NHS
Pennine Care
NHS Foundation Trust

2018/19 Annual report and accounts

Pennine Care NHS Foundation Trust

Annual Report and Accounts 2018/2019

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

Welcome to our Annual Report and Accounts for 2018/19.

This has been a momentous year in terms of transition as we develop an ambitious new strategy, which will enable us to focus on where we can make the greatest difference to patients and communities.

We have spent time looking at where we have been and appreciating what we have learnt; understanding the opportunities and challenges which face us; and determining where we want and need to be in the future.

Our future strategy will focus on improving and enhancing our mental health, learning disability and wellbeing services. It will also allow us to capitalise on the much-welcomed national focus on mental health.

As part of this new strategy, our community (physical health) services in Bury, Oldham, Rochdale and Trafford will transfer to new NHS provider organisations. We have been very proud to run these services over the last eight years and there have been significant achievements, but we believe other provider organisations are better positioned to enable community health services to achieve more for the benefit of local people.

Culture is as important as strategy, and therefore alongside work on a new strategic approach, we have been focusing on our culture in terms of style and values.

We believe an organisation has integrity when its management, operations, strategy and culture fit together and make sense. A positive and diverse culture where we can work, innovate and collaborate together is when extraordinary things can happen.

We can be proud of our achievements in 2018/19 and excited about the future.

We have had a greater emphasis on quality and are one of the first NHS trusts in the country to adopt a *Just Culture* approach.

The *Just Culture* initiative is based on an approach where staff are not blamed for honest errors, but instead feel supported and encouraged to come forward and share experiences to allow lessons to be learned.

Our Quality Strategy has been refreshed and we have improved our quality governance through a number of ways, including clinical presence visits and shared learning. We have also revised our Patient Experience Strategy to ensure this feeds into everything we do.

We received an overall ‘requires improvement’ rating from our CQC inspection in September 2018 and, whilst the overall and five domain ratings did not change from the

previous inspection in 2016, the report felt very different. It recognised the significant improvement we have made in many in areas and that we are on a positive journey towards 'good'.

A mental health integrated programme is underway, as well as extensive work to deliver on improvement priorities such as safer staffing, mixed sex accommodation, crisis care and use of informatics.

In terms of leadership we have invested in clinical and professional leadership, appointed a new Executive Director of Workforce and improved the visibility of the board. We have also refreshed our governance, risk management and committee structures, with clearer and stronger systems of accountability as well as a focus on identifying hotspots of excellence with assurance.

As well as welcoming Nicky Littler as our Executive Director of Workforce, we saw other board changes. We said goodbye to Martin Roe, Executive Director of Finance and Deputy Chief Executive, who retired after 35 years' service to the NHS, with Suzanne Robinson joining as his replacement. Lord Keith Bradley left at end of August after his three-year term as Non-Executive Director came to an end, and Cath Laverty joined as our new Non-Executive Director.

We were delighted to secure £4.8 million government funding for a new psychiatric intensive care unit. Other estate developments over the year included opening new safe havens in Oldham and Rochdale to help patients to provide support for mental health patients attending A&E.

Health informatics, quality improvement and research developments have also helped enhance our systems of learning, continuous improvement and innovation. These include opening a new young people's mental health research unit.

As well as celebrating many successes over the year, we were proud to mark the 70th anniversary for the NHS in July. It was a perfect opportunity to promote the achievements of one of the nation's most loved, respected and trusted institutions; to appreciate the vital role the service plays in our lives; and to recognise and thank the extraordinary NHS staff who are there to guide, support and care for us, day in, day out.

We recognise our challenges, especially around recruitment and financial sustainability.

We can only meet these challenges if we are innovative, open to change and proactive; with everybody pulling in the same direction. This includes building excellent relationships with our partners.

We are at a pivotal moment in the pursuit of the highest quality mental health and learning disability services for those we serve. There is an exciting future ahead of us and our new

strategy will provide us with a clear, focussed direction. Quality will always be at the heart of this and our key driver for all the developments and improvements we wish to make.

Of course, none of this is possible without the people who work in our organisation; our greatest and most valuable resource. We therefore want to acknowledge the incredible contribution of our staff who continually impress us with their thoughtfulness, ingenuity, resilience, sensitivity and kindness.

Thank you also to our governors, volunteers and members. Our dedicated governors and members continue to play an important role in shaping our work and are always focussed on what matters. Governors, in particular, have represented the needs of their constituencies in informing our strategy. Our volunteers both inspire and humble us by giving so much of their time, skills and expertise freely to help others.

Thank you to everyone for your unique contribution.

Our vision is a happier and more hopeful life for each and every person within our communities. Together we can enable and empower people to reach their potential and live fulfilling lives.

Best wishes,

Evelyn Asante-Mensah OBE
Chair
24 May 2019

Claire Molloy
Chief Executive
24 May 2019

Performance Report Overview

The purpose of this section is to provide sufficient information for the reader to understand Pennine Care NHS Foundation Trust, including our purpose, keys risks to the achievement of our objectives and how we have performed over the previous year.

The Board, having made appropriate enquiries, has a reasonable expectation that the Trust will still have access to adequate resources to continue its operational existence in the foreseeable future, being a period of at least twelve months from the date of the 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 annual accounts, starting on page 248 of this report.

Claire Molloy
Chief Executive
24 May 2019

About 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, in 2011, welcomed community health services from the boroughs of Bury; Heywood, Middleton and Rochdale; and Oldham. This was followed by a range of services in Trafford in 2013.

Since the Trust's formation, we have expanded to become a leading provider of health services in the Greater Manchester area, providing services that help to maximise people's potential to live healthier and more rewarding lives.

Pennine Care employs 5,500 staff and provides care to around 1.3million people across six boroughs in Greater Manchester as follows:

- **Bury** – community and mental health services for children and adults; intermediate care for adults; urgent care 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)

In addition, we also provide mental health services for military veterans and a range of dental services across Greater Manchester.

In 2018, the Trust's Board of Directors considered a proposal concerning maximising the potential for services for mental health, learning disabilities and community health; alongside our corporate services and functions. This paper proposed redefining our service portfolio, focusing on the delivery of an enhanced offer around mental health and learning disabilities, transferring community services to an alternative provider.

The work to transfer community services has begun and will take place throughout 2019.

Our Trust Strategy

For our Mental Health and Learning Disabilities Services

We want to create an organisation that builds on our known strengths and recognised expertise and positions ourselves within localities as the advocate for, and facilitator of, positive mental health and well-being by working in strong partnerships with others. This will capitalise on our deep understanding of our communities and our expertise in partnership working in order to become a more prominent and assertive voice for the mental health agenda locally.

By creating a single-minded clarity of purpose and playing to our acknowledged organisational strengths, we will build the platform to drive forward meaningful change, by taking a lead and giving Pennine Care the opportunity to become more pro-active and visible within the system: creating a powerful case for service transformation and new models of care in mental health that provide better experiences and outcomes for our service users. The opportunity to develop new and stronger partnerships with organisations that can support the delivery of person-centred care will also help to ensure better holistic outcomes for our communities.

For our Community Physical Health Services

We believe that the answer to maximising potential for our community services lies with greater alignment to the emerging Local Care Organisations who are focussed upon more seamless and patient-centred delivery of primary and community care. There is a natural fit for our community services provision within local integrated neighbourhood and locality models, which are supporting the drive to deliver more care closer to home and improved patient outcomes.

To facilitate this, we believe that there are other providers better positioned to enable our community services to achieve more; and we consider we can best maximise their potential by aligning their skills, expertise and ingenuity more closely with providers that are focussing more heavily on this agenda of ‘out of hospital care’. The predominant model for this across Greater Manchester is for acute providers to be positioned to lead this approach.

So, we will continue to work with our partners in supporting the move to new locality-based, service models. But alongside this, we will also work with local systems to make decisions on the providers most able to deliver integrated care.

Coming to these conclusions has not been easy but if we believe we are all here to maximise potential, for our patients, service users, staff and partners, then this approach seems to generate the biggest and most positive impact.

For our Corporate Services

In taking forward this direction of travel, it is recognised that this has a significant impact upon corporate service colleagues. Due to the reduction in income across the organisation we will need to carefully consider the future model for corporate services to support organisational sustainability and delivery of the future strategy.

This strategic position will be enacted during 2019/20 and beyond.

Performance Report

This section of the report will look in detail at the performance of the Trust during 2018/19, including service developments, achievements, updates and financial performance. It also looks ahead at future trends and challenges that may affect the Trust in the next financial year.

Review of Last Year's Achievements

The tables below detail the progress made against the delivery objectives we set in 2018/19.

Quality - To drive and sustain quality improvement and innovation

Implement the refreshed Quality Strategy

- Quality Strategy framework approved by the Board of Directors (2018-21).
- Engagement event held 21st September 2018 with staff, service users, carers, volunteers, governors, members of the Board to develop strategic delivery plans for the five quality domains. Follow up event held on 25th February 2019, checking we had understood the views and feedback from the earlier event.
- Strategic plans submitted to Trust Management Board and Quality Committee. Committee approval to extend the strategy to five years 2018-23.
- Reporting structures agreed via Quality Group to Committee and locally at the Integrated Leadership Groups.

Deliver CQC action plan priorities, enabling the move from 'Requires Improvement' to 'Good' across all services, supported by a review of quality governance arrangements

- CQC inspection concluded in 2018 with findings/report and recommendations produced early 2019. CQC Improvement Plan developed with executive leads and local delivery leads identified. The plan covers all the recommendations from the inspection in three sections:
  - Must do
  - Should do
  - Well-led
- Participated in the Moving to Good programme with NHS Improvement.
- Quality leads and supporting administrative staff recruited.
- Clinical and professional leadership framework continues to develop.
- Mixed sex accommodation stakeholder engagement held.

Develop and implement the Trust's approach to quality improvement (QI)

Quality - To drive and sustain quality improvement and innovation

- Quality Improvement principles, approach and process for the Trust was presented to all committees March 2019.
- Application of QI within HMR Health Visiting and School Nursing, the Military Veterans Service, Tameside inpatient wards and mental health access teams.
- Quality Improvement Enablement plan under development for June 2019 (in line with Quality Strategy).

Develop core standards for community services across the Trust footprint

- Core standards developed and piloted in Bealey Hospital and Bury District Nursing team. Due to the changes in strategy, community standards put on hold due to staff being engaged in locality priorities. Work to be reviewed and changed to in-patient standards within mental health during 2019/20.
- Audiology and new born hearing standards completed as per national data set and adapted for the Trust.

Additionally we have developed and launched a young people's mental health research unit and have continued to strengthen our partnership with Manchester Metropolitan University bringing together clinical and academic professionals to deliver excellence in research, innovation, workforce development and education.

We continue to support the Triangle of Care which is built upon a three way partnership between the patient, carer and service to focus service improvement in mental health services.

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

Implement the refreshed People Strategic Plan, which will include a robust workforce plan

- A new People Strategy and high level delivery plan developed and presented at Board in June 2018.
- Final delivery plan submitted to People and Workforce Committee.
- The new Executive Director of Workforce commenced in post during quarter three.
- Improved governance supporting the re-alignment of the People and Workforce Steering Group sub-groups to oversee the delivery of the People and Workforce Strategy action plans, including recruitment and retention, learning and development, effective leadership and staff health, wellbeing and engagement.

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

- Equality, Diversity and Inclusion Steering Group established - oversight of Workforce Race Equality Standard (WRES), staff networks, and Equality, Diversity and Inclusion Strategy development.

Undertake a culture audit and build findings into a new Organisational Development Strategic Plan

- Organisational Development action plan developed and underway.
- The development of the new Trust vision and values, and a plan in place to develop behaviours framework linked to the values.
- Culture audit complete and an organisational development improvement plan has been approved.

Additionally we achieved improvement across a wide range of areas in the staff survey results.

Various support mechanisms have continued to be invested in, including Schwartz rounds, the Staff Health and Wellbeing Service and the Go-Engage programme to temperature check engagement levels and produce improvement plans.

We are also growing our apprentice population body including nursing apprenticeships, with further developments planned for the coming year.

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

Work with partners to support the development of Local Care Organisations and the delivery of locality plans

- Locality Care Organisation network established. Representatives include Corporate Heads, Managing Directors and Associate Directors across community and mental health divisions. The network shares the latest updates across localities and reports progress into Trust Management Board.
- This year the network has specifically considered children's services and the Trust's input into this work.
- Divisions are now aligned to the Local Care Organisation arrangements, and representing the Trust at alliance boards across localities.
- HMR Local Care Alliance held an event on 9 October 2018, focusing on mental health.

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

- Involvement in the redesign of services in Bury into integrated neighbourhood teams.
- Executive representation on the Oldham Cares partnership board.
- Investment through the Local Care Organisation locality plans was secured for mental health schemes in Oldham and HMR.

Support implementation of the Greater Manchester Mental Health Strategy, whilst implementing the Trust's own Mental Health Strategy

- Integrated Mental Health Programme Board established and launched August 2018.
  The programme board brings together all mental health workstreams and projects (Greater Manchester and Locality) into one programme, providing oversight of developments.
- Project Leads and Associate Directors aligned to each of the workstreams.
- Safe Haven models mobilised in Oldham and HMR, with Bury to go-live in 2019/20.
- Core 24 service live in Oldham. Recruitment underway for Stockport service.
- Community Mental Health Team staff engagement workshops held.
- NHS Capital funding for female Psychiatric Intensive Care Unit was confirmed by Department of Health and Social Care (subject to full business case).
- The Greater Manchester Health and Social Care Partnership agreed to commission a joint sustainability work stream to be delivered in three phases with a view to developing a joint sustainability plan for the Trust. Phase 1 will work with key stakeholders to agree the baseline position, with phases 2 and 3 focusing on agreeing an optimal and affordable service model. This work stream is being independently facilitated by Niche Consulting.
- Pennine Care is providing the system leadership to the implementation of the new Children and Young People's Crisis Service across Greater Manchester. The Trust is also providing the system leadership to the Tier 4 CAMHS inpatient work stream across Greater Manchester.

