.2 million in 2017/18, compared to a planned budget deficit at the start of the year of £6.6 million, and a NHS control total surplus of £3.18 million. The Trust has set a deficit budget of £11.2 million for 2018/19 and requires cash support of £10.4 million to meet its future commitments.

In relation to the Trust not being able to agree to the NHS Improvement control total surplus for 2017/18 or 2018/19, this matter identifies weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures in line with NHS Improvement's financial control total. This is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accounting Officer

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

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and

deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Pennine Care 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.

John Farrar

John Farrar
Associate Director

for and on behalf of Grant Thornton UK LLP

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25 May 2018

Working together

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