Work with a small number of localities to develop and implement integrated community and mental health services

- Mental health services have been the key priority area for HMR Local Care Alliance. Mental health practitioners to be part of the neighbourhood teams – in HMR, Oldham and Stockport.

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

- Investment received for Psychological Medicine service in Stockport and Oldham. Teams established and at early stages of working into the integrated neighbourhood teams.

Work with commissioners to complete a comprehensive service review to ensure future financial sustainability of the Trust's service portfolio

- Joint service reviews held across each community locality and mental health division during quarter two. Outputs presented at the Strategic Partnership Board in August 2018.
- Further work continued with the Board, and consultation with commissioners which led to the Trust position paper that outlined the future direction of the Trust. Position paper approved at Board in December 2018.
- Transformation Programme Board established in December 2018 to manage the transfer of community services to alternative providers, redesign of the organisation, redesign of corporate services and the integrated mental health and learning disabilities programme.
- Strategy and Sustainability Plan being developed in line with national planning timescales.
- GM commissioned the joint sustainability work stream which is to look at achieving sustainable and effective Mental Health services.

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

Work with commissioners to agree a financial plan for 2018/19

- Financial plan agreed for 2018/19 underpinned by signed contracts with commissioners
- Operational plan for 2018/19 submitted to NHS Improvement. Delivered an improved outturn position, in agreement with NHS Improvement.

Develop a high-level, medium to long-term financial recovery plan that returns the Trust to financial sustainability.

- High level indicative Long Term Financial Model created to reflect a recovery period of three years (April 2021). Requires updating in line with national timescales (autumn 2019).
- The Grip and Control matrix introduced to review and strengthen processes.

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

- Sustainability plan redefined following the decision regarding future strategic direction and issue of national planning guidance.
- A proposed governance process, procedure and framework developed to manage service and cost improvements. Approach and framework presented at Performance and Finance Committee and Corporate Integrated Leadership Group in December 2018.
- Greater Manchester commissioned a piece of work to look at achieving sustainable and effective Mental Health services.
- Agreement regarding stranded costs for 18 months following transfer of community services.

Infrastructure – Ensure we have the right estates and IM&T to delivery our quality aspirations

- Implement Estates priorities
- Estates department are working with six out of the ten Strategic Estate Groups across Greater Manchester and public sector partners including local authorities, Police and Fire Service.
- NHS Capital funding for female Psychiatric Intensive Care Unit was confirmed by Department of Health and Social Care (subject to full business case). Detailed design works are in progress and the target submission date to NHS Improvement is September 2019.
- Performance to date on all estates schemes is to plan. Exceptions are the improvements to mixed sex accommodation which are on hold due to the consultation.
- Completed schemes year to date:
- Improvement schemes: Parklands House Oak and Aspen Ward, Stockport Community Mental Health reconfiguration, Callaghan House alterations to facilitate Children's Acute and On-going Needs Service, Forest House ground floor refurbishment.
- Fire safety improvements: Birch Hill Hospital: signalling and common fire link, Butler Green passive safety works, fire door refurbishment to bring to full design standard (Taylor and Tatton). Complete new wired fire alarm to Roch House and Irwell Unit.
- Patient Safety schemes: Royal Oldham Hospital upgrade secure access control systems, Stepping Hill Hospital installation of bedroom door anti-barricade devices, new door vision panels to Norbury Ward, Hollingworth Ward: alterations to bedroom doors and ironmongery, inpatient windows in Pennine House, Beech

Infrastructure – Ensure we have the right estates and IM&T to delivery our quality aspirations

Ward and Prospect Place, various minor works associated with CQC and Patient Led Assessments of the Care Environment (PLACE) inspections including the provision of five new medicine dispensary rooms and improved showering facilities at Beech Ward.

- Sustainability schemes including: Trust-wide lighting refurbishment (low energy LED), Rowan/Cedars/Bevan Wards - bedroom and en-suite lighting upgrade to corridors, Outram Road refurbishment/replacement of electrical distribution boards, insulation to roof voids, replacement heating ventilation and air conditioning plant at John Elliot Unit and Buckton Building.
- Lifecycle schemes: MacMillan Centre, Trafford - minor roof refurbishment, car park improvements at Butler Green, Phoenix Centre, Middleton-LIFT site-addition of air cooling to ventilation system, internal decoration to wards, various roofing works.
- External improvement works: Royal Oldham Hospital Cedars ward garden improvements, Birch Hill Hospital John Elliot Unit gardens.
- Implement the Health Informatics Strategy, including the electronic patient record
- Successful bids for Greater Manchester digital funding totalling £1.7m (included rollout of mobile devices in Trafford).
- Roll out of wireless services to the public at key sites. Public Wi-Fi deployed in waiting areas across the Trust estate.
- Further 33 services now live on Paris. In mental health, 10 services (65 teams) have transitioned on to a full Paris Electronic Patient Record and 23 services in Community.
- Mobile devices rolled out to teams – 509 deployed in Mental Health Services, 734 deployed in Community Services.
- Electronic Rostering System (eRS) project initiated, initial project board held, project brief scope to be updated and resubmitted.
- Procurement for electronic prescribing commenced.
- Graphnet went live on 27 Mar 2019. Pennine Care data for community and mental health data made available. As of 4 Apr 2019 Pennine Care staff can now access external data (local authority, Pennine Acute NHS Trust and GP data).
- The Virtual Desktop Infrastructure Project has been progressed, 2018/19 has been focussed on the scoping. Testing and deployment to be undertaken during 2019/20.
- Rollout of SafeQ printing completed in Trust HQ and started HMR, site surveys completed in Oldham and Bury.

Divisional achievements 2018/19

BURY

- Developed the Audiology service to offer click and post for audiology consumables, Flo technology and bookable appointments via e-referral.
- Full redesign, including skill mix review, of local Adult Community Nursing team.
- Improvements to Joint Equipment Store, operational from the Seedfield Centre for both NHS and council staff.
- Remodel of local IV Therapy service.
- Implementation of new toolkit for Paediatric Speech and Language Therapy Service.
- Improvements to PARIS, implementing improvements for the Child Health system and implementing a full Electronic Patient Record for the Adult and Paediatric Physiotherapy service.

HMR

- As part of Local Commissioning Organisation (LCO) work, Pennine Care led on planning and delivery of major Mental Health stakeholder event on 9th October 2018.
- Established a mental health thematic group aligned to LCO governance, developed the Mental Health and Wellbeing Neighbourhood plan linked to Rochdale's 10 strategic population outcomes.
- Management restructure in Health Visiting and School Nursing: Providing increased management support and supervision to embed new models and delivery of Cost Improvement Programmes.
- Joint Physical and Mental Health Showcasing Quality event and stakeholder wide event held on the 4 Oct 2018.
- The Child and Adolescent Ongoing Needs Service (CAONS) teams are now live using clinical electronic patient records.
- Established HMR Collective Leadership Forum to enhance engagement at all levels.

MENTAL HEALTH

- Establishment of an Operational Safe Haven in Oldham.
- Started the ongoing development of a Children and Young People Crisis Pathway.
- Funding to establish a female psychiatric intensive care unit (PICU) has been agreed, and work has begun to develop this.
- The Liaison Mental Health Service (Core 24) has been established in Oldham.
- Delivery of a Psychological Medicine in Primary Care service in Stockport.
- Ongoing development and expansion of the resilience hub, working in successful partnership with other agencies to support those who have experienced trauma e.g. through the use of virtual reality therapy
- 754 students commenced on Health and Wellbeing College courses. The College continues to demonstrate significant health improvements and facilitates opportunities for those with lived experience.

OLDHAM

- Co-location of services into cluster teams with health and social care colleagues and single line management and locality governance structure.
- Development of a local Integrated Therapies Hub, in the process of being implemented at the Link Centre.
- Established an 'enablement' workstream within Urgent Care.
- Re-established the Children and Young People's Strategic Partnership, chaired by the Head of Children's Services.
- Continued to develop leadership and governance capabilities.

TRAFFORD

- Health visitors have been awarded the Baby Friendly Accreditation, and have been instrumental in helping the borough to achieve the highest rate of breastfeeding at 6-8 weeks in Northern England.
- Let's Talk has been shortlisted for a national transformation award, thanks to the work of adult care staff implementing a new asset-based approach.
- Phase one of the Trafford Enhanced Care Home Team has produced positive outcomes in terms of reducing the number of transfers to hospital.
- The Urgent Care Control Room continues to be developed to provide support for patients discharged from secondary care and provide a 'bird's eye' of capacity within Trafford.
- Tableau implemented within division and deployment of phase one of mobile devices within division.

Performance Analysis

The Trust measures overall performance using a set of agreed strategic indicators. These indicators include internally agreed core standards, contractual operating and quality standards and key regulatory requirements.

To support monitoring of these indicators the Trust has introduced a new Integrated Performance Report (IPR) along with a set of new committee performance reports.

The IPR provides the Board with an overview of performance against our five strategic goals, our regulatory standards and requirements set out in the NHS Improvement Single Oversight Framework. The report also provides an integrated view of performance against our internal core standards across quality, people, finance and operational activity.

Our new committee reports provide a detailed view of performance against specific indicators relevant to their area of responsibility.

Each of the reports provide the Board and committees with a view of both current performance against agreed targets and a historical data using statistical process control charts to analyse trend and monitor change. The reports contain analysis of the data ensuring that any areas of underperformance are escalated with action plans to improve performance. The reports also aim to identify future performance risks.

At a divisional level Integrated Leadership Groups are in place. These groups meet monthly to seek assurance that overall performance of the division is in line with the agreed internal core standards, contractual requirements and national standards

An overview of performance during 2018/19 is shown in the table below, followed by a more detailed narrative where appropriate.

Current challenges/ areas for improvement	Future risks	Performing well	Key areas of improvement made in year
Safe staffing levels	Improving Access to Psychological Therapies (IAPT) recovery targets	Friends and Family recommendation scores	Early Intervention in Psychosis (EIP) access and waiting times
Mixed sex accommodation	Vacancies/ turnover rates	Incident reporting/ unexpected deaths	Delayed Transfer of Care (DTOC)
Physical health checks	Staff flu vaccination uptake	Patient Led Assessment of the Care Environment (PLACE) scores	Staff flu vaccination uptake
Safeguarding training		EIP access targets	Pressure ulcer training
Financial position		Care Programme Approach (CPA) seven-day follow-up	Staff recommendations scores
Individual personal development reviews compliance		Infection control	Information governance training compliance
IAPT waiting times targets			
Out of area placements / DTOC / bed occupancy			

- ***Mixed Sex Accommodation***

  The Trust has undertaken a significant Mixed Sex Accommodation (MSA) engagement exercise during 2018/19. Pending implementation of agreed outcomes, operational processes are in place to minimise MSA breaches.

- ***Physical Health Checks***

  A physical health strategy is in its first draft and will provide services with clear expectations linked to the Key Performance Indicators (KPIs). Training, education and documentation have been reviewed to ensure it is fit-for-purpose and supports services to meet our obligations.

- ***Safeguarding Training Compliance***

  The overall proportion of staff who have completed the relevant safeguarding training compliance has improved over the last 12 months; however it still remains below the overall 95% target. Compliance is set to become more challenging in 2019/20 as

new standards are introduced to include level 2 and 3 adult safeguarding. Requirements will also broaden for level 2 and 3 child safeguarding to include a wider cohort of staff. Work to assess and plan for these changes is being carried out by the Safeguarding Team.

- ***Improving Access to Psychological Therapies (IAPT)***

  Work is ongoing with commissioners regarding investment into IAPT services. Performance against the IAPT six-week access target has seen a significant decline over the past six months with the 75% standard being breached on a number of occasions. Performance has also shown a decline in relation to the 18-week target and recovery, although the overall standards are currently still being achieved. It is anticipated that this position will continue to decline pending the outcome of work with commissioners to secure appropriate investment into the service.

- ***Bed Occupancy***

  Occupancy levels have been consistently above the 90% standard in both adults and older people services during 2018/19 as the Trust continues to experience high demand for inpatient services. A key objective of the inpatient's workstream within the Mental Health Integrated Programme is to improve patient flow, eradicate any identified unwarranted variation and effectively reduce occupancy rates.

- ***Delayed Transfer of Care (DTOC)***

  The Trust has significantly improved performance against the DTOC standards during 2018/19 reducing from over 8% to 5.3% in year; however due to wider system pressures achievement of the 3.5% target remains a risk. Local escalation processes are in place to ensure patient discharges are supported across the system. The Trust is also working with Greater Manchester Mental Health NHS Foundation Trust to develop a Greater Manchester approach to escalation. The establishment of the new bed management bureau is expected to support further improvements in DTOC performance during 2019/20.

- ***Staff Uptake of Flu Vaccination***

  Data submitted for this year's return indicated a significant improvement from last year performance however the final position remains slightly under the 75% target at 73.4%. Flu vaccination remains a national target for 2019/20.

- ***Early Intervention in Psychosis (EIP)***

  Overall EIP access rates have showed significant improvement throughout the year, improving from 36% in April 2018 to 81.3% in March 2019. However, as the target increases, in line with the Five Year Forward View, there remains a risk to

sustainability of the position along with the requirement to also deliver a full NICE-compliant treatment and maintain safe caseload levels. Discussions are taking place with commissioners to ensure services are commissioned to meet the full requirements. Work also continues with the Greater Manchester Strategic Clinical Network to review requirements and agree regional approaches aimed at ensuring sustainability including a peer review process.

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 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 all Trust properties and are currently in a installation programme for installing Smart electric meters in Trust properties. This provides 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 also identified and implemented a Lifecycle and Backlog programme of upgrading and or replacing uneconomical heating, ventilation and air conditioning systems in premises to improve the building efficiency.

Sustainability has become increasingly important as the impact of peoples lifestyles and business choices are changing the world in which we live. In order to fulfil our responsibilities for the role we play, Pennine Care has the following sustainability mission statement located in our sustainable development management plan (SDMP):

“We continue to acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our carbon footprint”.

The Trust has also received a certificate of excellence awarded on behalf of the Sustainable Development Unit, NHS Improvement and the Healthcare Financial Management Association (HFMA) for Excellence in Sustainability Reporting 2019.

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 a sustainable development management plan to ensure 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 Sustainable Development Assessment (SDAT) tool.

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 plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events.

Performance

The NHS has undergone and continues to undergo an ongoing significant restructuring process. Therefore in order to provide some organisational context, the following table explains how the organisation's performance on sustainability has changed over time.

Context info	2014/15	2015/16	2016/17	2017/18	2018/19
Floor Space (m2)	78677	79682	81704	79463	78348
Number of Staff	5952	5847	5730	5527	5656

Energy

Pennine Care has spent £1,487,914 on energy in 2018/19, which is a 16% decrease on energy spending from the previous year. However in the previous year we did tolerate an unusually cold and extended winter period. Also, 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.

The Trust has engaged the services of specialist energy consultants to help us manage and reduce our utility costs. This involves reviewing surface water banding areas for various sites as well as optimising our electrical supply capacity so that the correct charges are applied to billing and also supporting several successful HMR applications for VAT relief on utility bills serving premises with long stay in-patient hospitals services.

The Trust procures utility energy through a publicly tendered duel fuel (gas and electricity) NHS framework supply contract which is administered by an industry leading energy procurement management company.

The gas utility contract was renewed in April 2019. In the current political climate and whilst trying to consider future gas commodity requirements the Trust decided on a combination procurement strategy of 75% Fixed Price rate and 25% Flexible Price rate over the next four year supply period.

This procurement strategy was chosen as it offers the Trust price certainty with protection from gas price increases following the outcome of the Brexit negotiations and concerns over the possible adverse effect on the strength of the pound, as well as offering some flexible opportunity to benefit from any possible downside commodity gas price movement.

The electricity utility supply contract is due to expire in March 2020. The current electrical utility provider supplies us with a percentage of electricity generated from renewable fuel sources currently circa 19% (biomass, wind, hydro and solar power). This figure is improving every year to meet EU Directives and to align with national averages.

The Trust is currently reviewing the benefits of renewed publicly tendered and procured duel fuel supply contracts.

The government has now removed the associated 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 and electric car charging points at suitable premises across the Trust.

Resource		**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Gas	Use (kWh)	13,290,788	12,874,786	12,856,250	12,152,090	11,704,344
	tCO_2e	3,031.648	2,381.487	2,378.059	2,247.808	2,164.987
Oil	Use (kWh)	166,700	166,400	2,04346	266,587	241,116
	tCO_2e	44.9250	44.8446	55.0710	72.5444	64.8805
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	7,657,320	7,417,645	6,883,365	6,537,183	6,477,608
	tCO_2e	3,784.707	3,666.245	3402.171	3,231.068	3,167.024
Total Energy tCO_2e		6,288.069	6,496.178	5,835.301	5,551.420	5,396.891

Waste breakdown

Waste		2014/15	2015/16	2016/17	2017/18	2018/19
Recycling	(tonnes)	309	336	387	342	367.39
	tCO_2e	6.489	7.056	8.127	7.18	7.7
Re-use	(tonnes)	78	143	157	0	24
	tCO_2e	1.638	3.003	3.297	0	1.142
Compost	(tonnes)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
WEEE	(tonnes)	5.4	6	6.5	6.5	6.5
	tCO_2e	0.113	0.126	0.1365	0.1365	0.1365
High Temp recovery	(tonnes)	22.78	41.14	13.3	45.26	38.4
	tCO_2e	0.478	0.863	0.2793	0.9508	1.827
High Temp disposal	(tonnes)	0	0	0	0	6.12
	tCO_2e	0	0	0	0	0.1285
Non-burn disposal	(tonnes)	0	0	42.11	41.30	39.24
	tCO_2e	0	0	0.8843	0.8676	0.8243
Landfill	(tonnes)	40.6	23.8	17.0	10.59	10.26
	tCO_2e	9.9234	5.8171	0.357	0.2224	0.2155
Total Waste (tonnes)		456	549.94	618	439.62	492.31
% Recycled or Re-used		91.09	95.67	97.25	97.00	97.00
Total Waste tCO_2e		18.6421	16.8651	13.0811	9.6869	11.9738

We continue to improve the management of waste in all parts of the Trust, including providing suitable guidance and online training has been introduced to make staff more aware of the methods the Trust uses to segregate and recycle waste products in order to reduce the environmental impact through beneficial use, where practicable.

Water breakdown

Water		2014/15	2015/16	2016/17	2017/18	2018/19
Mains	m^3	68660	66510	57920	58795	58648
	tCO_2e	63	61	53	55	55
Water and Sewage Spend		£321,885	£265,073	£309,032	£340,250	£347,200

With the changes to the retail water and wastewater market, which came in to effect on 1 Apr 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 however the savings in the market place at the current time remain minimal.

As part of an on-going improvement programme of work the Trust has decided that all Capital Investment Projects will have water efficient toilet and washroom facilities installed. This includes economy flush toilets, improved water efficient urinal flushing controls and timed flow showers and sink taps. These have been installed for patient and visitor areas in hospital wards and healthcare clinics. This action reduces the organisation's water consumption and waste water usage thus reducing the carbon footprint CO^2 output.

Carbon Footprint

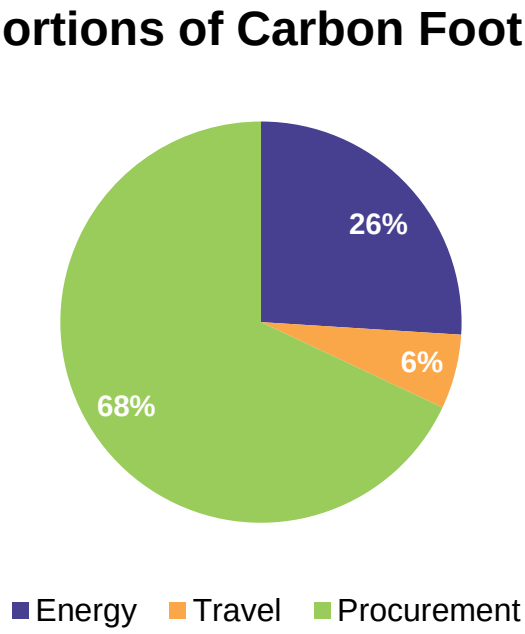
The information provided in the previous sections of this sustainability report uses the Environmental and Regulation Information Centre (ERIC) returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the information shown in the table below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

Pennine Care's exact annual carbon emission performance will be confirmed in the annual estates information return (ERIC).

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 dated properties and increased insulation levels to revised British Standards to reduce energy usage and utility costs.

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



Modern Slavery Act 2015

In accordance with the Modern Slavery Act 2015, we are committed to improving our practices to combat slavery and human trafficking. We are fully aware of our responsibilities we have towards patients, service users, employees and the local community. We have a robust set of ethical values that we use as guidance for our commercial activities. We also expect all suppliers to the Trust to adhere to the same ethical principles

A full Modern Slavery Act statement can be read on Pennine Care's website at https://www.penninecare.nhs.uk/media/1047167/slavery-and-human-trafficking-statement.pdf.

Financial performance and information

The key headlines of financial performance for the financial year ending 31 March 2019:

- The Trust is reporting a net surplus of £0.060m. The surplus includes the impact of impairments (i.e. changes in the valuation of the Trust's fixed assets) which amount to a loss of £1.442m. Adjusting for this as an exceptional item and also a cash donation for grounds maintenance capital works of £0.030m means that the normalised reported position is a surplus of £1.472m.

The following table summarises the actual financial performance for the period ending 31 March 2019.

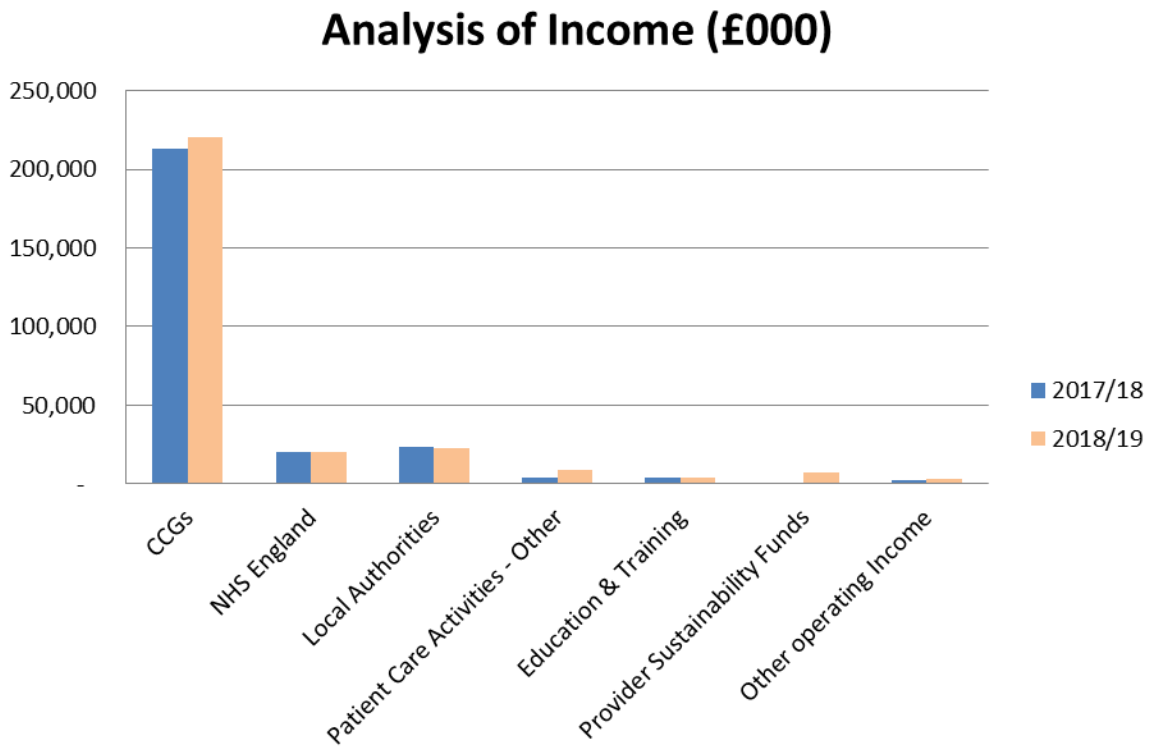
	£000
Income	285,837
Expenditure	(277,534)
Earnings before Interest, Tax, Depreciation and Amortisation	**8,303**
Non-operating costs (including depreciation, dividend and impairment)	(8,243)
Net surplus / (deficit)	**60**
Normalising adjustments:-	
Impairment Losses (Reversals) Net	1,442
Capital Donations	(30)
Normalised surplus per accounts	**1,472**

- The Trust delivered cost improvement savings of £6.7m, this represented 100% of the planned target and 2.4% of Trust operating expenditure.
- Capital Investment for the year totalled £10.581m and the Trust had a closing cash balance of £8.632m.

The Trust's finance and use of resources rating was a 2. Further details of this can be found in the Single Oversight Framework section (page 79)

Income

The following chart shows the split of the Trust's 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 £285.8m, (an increase of £18.4m from the previous year).

Of the total income received 95% (£271.7m) related to clinical income for the provision of patient care. The majority of this income (£240.4m) was received from NHS commissioners (CCGs and NHS England) for the provision of mental health (including specialist services) and physical community health services (including dental), with a further £22.5m received from local authorities for the provision of public health services such as health visiting.

During the year the Trust has secured additional mental health investment of £2.0m from CCGs targeted at the costs of safer staffing levels on mental health inpatient wards and £3.1m of transformation monies.

The reduction in 2018/19 income from local authorities relates primarily to the decommissioning of drug and alcohol services.

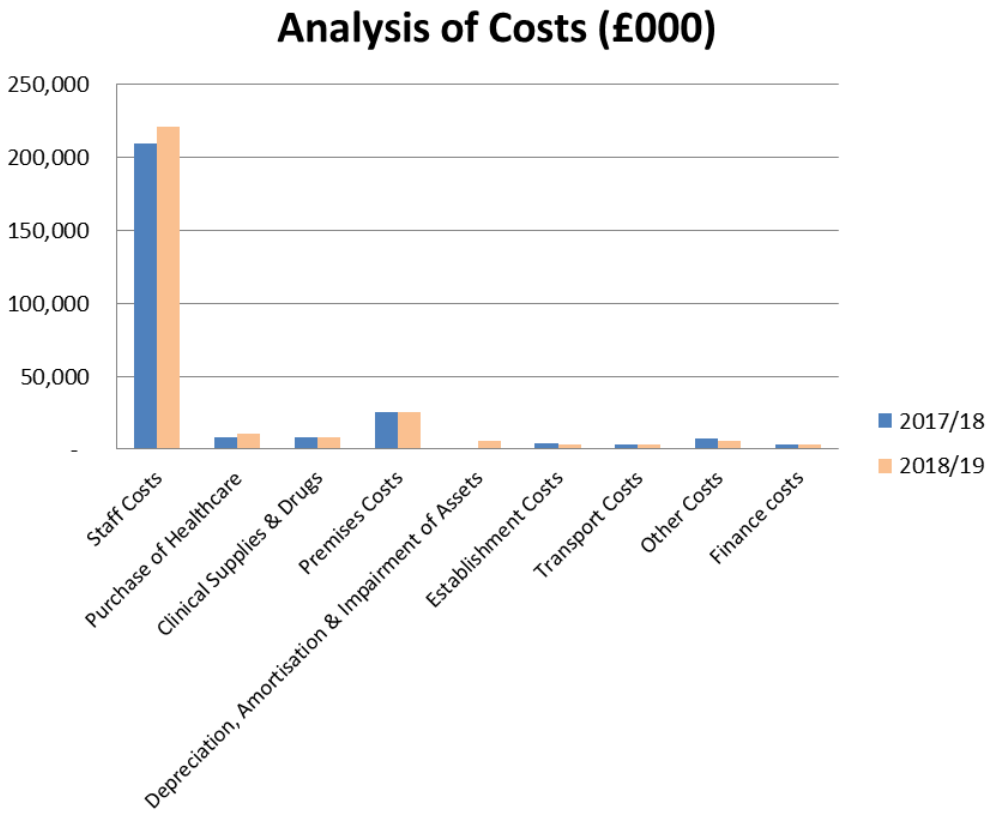
The Trust's financial performance for 2018/19 year has resulted in the receipt of £6.986m Provider Sustainability Funding; an increase of £6.5m compared to 2017/18.

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

The increase in expenditure for the year of £16.5m (6%) to £286.1m is lower than the additional income in the year of £18.4m (7%) to £286.1m.

The chart below sets out the major components of cost the Trust has incurred throughout the year and the 2017/18 costs for comparison.



The average number of staff employed by Pennine Care during 2018/19 was 5,398 whole time equivalent (WTE) (5,307 WTE staff in 2017/18). Expenditure on staff costs was the largest item of expenditure, totalling £221.4m (77%) of all costs. This compares to £208.0m (77%) in 2017/18.

Cost Improvement Plans (CIPs)

In line with the national guidance the Trust received an inflationary tariff uplift of 0.1% (£0.2m) in 2018/19 against NHS services commissioned by NHS commissioners.

The Trust set a cost improvement target of £6.7 million within its 2018/19 plan.

As a result of the dedication and hard work by staff, 100% (£6.7m) of the 2018/19 CIP was delivered.

Capital and Cash

During the year the Trust has completed £10.6m 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)	5,962
Estates - life cycle investment	311
Equipment	297
Estates scheme minor improvements/ resilience	2,075
Oldham Ward refurbishment (Parklands)	1,122
PICU design fees	84
Forest House ground floor conversion	730
Total	**10,581**

The planned capital expenditure for 2018/19 was £11.1m compared to the actual capital spend of £10.6m. Schemes not completed in 2018/19 have been reassessed and prioritised in 2019/20.

During 2018/19 the Trust was fortunate enough to receive a capital allocation of £1.7m from the Department of Health and Social Care to support digital transformation.

The liquidity of the Trust is a measure of 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 Trust's overall surplus position there has been a decrease in the cash balance of £8.8m during the year, giving a closing cash balance of £8.6 million. The decrease was due primarily to timing differences between income being received, including Provider Sustainability Funding of £5.7m which will be received in July 2019.

The average daily cash balance during 2017/18 was £23.4m and the closing cash balance of £8.6m which represents approximately 11 days of planned operating expenditure.

Better Payment Practice Code

The Trust continues to monitor its performance against the Better Payment Practice Code, which requires payment of all trade creditor invoices within 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 91.9% by value and 90.6% by volume, which is a reduction on 2017/18 (95.3% by value, 96.0% volume). This drop in performance is expected to be temporary and is a result of new accounting systems being implemented from 1st February 2019.

	2018/19 number	2018/19 £000	2017/18 number	2017/18 £000
Non-NHS				
Total invoices paid in the year	61,052	100,067	54,077	101,501
Total invoices paid within the target	55,396	92,970	52,137	98,285
Percentage of invoices paid within the target	90.7%	92.9%	96.4%	96.8%
NHS				
Total invoices paid in the year	1,871	30,653	1,351	24,826
Total invoices paid within the target	1,612	27,181	1,077	22,134
Percentage of invoices paid within the target	86.2%	88.7%	79.7%	89.2%
Total				
Total invoices paid in the year	62,923	130,720	55,428	126,327
Total invoices paid within the target	57,008	120,151	53,214	120,419
Percentage of invoices paid within the target	90.6%	91.9%	96.0%	95.3%

Finance and Use of Resources

The assessment of the Trust's financial performance by NHS Improvement is based on the Single Oversight Framework (SOF). Within this there are five key financial performance measure known as the Use of Resources ratings. 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 Trust's 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 trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year.
- Agency spend - measures agency spend for the Trust against the NHSI target value (£7.6m) in 2018/19.

The table below details the financial performance by the Trust against the plan submitted to for 2018/19. The actual performance in 2018/19 was an improvement from a plan deficit position to a small surplus. The overall Use of Resources score for the Trust for the financial year 2018/19 is a score of 2.

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

The improvements against the capital service capacity metric, liquidity metric and I&E margin rating are as a direct result of the improved financial performance against plan, moving from a deficit position to a surplus position in the accounts.

The deterioration in the agency metric reflects the increased spend on agency of £10.9m in 2018/19 compared to £9.1m in 2017/18. This increased spend is as a result of increased patient acuity on mental health wards and high levels of vacancies and sickness.

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
- Statement of compliance with the NHS Foundation Trust Code of Governance
- NHS Improvement's Single Oversight Framework
- Statement of Accounting Officer responsibilities
- Statement as to disclosure to the auditors
- Council of Governors and Foundation Trust membership
- Annual Governance Statement

Claire Molloy
Chief Executive
24 May 2019

Directors' 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 the principals enshrined in the NHS 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 from page 11.

The Board of Directors

The Trust is led by a unitary Board of Directors comprising eight independent Non-Executive Directors (including the Chair) and seven Executive Directors (including the Chief Executive). Board members each contribute to the collective skill set and wide ranging experience of the Board, gained from a variety of professions and industry. More detailed information on the individuals who make up the Board of Directors can be found from page 46.

All members of the Board have the same general legal responsibilities to the Trust and have a collective responsibility to act with a view to promoting the success of the organisation to maximise the benefits for the members of the Trust and for the public.

As at 31 March 2019, membership of the Board of Directors was as follows:

Evelyn Asante-Mensah OBE	Chair
Daniel Benjamin	Non-Executive Director
Joan Beresford	Non-Executive Director / Deputy Chair
Professor Sandra Jowett	Non-Executive Director / Senior Independent Director
Catherine Laverty	Non-Executive Director
Michael Livingstone	Non-Executive Director
Dr Julia Sutton-McGough	Non-Executive Director

John Scampion	Non-Executive Director
Claire Molloy	Chief Executive
Judith Crosby	Executive Director of Service Development and Delivery
Nicola Littler	Executive Director of Workforce
Clare Parker	Executive Director of Nursing, Healthcare Professionals and Quality Governance
Suzanne Robinson	Executive Director of Finance
Dr Henry Ticehurst	Medical Director / Acting Chief Executive
Keith Walker	Executive Director of Operations

There have been several changes to the Board of Directors during 2018/19.

- Clare Parker commenced in post as Executive Director of Nursing, Healthcare Professionals and Quality Governance on 21 May 2018 (following a thorough recruitment process that took place during 2017/18). At this time, Jackie Stewart concluded her appointment as Interim Executive Director of Nursing and Healthcare Professionals (which she had held since September 2017) and returned to her substantive role as Managing Director (Mental Health and Specialist Services).
- Sally Baines joined the Trust as Interim Director of Workforce (non-voting) from 12 June 2018 until 13 December 2018. During this time, a process was undertaken to appoint substantively to a voting Executive Director of Workforce. Nicola Littler commenced in this role on 3 December 2018.
- Martin Roe retired from the post of Executive Director of Finance / Deputy Chief Executive on 7 November 2018. Emma Tilston was appointed as Interim Executive Director of Finance from 8 November 2018 until 27 January 2019 whilst the process of appointing substantively to the role was concluded.
- Suzanne Robinson commented in post as Executive Director of Finance on 28 January 2019.
- Henry Ticehurst was appointed as Acting Deputy Chief Executive from 8 November 2018.
- Keith Bradley concluded his term of office as Non-Executive Director on 31 August 2018.
- Catherine Laverty was appointed as a Non-Executive Director for a three year term of office from 28 November 2018.

The work of the Board's Appointment and Remuneration contains further information regarding the appointments of Executive Directors. Information regarding the appointment, re-appointment or removal of Non-Executive Director roles can be found within the Council of Governors section of this report.

All of 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; and none of the current Non-Executive Directors have served terms of office greater than six years.

All of the directors on the Board meet the 'fit and proper' persons test as described in the provider licence; and declare any potential conflicts of interest as part of the Trust's robust Declaration of Interests process. The Trust maintains a register of interests for all directors, which is published on the Trust's website.

Attendance (actual/ eligible) at Board of Directors meetings and statutory committees
1 April 2018 to 31 March 2019

Board member	Board of Directors	Audit Committee	Appointment and Remuneration Committee	Term of appointment
Non-Executive Directors				
Evelyn-Asante Mensah	11/11		6/7	1 November 2017 – 31 October 2020
Joan Beresford	11/11		7/7	1 November 2017 – 31 October 2020 (second term of office)
Sandra Jowett	11/11	4/4	7/7	1 November 2017 – 31 October 2020 (second term of office)
Daniel Benjamin	10/11	3/4	6/7	4 September 2017 – 3 September 2020
Michael Livingstone	6/11		1/7	21 September 2018 – 20 September 2021 (second term of office)
Julia Sutton-McGough	10/11		5/7	1 September 2017 – 31 August 2020
John Scampion	11/11	4/4	4/7	19 February 2018 – 18 February 2021
Catherine Laverty	5/5	2/2	1/1	28 November 2018 – 27 November 2021
Keith Bradley	3/4	1/1	2/3	1 September 2015 – 31 August 2018

Board member	Board of Directors	Audit Committee	Appointment and Remuneration Committee	Term of appointment
Executive Directors				
Claire Molloy	8/11			
Henry Ticehurst	10/11			
Keith Walker	10/11			
Judith Crosby	8/11			
Clare Parker	9/10			
Nicola Littler	4/4			
Suzanne Robinson	3/3			
Martin Roe	5/6			
Jackie Stewart	2/2			
Emma Tilston	2/2			
Sally Baines	4/5			

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 Council of Governors is 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.

Formal Committees of the Board

As at 31 March 2019, the Board committee structure comprises of six formal 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 committees is described below.

Audit Committee

Audit Committee is a statutory committee of the Board, and the Code of Governance requires the committee membership to comprise independent Non-Executive Directors. The Audit Committee supports the Board by critically reviewing and reporting on the relevance and robustness of governance structures, assurance process, and systems of internal control on which the Board places reliance. In particular, the Committee is responsible for:

- Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that support the achievement of the Trust's objectives. The Annual Governance Statement provides further information regarding the effectiveness of the system of internal control.
- Ensuring the establishment of an effective internal audit function in line with mandatory Public Sector Internal Audit Standards, which provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. In 2018/19, the Trust changed internal audit provider from KPMG to Mersey Internal Audit Agency (MIAA). The Audit Committee agreed an internal audit plan aimed at providing assurances on the effectiveness of governance, risk and controls across key systems that support the delivery of the Trust's objectives and functions of the organisation. Audit Committee seeks assurance regarding the delivery of the internal audit plan, the results of audit reviews.
- Reviewing the work, findings and opinions of the external auditor, and assuring itself of the independence of the external auditor and monitoring any non-audit work that the external auditors are asked to perform. Grant Thornton was appointed by the Council of Governors as the Trust's external auditor for a three-year term in 2015, following a procurement exercise. The contract was extended for a further two years in 2018, up to 31 May 2020. The Audit Committee continually assesses the effectiveness of external audit through regular reports regarding delivery against agreed audit plans.
- Testing assurance processes and reviewing the findings of other significant internal and external assurance functions and their implications for the governance of the Trust.

The Audit Committee produces an annual report that outlines its programme of work undertaken during the year, which is formally presented to the Board of Directors. The Committee also reviews its terms of reference on an annual basis, and self-assesses its effectiveness in line with best practice using the process set down in the HFMA NHS Audit Committee handbook (fourth edition).

Audit Committee membership as at 31 March 2019:

- John Scampion (Chair)
- Professor Sandra Jowett
- Daniel Benjamin
- Catherine Laverty

Appointment and Remuneration Committee

Chaired by the Trust Chair, 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.

In April 2018, the Committee approved the process for substantively recruiting into the posts of Executive Director of Finance (to replace the incumbent post holder when they retired in November 2018) and Executive Director of Workforce (new voting Executive Director post). The Committee approved the appointment of Odgers Berndtson as the executive search agency to manage the recruitment process.

Recruitment to both roles was subject to a rigorous assessment and interview process; comprising of a stakeholder panel that included Board members, staff, service users, carers, governors, and commissioners; which was then followed by a formal interview panel consisting of the Chair, Chief Executive, Non-Executive Directors and an independent external assessor:

Post	**Assessment / interview date**	**Appointment and Remuneration Committee**
Executive Director of Workforce	28 August 2018	Approves the appointment of Nicola Littler
Executive Director of Finance	5 September 2018	Approves the appointment of Suzanne Robinson

In November 2018 Martin Roe retired from the Trust, vacating the post of Executive Director of Finance / Deputy Chief Executive. On 6 November 2018, the Committee approved the appointment of Emma Tilston as acting Executive Director of Finance effective from 8 November 2018 until Suzanne Robinson commenced in post on 28 January 2019; and Dr Henry Ticehurst as Acting Deputy Chief Executive from 8 November 2018 until 31 March 2019. The Committee met on 27 March 2019 to agree an extension Dr Ticehurst's tenure as Acting Deputy Chief Executive until 31 May 2019.

Quality Committee

Chaired by a Non-Executive Director, the Quality Committee meets on a monthly basis to seek assurance that effective and appropriate systems are in place to drive quality improvements; and that the Trust is delivering high quality care.

Quality Committee membership as at 31 March 2019:

- Dr Julia Sutton-McGough (chair)
- Mike Livingstone
- Joan Beresford
- Catherine Laverty
- Clare Parker
- Dr Henry Ticehurst

Performance and Finance Committee

Chaired by a Non-Executive Director, the Performance and Finance Committee meets on a monthly basis to oversee the performance of the Trust and to seek assurance in respect of Finance, Investment and Performance.

Performance and Finance Committee membership as at 31 March 2019:

- Daniel Benjamin (chair)
- Professor Sandra Jowett
- John Scampion
- Joan Beresford
- Keith Walker
- Suzanne Robinson
- Judith Crosby

People and Workforce Committee

Chaired by a Non-Executive Director, t

The People and Workforce Committee meets on a bi-monthly basis to seek assurance in relation to the development, implementation and effectiveness of the People and Workforce Strategy.

People and Workforce Committee membership as at 31 March 2019:

- Professor Sandra Jowett (chair)
- Michael Livingstone
- Dr Julia Sutton-McGough

- Nicola Littler
- Keith Walker
- Judith Crosby

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 and is chaired by the Trust's Chair.

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 Trust Chair. Non-Executive Directors are appraised annually by the Chair 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.

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. Further information regarding the Well-led review can be found in the Annual Governance Statement on page 97. 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. The Board has received regular updates on progress with the delivery of the actions throughout the year and has undertaken various pieces of work to continually review its effectiveness including externally facilitated away days, independent audit of the revised governance structures and self-assessments of each of the new committees.

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. Details of how this is undertaken are reported in the Council of Governors section of this report (page 83).

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. All Non-Executive

Directors attend the Chair, NED and Governor Committee, during which governors have the opportunity to understand the views of governors and members, and seek assurance the Board is addressing all matters relating to the delivery of objectives, quality and safety, workforce, finance, and operational delivery. Moreover, Non-Executive Directors attend full Council of Governors meetings and governor-led local constituency meetings. The Chief Executive (or her representative) attends each meeting of the Council of Governors to deliver an organisational update and to invite the views of members. During 2018/19 arrangements have been in place for governor representatives to observe monthly meetings of the Board of Directors.

Board Directors' Profiles

EVELYN ASANTE-MENSAH OBE commenced in post as Chair of the Trust in November 2017, 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.

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 eighteen 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 was appointed Senior Independent Director from 1 January 2017.

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 Greater Manchester 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. 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.

JOHN SCAMPION was appointed as a Non-Executive Director in February 2018. Qualifying as a chartered accountant in 1981, he joined the NHS in 1983, holding 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 also chair of Manchester Mental Health and Social Care Trust until it merged with Greater Manchester West in 2015. John chairs the Trust's Audit Committee, which oversees the system of governance for the organisation.

CATHERINE LAVERTY was appointed as Non-Executive Director in November 2018. Cath has a strong background in mental health nursing; beginning her career on hospital wards before moving into a community-based role. She later provided mental health support to homeless people across the city of Manchester.

In addition to her clinical expertise, Cath also has significant senior management and board-level experience. She worked as a locality director in south Manchester, before managing hospital services across Manchester. She has held board-level roles in primary care commissioning and provider organisations and was the nurse board member and mental health lead for North Manchester Primary Care Trust from 2000 to 2004.

LORD KEITH BRADLEY served a Non-Executive Director from September 2015 until August 2018. 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 Council in 2001 and ennobled in 2006.

CLAIRE MOLLOY commenced as Chief Executive in September 2017. Claire has over 20 years' experience in the NHS; and was Chief Executive at Cumbria Partnership NHS Foundation Trust for four years before joining Pennine Care. Prior to this she was Managing Director at Heart of England NHS Foundation Trust; and has worked within primary, community, and acute settings. Claire has extensive experience of building strong relationships with partners in order to improve patient care and is passionate about staff engagement to build a strong and motivated workforce.

DR HENRY TICEHURST, was appointed as the Medical Director from 1 June 2010; having previously served as Lead Consultant in Bury, and as a Consultant Psychiatrist in a number of our localities. Since November 2018, Henry's portfolio was extended to incorporate Acting Deputy Chief Executive.

KEITH WALKER was appointed as Director of Operations in August 2014. The role was conferred Executive Director status from 1 December 2014. 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. Keith is a qualified mental health nurse and has worked in the NHS for over 20 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 has been Executive Director of Service Development and Delivery since 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 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.

CLARE PARKER is the Trust's Executive Director of Nursing, Healthcare Professionals and Quality Governance. She joined the Trust in May 2018. Clare is a learning disability nurse by background. She spent most of her early career working within learning disability and mental health services, specifically with people who have challenging behaviour, complex and forensic needs. She gained her Masters in Management from Manchester University and then moved into management, quality and nursing roles. Clare has worked for provider organisations, commissioning organisations and a local authority. Clare's previous role was Executive Director of Quality and Nursing for Cumbria Partnership NHS Trust which is a mental health, learning disability and community trust.

NICOLA LITTLER was appointed as Executive Director of Workforce from December 2018. Nicky has 16 years' experience working within mental health NHS services in a senior

human resources role. She started her career at Tameside Council, before joining our Trust for the first time in 2002.

Nicky held the role of deputy director of human resources and operational development in a large mental health trust from 2008 and became Associate Director of Human Resources in 2015 holding this role until the end of November 2018.

SUZANNE ROBINSON was appointed as Executive Director of Finance from January 2019. Suzanne has over 17 years' experience working at a senior level at a number of large acute and specialist providers as well as commissioning organisations in the North West of England. She has a passion for finance skills development and improving the visibility and understanding of finance across the NHS, leading many of her teams to succeed in national finance awards. In 2018 she became senior responsible officer for the Future Focused Finance Valuemakers programme which represents over 600 finance staff across the country.

Suzanne also serves as chair of the healthcare financial management association (HFMA) Mental Health Finance Faculty, which supports and represents the interests of finance professionals in organisations delivering mental health and learning disability services providing an opportunity to promote the mental health agenda working on solution for common issues.

EMMA TILSTON held the position of Acting Executive Director of Finance from November 2018 until January 2019 whilst the process was underway to appoint a substantive Executive Director of Finance. 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.

MARTIN ROE was the Executive Director of Finance / Deputy Chief Executive until he retired in November 2018. Martin had been a financial director for over 20 years, working in a range of NHS organisations; and had served as Director of Finance at Pennine Care since it was formed in 2002.

JACKIE STEWART was the Interim Executive Director of Nursing and Healthcare Professionals from September 2017 until May 2018 whilst the process to recruit substantively to the post of Executive Director of Nursing, Healthcare Professionals and Quality Governance took place. Jackie's substantive role is Managing Director in the Mental Health and Specialist Service Group.

Remuneration Report

Annual Statement 2018/19

There have been no major decisions or changes to senior managers' remuneration during 2018/19.

For the period April 2018 to March 2019 the employees involved have received a 3% 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 42.

Details of senior managers' remuneration are provided on page 52.

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 £150,000, periodic reviews are undertaken in order to satisfy that the remuneration is reasonable.

For remuneration in relation to Non-Executive Directors see page 52. The fees of Non-Executive Directors are set by the 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 37 for details of the membership and purpose of the Appointment and Remuneration Committee.

Section A: Total remuneration 2018/19 and 2017/18

Name	Title	2018/19 Salary and fees (in bands of £5k) £000s (Band of £5k)	2018/19 All taxable benefits (total to the nearest £100) £s (nearest £100)	2018/19 Annual performance-related bonuses (in bands of £5k) £000s (Band of £5k)	2018/19 Long-term performance-related bonuses (in bands of £5k) £000s (Band of £5k)	2018/19 All pension-related benefits (in bands of £2.5k)* £000s (Band of £2.5k)	2018/19 Total (bands of £5k) £000s (Band of £5k)	2017/18 Salary and fees (in bands of £5k) £000s (Band of £5k)	2017/18 All taxable benefits (total to the nearest £100) £s (nearest £100)	2017/18 Annual performance-related bonuses (in bands of £5k) £000s (Band of £5k)	2017/18 Long-term performance-related bonuses (in bands of £5k) £000s (Band of £5k)	2017/18 All pension-related benefits (in bands of £2.5k)** £000s (Band of £2.5k)	2017/18 Total (bands of £5k) £000s (Band of £5k)
Executive Directors													
Ms C Molloy	Chief Executive	160 - 165	-	-	-	32.5 - 35.0	195 - 200	95 - 100	-	-	-	47.5 - 50.0	145 - 150
Mr M Roe	Deputy Chief Executive / Executive Director of Finance (until 7 November 18)	80 - 85	-	-	-	-	80 - 85	155 - 160	-	-	-	150.0 - 152.5	305 - 310
Ms E Tilston	Acting Executive Director of Finance (from 7 November 18 to 27 January 19)	20 - 25	-	-	-	-	20 - 25	50 - 55	-	-	-	162.5 - 165.0	215 - 220
Ms S Robinson	Executive Director of Finance (from 28 January 2019)	20 - 25	-	-	-	-	20 - 25	-	-	-	-	-	-
Dr H Ticehurst	Executive Medical Director	170 - 175	-	-	-	97.5 - 100.0	270 - 275	165 - 170	-	-	-	-	165 - 170
Ms J Stewart	Executive Director of Nursing and Healthcare Professionals (from 28 September 17 to 1 June 18)	20 - 25	-	-	-	-	20 - 25	65 - 70	-	-	-	282.5 - 285.0	345 - 350
Mr I Trodden	Executive Director of Nursing and Healthcare Professionals (until 28 September 17)	-	-	-	-	-	-	60 - 65	-	-	-	20.0 - 22.5	85 - 90
Ms C Parker	Executive Director of Nursing, Healthcare Professionals & Quality Governance (from 21 May 18)	115 - 120	-	-	-	-	115 - 120	-	-	-	-	-	-
Ms J Crosby	Executive Director of Service Development and Delivery	130 - 135	-	-	-	-	130 - 135	130 - 135	-	-	-	-	130 - 135
Ms N Littler	Executive Director of Workforce (from 3 December 18)	35 - 40	-	-	-	-	35 - 40	-	-	-	-	-	-
Mr K Walker	Executive Director of Operations	130 - 135	-	-	-	-	130 - 135	130 - 135	-	-	-	10.0 - 12.5	140 - 145
Chair													
Ms E Asante-Mensah	Chair	45 - 50	-	-	-	-	45 - 50	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	15 - 20	-	-	-	-	15 - 20	0 - 5	-	-	-	-	0 - 5
Mr D Benjamin	Non-Executive Director	15 - 20	-	-	-	-	15 - 20	5 - 10	-	-	-	-	5 - 10
Dr J Sutton-McGough	Non-Executive Director	15 - 20	-	-	-	-	15 - 20	5 - 10	-	-	-	-	5 - 10
Mr M Livingstone	Non-Executive Director	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Lord K Bradley	Non-Executive Director (until 31 August 18)	5 - 10	-	-	-	-	5 - 10	15 - 20	-	-	-	-	15 - 20
Ms J Beresford	Non-Executive Director	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Dr S Jowett	Non-Executive Director	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Ms C Laverty	Non-Executive Director (from 28 November 18)	5 - 10	-	-	-	-	5 - 10	-	-	-	-	-	-
Mr I Bevan	Non-Executive Director (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

* For new executive directors during 2018/19 no pension-related benefit figures have been shown. This is due to the Trust not holding the previous employment pension
** The 2017/18 all pension-related benefit figures have been restated in line with the 'HMRC method' as directed by the DHSC Group Accounting Manual.

Section B: Total pension entitlement 2018/19

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 Mar 2019 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 Mar 2019 (bands of £5,000) £000	Cash Equivalent Transfer value at 1 Apr 2018* £000	Real increase in Cash Equivalent Transfer Value* £000	Cash Equivalent Transfer Value at 31 Mar 2019 £000	Employer's contribution to stakeholder pension £000
Claire Molloy Chief Executive	0 - 2.5	5.0 – 7.5	50 - 55	155 - 160	1,001	156	1,182	0
Martin Roe Deputy Chief Executive / Executive Director of Finance (until 07 Nov 18)	0	0	0	0	1,741	0	0	0
Henry Ticehurst Executive Medical Director	5.0 - 7.5	15.0 - 17.5	60 - 65	190 - 195	1,129	244	1,401	0
Jacqueline Stewart Executive Director of Nursing (until 01 Jun 18)	0	0	50 - 55	160 -165	1,077	87	1,191	0
Judith Crosby Executive Director of Service Development and Delivery	0 - 2.5	0 - 2.5	50 - 55	150 - 155	1,041	114	1,181	0
Keith Walker Executive Director of Operations	0	0	30 - 35	60 - 65	430	46	487	0
Emma Tilston Acting Executive Director of Finance (from 07 Nov 18 to 27 Jan 19)	0	0	35 - 40	80 - 85	555	51	619	0
Clare Parker Executive Director of Nursing, Healthcare Professionals & Quality Governance (from 21 May 18)	0	0	55 - 60	0	0	0	713	0
Nicola Litter Executive Director of Workforce (from 03 Dec 18)	0	0	25 - 30	55 - 60	0	0	421	0
Suzanne Robinson Executive Director of Finance (from 28 Jan 19)	0	0	25 - 30	65 - 70	0	0	449	0

* For new executive directors during 2018/19 no opening cash equivalent transfer value or real increase in pensions figures have been shown. This is due to the Trust not holding the previous employment pension information required to calculate these figures.

Section C: Pay Multiples 2018/19

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 2018/19 was £175,000 (2017/18: £175,000). These figures are based on an annualised salary.

This was 6.24 times (2017/18: 7.61) the median remuneration of the workforce, which was £28,050 (2017/18: £22,997).

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 2018-19	**Number in post**	**Number claiming expenses**	**Total expenses claimed £'00**
Governors	33	12	19
Executive and Non-Executive Directors	19	12	95
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

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
24 May 2019

Staff report

We have a diverse workforce and employ 6590 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 935 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 split of male and female employees.

Category	Female	Male	Total
Employee	4,700	908	5,608
Senior Manager	21	11	32
Trust Board	10	5	15
Total	**4,731**	**924**	**5,655**

Notes

The figures in the table above are a snapshot as at 31 Mar 2019 and are headcount, so a staff member with more than one assignment would only be counted once. The figures referenced exclude bank staff. The Trust Board category includes CEO, Executive and Non-Executive Directors and the Senior Manager category includes anyone reporting directly to a Director.

Analysis of staff costs

Staff costs

	Permanent	Other	2018/19 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	141,186	32,787	**173,973**	165,039
Social security costs	12,531	1,911	**14,442**	13,826
Apprenticeship levy	832	24	**856**	808
Employer's contributions to NHS pensions	18,768	2,376	**21,144**	20,388
Pension cost - other	38	-	**38**	-
Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	10,898	**10,898**	9,089
Total gross staff costs	**173,355**	**47,996**	**221,351**	**209,150**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**173,355**	**47,996**	**221,351**	**209,150**
Of which				
Costs capitalised as part of assets	2,101	-	**2,101**	1,106

The above table has been subject to audit.

Average number of employees (WTE basis)

	Permanent	Other	2018/19 Total	2017/18 Total
	Number	Number	Number	Number
Medical and dental	48	110	**158**	221
Ambulance staff	-	-	**-**	-
Administration and estates	1,073	235	**1,308**	1,271
Healthcare assistants and other support staff	958	343	**1,301**	1,243
Nursing, midwifery and health visiting staff	1,512	207	**1,719**	1,692
Nursing, midwifery and health visiting learners	-	10	**10**	9
Scientific, therapeutic and technical staff	733	160	**893**	862
Healthcare science staff	1	-	**1**	-
Social care staff	-	-	**-**	1
Other	1	7	**8**	8
Total average numbers	**4,326**	**1,072**	**5,398**	**5,307**
Of which:				
Number of employees (WTE) engaged on capital projects	53	-	**53**	-

The above table has been subject to audit.

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 2018/19 was 5.47% which is a slight increase to the 2017/18 rate (5.24%).

Occupational Health Service and Staff Wellbeing Services:

The Trust has a contract with an external occupational health provider, as well as offering the internal Staff Wellbeing Service.

The Staff Wellbeing Service is a highly confidential provision that continues to be evaluated as excellent in feedback by staff. The service offers psychological help with mild to moderate difficulties, and is accessed through direct or manager referral. The team receive between 40 and 50 individual referrals per month, as well as supporting 20-40 people per month in groups, and there is scope to flex provision to meet changing demands.

Group and individual sessions are provided at flexible times across the Trust footprint and provide help with a wide range of difficulties commonly including anxiety, depression, bereavement and following trauma; as well as mixed presentations such as stress alongside chronic pain. Interventions include counselling, Cognitive Behavioural Therapy, support from a Psychological Wellbeing Practitioner and mindfulness training with yoga. This year the team will also begin to offer Eye Movement Desensitisation Reprocessing (EMDR) as a further resource for staff following trauma.

Sickness Absence data

	2018/19	2017/18
Total days lost	57,053	55,349
Total staff years	4,850	4,752
Average working days lost (per WTE)	11.8	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 to provide a supportive return to work; this can include making reasonable adjustments for staff that return from long term sick leave, or where an employee may have developed a disability to remain in work. 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.

Staff Policies and Actions Applied During the Financial Year:

Equality, diversity and inclusion (EDI)

The Legislative Framework underpinned by Equality Act 2010, Human Rights – the Mental Health Act Code of Practice, the Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES), Gender Pay Gap (GPG), and the Accessible Information Standard (AIS), has expanded and mandates the Trust in addressing Equality and Diversity in each of these areas.

To ensure fair and equal treatment of staff, the employment function is monitored via a variety of equality and quality assessment frameworks (clinical and non-clinical) including information from the National NHS Staff Survey and Workforce Race Equality Standards (WRES).

Our governance framework aims to ensure that the Board receives regular assurance regarding compliance with the Public Sector Equality Duty. The Executive Director of Workforce provides Board level leadership for equality and diversity with the Equality and Diversity team managed within the Workforce Directorate.

An equality, diversity and inclusion group has been established to support the development and delivery of the Trust's Equality, Diversity and Inclusion agenda. The current EDI governance process is under review with an aim to create direct line of accountabilities by mainstreaming governance reporting.

Our Equality and Diversity governance structure consists of the Equality and Diversity Working group, reporting into the Equality Diversity and Inclusion Steering Group. The steering group reports in turn to the People and Workforce Committee. This structure ensures that risks are identified, action plans monitored, data analysed and issues addressed at all levels of organisation.

Equalities in Employment policy was refreshed in July 2018 setting out the roles, responsibilities and processes for recruitment, promotion, learning and employment. The Trust will ensure that all required data is captured to inform our Equality and Diversity activities for employment and service delivery. In addition, the Trust carries out on-going assessments using the Equality Delivery System and other equality frameworks.

We publish an annual equality report, the latest version of which is available for the public to view online at https://www.penninecare.nhs.uk/media/497848/annual-equality-diversity-and-inclusion-publication-2018-19-v2.pdf.

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

An Accessible Information Standard Working Group has been established with an aim to provide leadership for the development and implementation of action plans. The group is chaired by the Managing Director of HMR with representation from Clinical Change Lead, Data Flow Mapping Lead, Speech and Language Therapist, Learning Disability Services, Equality and Diversity Team and Records Manager. An AIS policy (supporting communication needs of the service users) was developed in September 2017 and refreshed in 2018 and is available for all staff on our intranet page.

To assess how the standard is being applied, a baseline audit in community services was undertaken and a specific action plan to support our findings is being produced. Aspects around compliance with the standard are part of the on-going Information Culture Project group and will cross reference the requirements of the AIS Charter, signed by the local NHS trusts to ascertain how we can work together to ensure a consistent approach.

Whilst there are pockets of good practice in recruitment, selection and retention, further work to address the findings of Workforce Race Equality Standard information is being undertaken. Our baseline data from the WRES shows lower representation of black and minority ethnic (BAME) staff in Band 8-9 compared to the rest of the workforce. Findings and recommendations from the 2018/19 WRES have been presented to the Board, from which an action plan has been developed, which will be monitored through the Equality, Diversity and Inclusion Group and the People and Workforce Steering Group. The Trust WRES report (2018-19) is available on our website (www.penninecare.nhs.uk/media/497338/wres-analysis-report-2018.pdf). 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. 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.

The Trust continues to review its policies and procedures by undertaking Equality Analysis prior to the policies being ratified.

Pennine Care was accredited with the Disability Confident Employer Status for a second year in 2018. The Disability Confident Employer Scheme replaced the Disability Two Ticks scheme and is designed to help organisations show that they are disability friendly employers. This goes on to support the recruitment and retaining of disabled people and people with health conditions for their skills and talent. In 2019 the Equality, Diversity and Inclusion Team will be working to continue to raise awareness of the scheme and to meet

level 3. 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.

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.

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

Anti-fraud, bribery and corruption

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption. An Anti-Fraud, Bribery and Corruption Policy is available on the intranet for staff. This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud, corruption or bribery. It provides a framework for responding to suspicions of fraud, bribery and corruption, advice and information on various aspects of fraud, bribery and corruption and implications of an investigation. Work has also continued to raise the profile of the Local Anti-Fraud Specialist through a range of initiatives. This has helped to create an anti-fraud culture, which has enabled deterrence and prevention measures to be embedded in the organisation.

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).

Freedom to Speak Up (FTSU) Guardian

Our fulltime Freedom to Speak Up Guardian is independent and impartial. All staff can speak to this person in confidence. The FTSU Guardian works alongside the senior leadership team to ensure concerns are addressed promptly and effectively.

Quarterly reports to Board identify themes from the issues staff are speaking up about and provide assurances that staff are feedback to appropriately.

Concerns that staff have spoken up about include: patient safety, staff safety, failure to follow correct process, understaffing, wrongdoing, sexual harassment, biased recruitment, nepotism and bullying.

Time period	Numbers of staff speaking up to the FTSU Guardian
April 2018 – March 2019	69

Policy

The Freedom to Speak Up (FTSU) policy was reviewed. Staff who had spoken up in the past contributed to its development. The policy encourages staff to speak up to their line manager if they can, but it recognises that this is not always possible and so where staff do not feel able to speak up to their line manager or they have already tried to speak up to their line manager and they have not had a satisfactory response, they are asked to go to the Freedom to Speak Up Guardian.

Communicating the message

The FTSU Communication plan aims to ensure that the FTSU message is communicated widely to all staff groups.

Triangulating information

FTSU information is used together with other data relating to patient safety, complaints and friends and family test. This supports the identification of areas in need of support and improvement and helps to share lessons learnt across the trust.

Speak Up Ambassadors

Plans are in place to appoint five Speak Up Ambassadors in June 2019 who will have one day a week to promote a culture of openness, honesty, transparency and learning, where staff are supported to speak up.

Staff from groups with additional barriers to speaking up, such as LGBTQ and BAME groups will be particularly encouraged and supported to apply.

Freedom to speak up is one element of a wider strategic approach to positive cultural transformation and improvement. We aim to create an environment where all staff feel confident in speaking up because they know they will be valued for doing so and listened to.

Engaging with employees

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 individuals 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.

There are 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' Team 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 priorities.

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.

Involving employees in the Trust's performance

Staff across the Trust were invited to support a Culture audit to inform the development of the Trust Organisation Development Improvement Plan. A number of engagement events took place and data was gathered against the NHS Improvement Leadership and Culture Framework. Two "Big Culture Conversation" events were held for staff to suggest ideas that could improve the culture of the Trust and its performance. A Culture Steering Group was developed to provide oversight and direction and a number of changes have been implemented shown in the staff survey section of this report.

The development of the use of Tableau to provide information in an accessible and consistent way and the provision of training to managers about "Data Matters" has increased the visibility of Trust performance information both Trust wide and with individual teams. Managers are able to access their own team performance data and use within team meetings.

A new Team Brief has been introduced which provides highlights of Trust performance for all staff to hear. It is designed to be used by team managers within meetings and is also available through the Trust intranet pages.

Health and Safety Performance and Occupational Health

The staff survey measures a number of questions relating to a safe environment for staff. Staff rated us as 9.6 out of 10. The best performing trust in our benchmark group is 9.7 and the worst 9.2.

We have a specialist team who provide advice and training and support the development of best practice and policy for the Management and Prevention of Violence and Aggression and Moving and Handling.

Staff Survey results

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among Trust staff was 37% (2017: 32%). We give all staff the opportunity to complete the survey and are pleased that we have increased the percentage of those that have completed the survey this year.

Scores for each indicator together with that of the survey benchmarking/comparison group (combined mental health, learning disability and community services trusts) are presented below.

	2018/19		2017/18		2016/17	
	Trust	**Comparison group (av)**	**Trust**	**Comparison group (av)**	**Trust**	**Comparison group (av)**
Equality, diversity and inclusion	9.2	9.2	9.3	9.2	9.4	9.2
Health and wellbeing	6.2	6.1	6.2	6.1	6.3	6.2
Immediate managers	7.2	7.2	7.2	7.1	7.2	7.1
Morale	6.3		6.2		No data available, new question set	
Quality of appraisals	5.2	5.5	5.1	5.4	5.1	5.4
Quality of care	7.4	7.4	7.3	7.4	7.5	7.5
Safe environment: Bullying and harassment	8.3	8.2	8.3	8.3	8.4	8.2
Safe environment Violence	9.6	9.5	9.5	9.5	9.6	9.5
Safety culture	6.7	6.8	6.7	6.7	6.8	6.7
Staff engagement	7.1	7.0	7.0	7.0	7.1	7.0

The combined indicator scores do not highlight a statistically significant change across the themes. However, a number of notable improvements over the previous year have been observed**:**

- 4% more would recommend us as a place to work;
- 4% more feel that communication between senior management and staff is effective;
- 4% more feel they are able to deliver the care they aspire to;
- 4% more feel they get recognition for good work;
- 3% more feel they are able to meet conflicting demands on their time;
- 5% increase in feeling satisfied with their level of pay;
- 5% increase in staff feeling that the Trust values their work;
- 4% increase in staff feeling that senior managers try to involve them in important decisions;
- 4% increase in staff saying the feel that the care of patients/ service users is the Trusts top priority.

Areas of deterioration from the previous year are as follows:

- 4% increase in staff saying that they have had less training learning or development in the last 12 months;
- 3% of staff saying they have seen an increase in errors, near misses or incidents that could have hurt patients or service users;
- 3% reduction in staff saying that they have reported incidents of bullying, harassment or abuse at work that they were involved in.

There are a number of further areas which we are prioritising for improvement in the coming year:

- The quality of our appraisals are rated lower that the national average, in particular 6% less staff than the average say that the Trust values are discussed during their appraisals;
- 15% of staff say they have experienced bullying from colleagues;
- Although improved by 2%, 57% of staff are still saying they are working unpaid hours;
- 45% of staff say that they are not given feedback about changes made in response to errors, near misses or incidents.

Local surveys

The Trust carries out quarterly pulse checks with staff to focus in detail on levels of staff engagement and what actions work well to increase engagement and what areas we could improve on. We continue to achieve a moderate to positive score on staff engagement and consistently identify that the levels of trust and working relationships positively influence our staff engagement score whereas improvements could be made in how staff feel about the recognition they gain and their ability to influence the service they deliver.

Actions during 2018/19

A major focus during the last year has been how we can work to improve the Trust's culture. We completed a culture audit using the NHS Improvement Culture and Leadership framework and used the results to inform the development of the Trust's organisational development improvement plan. A number of ideas identified by staff to improve the culture have been implemented including:

- Revised process of clinical presence visits, providing a more visible senior management team;
- Introduction of a recognition card scheme to provide a way of staff thanking each other for particularly valuable work;
- Agreement of a methodology for quality improvement for the Trust;
- Development of a People and Workforce Strategy and associated delivery plan;
- A new plan for the development of managers and leaders;
- Revised welcome to new starters.

Future plans to support improving results

The key priorities for the Trust as a result of the results from our surveys are shown below.

Priority area	**Action**
Staff Bullying and Harassment	A working group has been established to investigate the reasons and themes behind the levels of perceived bullying and harassment. We are working with NHS Improvement to support this work.
Feedback about changes made in response to errors, near misses and incidents	The Trust has signed up to embedding a *Just Culture* and we will be aligning the introduction of this for both the way we manage incidents for patients and incidents for staff. We will build feedback about incidents and mechanisms for managing bullying and harassment into our work on *Just Culture*
Access to staff training and development	The Trust has now allocated funding for staff to access for continuous professional development since the withdrawal of funding though Health Education England. We are re-establishing learning champion roles and learning needs analysis processes to ensure the funding is allocated to priority areas.
Recognition	We are part of the NHS Improvement retention programme and will build recognition processes into this work including implementing the recommendations of our recognition card pilot scheme and roll out across the Trust.

Influence	We have already built quality improvement training into our Team Leader programme and during the next year will be rolling out additional training for all staff and quality improvement champions and leaders. The focus of the methodology is to increase the involvement of those closest to the service being delivered, which will improve the feeling of being able to influence.
Quality of one to one discussions and reviews	We will work to help redesign the one to one and appraisal processes in line with the new pay awards, focussing on the quality of the conversation rather than the paperwork associated with it.
Accessibility of information	A large number of our service will be transferring to new organisations during the year. We will work to ensure that information about survey results is available and accessible to the new organisations to inform their plans.

Monitoring improvements

Over the past two years we have selected a representative sample of staff to complete the pulse survey, in future we plan to ask all staff to complete the surveys to increase the representation of views. The pulse surveys provide a quick turnaround of results and provide a useful monitoring mechanism to see whether changes made are impacting on the feelings of staff.

The Trust's Staff Health, Wellbeing and Engagement Group is made up of workplace champions and specialists. This group has oversight of the action plan and support implementation of changed ways of working. This group forms part of the people and workforce governance system in support of the People and Workforce Strategy and delivery plan.

Trade Union Facility Time

From 1 Apr 2017 public sector organisations have been required to report on trade union facility time. Facility time is paid time off for union representatives to carry out trade union activities. The Trust has four partnership officers, comprising of a full-time chair plus three partnership officers working part-time, who are supported by an administrative support post. The function is funded to undertake 70 hours of trade union work per week – as at 31 Mar 2019 the actual number of hours worked each week was 52.5 (total workforce headcount 6,590).

We can provide information directly relating to Partnership Officers and admin support. Pennine Care is currently working to ensure that a full disclosure, stating

information relating to the percentage of time spent on facility time and percentage of pay bill spent on facility time and paid trade union activities in line with the Trade Union Regulations 2017 (Facility Time Publication Requirements) is published on the Pennine Care website, this will include roles over and above formal partnership officer roles.

Additional payment information

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

Table 1: off-payroll engagements of longer than 6 months

All off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months.

	Number
Number of existing engagements as of 31 March 2019	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
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 2018 and 31 March 2019, 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 2018 and 31 March 2019	1
Of which...	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	1
No. of engagements reassessed for consistency / assurance purposes during the year.	0
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/Governing Body members, and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019.

Number of off-payroll engagements of board/governing Body members and/or senior officials with significant financial responsibility during the financial year.*	0
The total number of individuals both on and off payroll that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year, (includes engagements which are ON PAYROLL as well as those off payroll).	11

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 2018/19 expenditure on consultants was £286k.

Exit Packages

Reporting of compensation schemes - exit packages 2018/19

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
<£10,000	-	3	**3**
£10,000 - £25,000	-	3	**3**
£25,001 - 50,000	3	2	**5**
£50,001 - £100,000	2	-	**2**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**6**	**8**	**14**
Total cost (£)	£385,000	£129,000	**£514,000**

Reporting of compensation schemes - exit packages 2017/18

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
<£10,000	3	3	**6**
£10,000 - £25,000	-	3	**3**
£25,001 - 50,000	5	2	**7**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	1	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**9**	**9**	**18**
Total cost (£)	£330,000	£302,000	**£632,000**

Exit packages: other (non-compulsory) departure payments

	2018/19		2017/18	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	1	160
Mutually agreed resignations (MARS) contractual costs	8	129	8	142
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**8**	**129**	**9**	**302**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

The above exit package tables have been subject to audit.

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 tables above.

The exit package tables above report the number and value of exit packages taken by staff leaving in the year. Note that the expense associated with these departures may have been recognised in part or in full in a previous year.

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 2019, the Trust was compliant with all the code's provisions.

The following table sets out the Trust's compliance with the disclosure requirements set out in the NHS Foundation Trust Code of Governance and the NHS Foundation Trust Annual Reporting Manual. Please refer to the director's report from page 37, council of governors and membership section from page 84, and the Annual Governance Statement from page 98 for full disclosures.

Code provision / requirement of FT ARM	**Reference**	**Comply or Explain**
(A.1.1) The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Accountability report: • Directors' report • Council of Governors section	**Comply**
(A.1.2) The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Accountability report • Directors' report • Board profiles • Meetings of the Board of Directors	**Comply**
(A.5.3) The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or	Accountability report • Council of Governors section	**Comply**

appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.		
(Requirement of FT ARM) The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors	Accountability report • Council of Governors section	**Comply**
(B.1.1) The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Accountability report • Directors' report	**Comply**
(B.1.4) The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Accountability report • Directors' report • Board profiles	**Comply**
(Requirement of FT ARM) The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Accountability report • Directors' report • Council of Governors section	**Comply**
(B.2.10) A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Accountability report • Directors' report • Council of Governors section	**Comply**
(Requirement of FT ARM) The disclosure in the annual report on the work of the nominations committee should include an explanation if either an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Accountability report • Council of Governors section	**Comply**
(B.3.1) A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	Accountability report • Directors' report • Council of Governors section	**Comply**
(B.5.6) Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Accountability report • Council of Governors section • Membership section	**Comply**

(Requirement of FT ARM) If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Not applicable	**Comply**
(B.6.1) The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Accountability report • Directors' report	**Comply**
(B.6.2) Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Accountability report • Directors' report	**Comply**
(C.1.1) The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement.	Accountability report • Directors' report • Annual Governance Statement	**Comply**
(C.2.1) The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Accountability report • Directors' report • Annual Governance Statement	**Comply**
(C.2.2) A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Accountability report • Directors' report (Audit Committee)	**Comply**

(C.3.5) If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable	**Comply**
(C.3.9) A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Accountability report • Directors' report (Audit Committee)	**Comply**
(D.1.3) Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable	**Comply**
(E.1.4) Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Accountability report • Membership section	**Comply**
(E.1.5) The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Accountability report • Directors' report	**Comply**

(E.1.6) The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Accountability report • Directors' report • Council of Governors section • Membership section	**Comply**
(Requirement of FT ARM) The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	Accountability report • Membership section	**Comply**
(Requirement of FT ARM) The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	Accountability report • Directors' report • Council of Governors section	**Comply**

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 11
An indication of likely future developments at the NHS foundation trust.	Refer to the performance report, future priorities and challenges from page 11

An indication of any significant activities in the field of research and development.	Refer to the quality account, from page 116
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 staff report from page 56
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 staff report from page 56
Policies applied during the financial year for the training, career development and promotion of disabled employees.	Refer to the staff report from page 56
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees.	Refer to the staff report from page 56
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 staff report from page 56

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.

Segmentation

Our segmentation position as at 31 March 2019 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 98.

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

Finance and use of resources

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

Area	Metric	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q2	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	3	4	4	4	4	4	4	4
	Liquidity	3	3	3	3	2	2	2	1
Financial efficiency	I&E margin	2	3	3	3	4	4	4	4
Financial controls	Distance from financial plan	1	1	1	1	4	4	4	4
	Agency spend	3	3	2	1	2	2	2	2
Overall scoring		2	3	3	3	3	3	3	3

For further details on the performance versus planned performance see the financial performance and information section of the Performance Report.

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 Pennine Care 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy, and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable 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
24 May 2019

Statement as to disclosure to the auditors

Each of the individuals who are directors at the date of approval of this report confirms that:

- They consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS foundation trust's performance, business model and strategy;
- So far as the director is aware, there is no relevant audit information (which means information needed by the NHS foundation trust's auditor in connection with preparing their report) of which the NHS foundation trust's auditor is unaware; and
- The director has taken all 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 NHS foundation trust's auditor is aware of that information.

For and on behalf of the Board:

Evelyn Asante-Mensah OBE
Chair
24 May 2019

Claire Molloy
Chief Executive
24 May 2019

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 37

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 feedback 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.

During 2018, the Trust commissioned an independent external Well-led review, from which a number of recommendations related to the Council of Governors, in particular its

composition and the alignment of its activities to its core statutory duties. The Trust has worked with the Council to co-produce revised processes, including its meeting structures, to ensure they better reflect its statutory duties of holding Non-Executive Directors (NEDs) to account and representing the views of the membership and public. During 2019, the focus will be to embed these new arrangements and assess their effectiveness. Feedback received to date has been positive with the new processes expected to further strengthen our governance arrangements.

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. One way in which we have strengthened the process is to establish a Chair, NED and Governor Committee to offer governors the opportunity to seek assurance from the Non-Executive Directors that they are confident the Board is running the organisation in the best interests of patients, members and the wider community. This Committee provides an opportunity for constructive dialogue between governors and Non-Executive Directors across the breadth of the Trust's business, including strategy, quality, finance, performance, and workforce.

In line with the revised meeting structure for the Council, a formal committee has been established to address the need for a cohesive approach to member engagement. The Trust will work with the governors to establish a programme of work to support this agenda in the context of the Trust's strategic direction of travel. In addition, local constituency meetings take place regularly, where governors hear from services about local developments and discuss member engagement opportunities. Governors are also given the opportunity to visit service areas so they can meet staff and learn more about the services we provide.

Meetings of the Full Council of Governors

The formal meeting of the Council of Governors (CoG) is chaired by the Trust Chair. Meetings are also attended by Non-Executive Directors and the Chief Executive (or her representative). One of the key functions of the meeting is to provide assurance about the Trust's performance to governors and for the governors to approve recommendations made by its committees. There have been four full meetings of the Council of Governors between April 2018 and March 2019 and all were open to the public.

Appointment and Remuneration Committee

Chaired by the Trust Chair, this Committee is responsible for making recommendations to the full Council of Governors regarding the appointment, re-appointment or removal of Non-Executive Directors, setting the remuneration and terms and conditions of, and evaluating

the performance of, the Non-Executive Directors. The Committee has met five times during the period 1 April 2018 to 31 March 2019.

During the reporting period the Committee ensured appropriate oversight and made recommendations to the full Council in relation to:

Review of Chair and NED Remuneration

In April 2018, the Committee reviewed an independent benchmarking report by Capita on the Chair and Non-Executive Director remuneration. The Committee agreed to recommend a pay freeze for the financial year 2017/18, and this was in turn approved by the Council of Governors on 15 May 2018.

Reappointment of Non-Executive Director

Following an agreed process, which comprised an automatic entitlement for Non-Executive Director re-appointment based on a number of agreed criteria, the Committee recommended to the Council of Governors the re-appointment of Michael Livingstone as Non-Executive Director for a second term of three years with effect from 21 September 2018. This recommendation was approved by the Council of Governors on 8 August 2018.

Appointment of new Non-Executive Director

In August 2018, the Committee approved the recommendation from the Deloitte Well-led review to address the gap amongst the Non-Executive Directors in relation to clinical experience. It was therefore agreed that the appointee to the post vacated by Lord Keith Bradley would be required to demonstrate senior level clinical experience.

Lord Bradley vacated his post on 31 August 2018. Interviews for a new Non-Executive Director were held on 5 November 2018. The Committee met on 6 November 2018 and agreed to recommend the appointment of Catherine Laverty from 28 November 2018 for terms of three years; and this was in turn approved by the Council of Governors on 6 November 2018.

Succession Planning

The Council of Governors Appointment and Remuneration Committee reviews the Non-Executive Director terms of office and discusses succession planning at each meeting. No further Non-Executive Director appointments or re-appointment are scheduled for 2019. Towards the end of 2020, three Non-Executive Directors are eligible for re-appointment (Evelyn Asante-Mensah, Dr Julia Sutton-McGough, and Daniel Benjamin); and two Non-Executive Directors come to the end of second three year term of office (Joan Beresford and Professor Sandra Jowett).

Composition of the Council of Governors, terms of office and attendance at statutory meetings: 1 April 2018 to 31 March 2019

The table below shows the attendance (actual/eligible) of individual governors at the aforementioned statutory meetings during 2018/19.

Name and Constituency	Term of Office	Attendance at Full Council of Governors	Attendance at Appointment and Remuneration Committee
Public Governors: Bury			
Ken Kendall	1 July 2016 to 30 June 2019	1/4	5/5
Derek Rowley	1 July 2018 to 30 June 2021	2/4	2/5
Clive Brown	1 July 2017 to 30 June 2020	4/4	5/5
Lucette Tucker	1 July 2018 to 30 June 2021	3/4	1/5
Public Governors: Oldham			
John Starkey	1 July 2018 to 30 June 2021	4/4	5/5
Norma Bewley	1 July 2018 to 30 June 2021	4/4	3/5
Kath Oldham	1 July 2017 to 30 June 2020	3/4	3/5
Jim McDermott	1 July 207 to 30 June 2019	4/4	1/5
Public Governors: Heywood, Middleton and Rochdale			
Karen Kelland	1 July 2016 to 30 June 2019	4/4	3/5
Sohail Ahmad	1 July 2018 to 30 June 2020	3/3	0/3
Howard Bowden	1 July 2018 to 30 June 2019	1/3	0/3
Margret Chadwick	1 July 2018 to 18 Jan 2019	1/2	2/3
Mohammed Sarwar	1 July 2015 to 30 June 2018	0/1	0/2
Public Governors: Stockport			
Paul Carter	1 July 2016 to 30 June 2019	4/4	3/5
Brian Wild	1 Feb 2017 to 3 June 2019	2/4	0/5
Mary Foden	1 July 2017 to 30 June 2020	4/4	4/5
June Somekh	1 July 2018 to 30 June 2021	3/3	1/3
Public Governors: Tameside and Glossop			

Name and Constituency	Term of Office	Attendance at Full Council of Governors	Attendance at Appointment and Remuneration Committee
Wendy Hartley	1 July 2016 to 30 June 2019	4/4	4/5
Joyce Howarth MBE (Lead)	1 July 2016 to 30 June 2018	4/4	5/5
John Reddy	1 July 2017 to 30 June 2020	4/4	3/5
Stephen Moss	1 July 2016 to 13 Feb 2019	2/3	0/5
Public Governors: Trafford			
Irving Normie	1 July 2016 to 30 June 2019	0/4	0/5
George Devlin	1 July 2018 to 30 June 2021	0/3	0/3
Donna Hefferon	1 July 2018 to 30 June 2020	0/3	0/3
Angela Lawrence MBE	1 July 2018 to 30 June 2021	0/3	0/3
Martin Stevenson	1 July 2016 to 30 June 2018	0/1	0/2
Public Governor: Rest of England			
Cathie Marsland	1 July 2018 to 6 Nov 2018	0/1	0/3
Staff Governors: Allied Health Professionals			
Beth Kilmartin	1 July 2018 to 30 June 2020	2/3	1/3
Goudon Mahamoud	1 July 2018 to 30 June 2019	0/3	0/3
Staff Governors: Corporate and Support			
Julia Nicholson	1 July 2017 to 30 June 2020	3/4	3/5
Richard Cliff	1 July 2018 to 30 June 2021	3/4	4/5
Staff Governor: Medical and Dental			
Richard Valle-Jones	1 July 2016 to 30 June 2019	2/4	1/5
Staff Governors: Nursing			
Sara Handley	1 July 2017 to 30 June 2020	0/4	0/5
Lisa Moulden	1 July 2018 to 30 June 2021	0/3	0/3
Jan Trainor	1 July 2017 to 30 June 2018	0/1	0/2
Social Care			

Name and Constituency	Term of Office	Attendance at Full Council of Governors	Attendance at Appointment and Remuneration Committee
Liz McCoy	1 July 2017 to 30 June 2020	2/4	0/5
Appointed Governors: Bury			
Lisa Featherstone	29 September 2015	0/4	0/5
Cllr Annette McKay	27 July 2018	0/3	0/3
Appointed Governors: Oldham			
Graham Foulkes	1 June 2013	0/4	0/5
Cllr Eddie Moores	1 July 2016	1/4	0/5
Appointed Governors: Rochdale			
Charlotte Booth	13 March 2017	0/4	0/5
Cllr Peter Joinson	10 May 2013	3/4	0/5
Appointed Governors: Stockport			
Vacant			
Cllr Angie Clark	27 July 2018	2/3	0/3
Appointed Governors: Tameside			
Dr Alan Dow	15 August 2018	1/2	0/2
Cllr Jackie Lane	1 July 2008	1/4	0/5
Appointed Governors: Trafford			
Vacant			
Cllr Dylan Butt	18 October 2017	3/4	0/5

There has been attendance by Non-Executive Directors at full Council of Governors meetings throughout this reporting period:

Non-Executive Director	Attendance (actual / eligible)
Evelyn Asante-Mensah	4/4
Joan Beresford	4/4
Sandra Jowett	3/4
Daniel Benjamin	2/4
Michael Livingstone	2/4
Julia Sutton-McGough	2/4
John Scampion	2/4
Catherine Laverty	0/1
Keith Bradley	0/2

Independent Well-led review

In April 2018, the Council of Governors received feedback from an external independent Well-led review, undertaken by Deloitte LLP. Six recommendations were made in relation to the Council of Governors, four of which were rated ‘low priority’, one ‘medium priority’, and one ‘high priority’.

Recommendation	Priority
Reduce the number of Governors per constituency from four to three to bring the size of the Council of Governors more into line identified benchmarking.	Low (6 to 12 months)
Undertake a programme of support and development to refocus the activities of Governors, the Council of Governors and its sub groups on the core statutory roles of holding Non-Executive Directors to account and representing the views of the membership.	Medium (3 to 6 months)
Restate the role of the Lead Governor to more closely align it to the statutory expectations that it acts as the point of liaison between the Council of	Low (6 to 12 months)

Governors and NHS Improvement should circumstances arise requiring such a dialogue to take place.	
The potential conflicts of interest presented by the Lead Governor now working for the Trust should be addressed promptly and more open discussion of such conflicts should be undertaken at the Council of Governors should similar circumstances arise again in future.	High (0 to 3 months)
Establish arrangements to ensure that the Council of Governors is engaged in the Non-Executive Director appraisal process.	Low (6 to 12 months)
Introduce a themed approach to membership engagement over a significant time period, to provide greater scope for gathering of a wider view of issues, plans or service changes from across the membership, to inform discussion and debate at the Council of Governors.	Low (6 to 12 months)

The Council of Governors established a steering group to oversee the response to the recommendations, with some elements of work undertaken by task and finish groups on its behalf. The Trust has worked closely with governors to co-produce new ways of working, processes and procedures to ensure they are robust and supports a collaborative approach. In February 2019, the Council of Governors recognised the work completed by the steering group and the task and finish groups, and concluded that the recommendations had either been addressed or had been incorporated into revised processes.

This included revision of the Council of Governors meeting structure and the establishment of two new formal committees:

Chair, NED and Governor Committee – the principle purpose of the Committee is to support the fulfilment of the Council of Governor's statutory role in holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors. This will include, but not limited to, seeking assurance on behalf of the Council of Governors that the Trust is addressing all matters relating to:

- Quality improvements against core standards
- Patient safety and experience
- Contractual requirements, risks and issues
- Financial sustainability
- Partnership working within the wider health and social care economy
- Progress against strategic goals and objectives
- Regulatory and statutory compliance
- Trust achievements and best practice

Membership and Engagement Committee – the purpose of the Committee is to support the fulfilment of the Council of Governor's statutory role in representing the interests of the members of the Trust as a whole and the interests of the public.

During 2019/20, there will be a review the impact of the changes as part of the periodic self-assessment of the collective performance undertaken by the Council of Governors.

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. The Trust facilitates an on-going governor development programme, commencing with a welcome and induction for all new governors in July each year. Existing governors are invited to participate in this process to refresh their own skills and knowledge and also to share their learning with new incumbents. There are monthly development sessions, incorporating 'formal' sessions linked to the Council of Governors statutory duties and 'informal' sessions on Trust services. Additionally, governors are given the opportunity to attend a range of external events, such as the NHS Providers Governwell programme, the North West Governors' Forum, and the national NHS Providers Annual Governor Focus conference. The Trust also facilitates joint Board of Directors and Council of Governors development sessions.

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:

- Feedback from the Deloitte Well-led review
- Partnership working between Pennine Care and Manchester Metropolitan University
- Learning from deaths
- Quality Account
- NHS Providers bespoke training session regarding the role of the governor, core skills and accountability
- Care Quality Commission new framework and inspection planning
- Overview of NHS Finances and the 2018/19 Financial Plan
- Trust Business Plan
- Update on the Mental Health Strategy and Integrated Mental Health programme
- Trust Strategy (joint session with the Board and Governors)
- Equality Agenda (joint session with Board and Governors)
- Quality Strategy and Quality Improvement
- Headlines from the Care Quality Commission Inspection
- Mixed Sex Accommodation update
- Operational Plan/Financial Plan 2019/20*
- Joint session between Governors and Joint Health and Overview Scrutiny Committee

*Directors must take account of governors views when setting forward plans for the Trust; giving governors the opportunity to feed in the views of Trust members and the public and to question the Non-Executive Directors if these views do not appear to be reflected in agreed plans. Governors are regularly consulted on the Trust's strategy and operational plans as the Chief Executive (or her representative) attends each full Council of Governors meetings to offer updates and invites views that can be communicated to the Board of Directors. Please see the Membership and Engagement section for more information about how governors seek the views of Trust's members and public. Governors are provided with weekly communications, which includes information on the direction of travel for the Trust in the form of a blog written by the Chief Executive and other Executive Directors. The blog invites feedback and questions to seek members views.

Nominated Lead Governor

The Deloitte Well-led review identified the need to realign the lead governor role to its statutory function of taking the lead role in liaising with NHSI in 'specific circumstances'. Consequently, a new role description was developed which was then approved by Council of Governors in May 2018.

The existing Lead Governor is Joyce Howarth MBE who was elected in for the period 1 October 2018 to 30 September 2019.

Register of interests

The Trust maintains a full register of governor interests, which can viewed on the Trust 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.

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.

As at the end of March 2019, the Trust has 22,578 members, approximately 16,438 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 2019, there were seven public constituency areas, as listed below:

- Bury
- Heywood, Middleton and Rochdale
- Oldham
- Stockport
- Tameside and 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.

At the end of March 2019, the staff constituency comprises five classes, as follows:

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

How to get in touch

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 / 3978

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 2018/19, the Trust recruited 136 new public members, whilst 280 left. The Trust continues to work on more meaningful engagement with members rather than aim for mass recruitment. Governors in each borough continue to work closely with managing directors and service managers within their local constituency areas to ensure there is a route by which they can communicate and engage with our membership to ensure it is reflective of

local communities. The membership team uses information collected from local meetings to inform where they need to focus any engagement opportunities and develop awareness of the Trust and its services.

The Trust monitors its membership by ethnicity, age and gender. The total number of members of non-white British has grown by 2.4% and there has been a significant 7.5% increase in 'any other ethnic group' during this reporting period. The age category that we have the highest membership rates from is: age 60 – 74, and the largest increase this year was 22 – 29 at 15%. We have twice as many female members as we do male.

The membership team continues to support a diverse range of people and make every effort to ensure that individual needs are met, from members with hearing impairments and health issues to supporting individual faith needs. In order to increase awareness of the governor role and the membership scheme within the Trust, the membership team have made additional efforts to target various communities and groups which have been previously under-represented including people of working age, younger people and ethnic minorities. As a result of this we were pleased that we had nominations from a wide range of diverse backgrounds in the 2018 elections to the Council of Governors.

As at 31 March 2019, the breakdown of members by public constituency was as follows:

Constituency	Number of members
Bury	2,172
Heywood, Middleton and Rochdale	2,841
Oldham	2,481
Stockport	2,385
Tameside and Glossop	2,898
Trafford	1,525
Rest of England:	2,136
Total	16,438

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 continues with its series of public engagement events to reach into the communities, which are aimed at promoting the governor role, health and wellbeing messages, signposting to services, and linking 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. The membership team also records videos by governors to provide information and feedback for a more interactive approach to engagement. An animation was produced to promote membership and the governor role, which has been distributed widely and received positively.

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 to ensure governors have the opportunity to meet with, and seek views from, members and the public across different communities. The Stockport "Big Conversation" Mental Health Event was repeated on world mental health day 10 October 2018 and, with approximately 200 people in attendance, proved to be very popular with local members, partner and third sector organisations. The team has worked closely with the Council of Governors to co-produce new processes to support engagement with our members. These will be monitored within the newly formed Membership and Engagement Committee, which is chaired by the Deputy Chair to ensure there is robust feedback to the Board about the effectiveness of member engagement and the representativeness of the Trust's membership.

Annual Governance Statement

a) Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

b) The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Pennine Care NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Pennine Care NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

c) The risk and control framework

The Trust uses an integrated approach to managing risk across the organisation, which is consistent with best practice and set out in the Trust's Risk Management Strategy (RMS).

The Board Assurance Framework (BAF) reflects strategic level risks that could impact on the achievement of the Trust's overarching objectives, along with controls to mitigate these. These risks are each assigned to an Executive Director lead and aligned to the relevant governance committees and Board sub-committees to support the commissioning and reporting of assurances.

The BAF risks are used to inform the setting and prioritisation of agendas for the sub-committees, to provide assurance that they are being managed, and in turn these help drive the agendas for the Board of Directors meetings.

The BAF sets out the key strategic risks in the context of the organisation's strategic goals, as follows:

- Quality
    - Key risks linked to Mixed Sex Accommodation and Safer Staffing requirements
- People
    - Key risks linked to recruitment and retention and impact on organisational capacity
- Partnerships
    - Key risks linked to profiling of Mental Health and Learning Disability services and understanding the needs of our communities.
- Money
    - Key risks linked to strategic plan and sustainability
- Infrastructure
    - Key risks linked to Health Informatics

Risk reporting forms an inherent part of the Trust's Integrating Performance Reporting (IPR) mechanism, drawing out key current risks, and highlighting potential risks based on a range of performance indicators.

Risk Management requires participation, commitment and collaboration from all staff. Risks are identified and assessed proactively at corporate or local / Divisional Business Unit (DBU) / borough level, to identify actual or potential threats and to ensure that adequate control measures are in place to either eliminate or reduce any potential consequences of the risk.

Proactive risk assessment is informed by inspection processes, e.g. the Care Quality Commission (CQC) and other regulatory or compliance measures. Risks are also identified and assessed reactively in response to incidents, complaints, claims and the ability to deliver business as usual activity. The RMS has a generic risk assessment form and scoring system to support consistency.

All risks are scored using the risk matrix that considers the likelihood of occurrence and the impact of it; actions taken and on-going review. The escalation process ensures that all identified risks are either eliminated or controlled to the best manageable and acceptable level. The level of scrutiny is proportionate to the significance of the risk.

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

New risks are recorded onto the Ulysses system (our electronic risk and incident reporting system) by the DBU / borough or central staff. The system allows information to be extracted in many ways for example DBU level, Trust wide, Corporate.

Risks on the register are reviewed at team / service / division / Trust-wide forums. The Trust's governance architecture has recently been reviewed, with all Divisions holding a monthly Integrated Leadership Group (ILG), reporting to the Trust Management Board, Trust-wide Executive Director chaired groups (e.g. Quality Group) to Non-Executive Director chaired sub Board committees (e.g. Quality Committee).

Risk Management features as an agenda item within the Trust Management Board, and at local Integrated Leadership Groups. The Risk Register is reviewed and scrutinised on a monthly basis through these groups, with items for escalation being reviewed by the relevant Executive Director on a monthly basis and being referred to the relevant Board sub-committee for monitoring and assurance. These processes are an integral part of the Board Assurance Framework, which is reviewed by the Board on a quarterly basis.

The Trust is fully compliant with the registration requirements for the CQC. Our recent inspection of 2018 provided the Trust with an overall rating of Requires Improvement, with number of 'must do' / 'should do' / well-led recommendations in relation to regulatory breaches. Our improvement plan, submitted to the CQC on 7 March 2019, provides a framework for improvement and regulatory compliance.

Pennine Care staff are trained in and familiar with the Ulysses system. On average the Trust reports 1,200 incidents per month.

Patient Safety incidents are uploaded to the National Reporting and Learning System (NRLS) by our risk team. Our organisation remains in a positive position when benchmarked against similar trusts.

During 2017/18 the Trust faced unprecedented financial and quality challenges and negotiated a series of Enforcement Undertakings with NHS Improvement (NHSI) in relation to finance and quality based on:

i) The forecast deficit of £6.6m for 2017/18 and likelihood of requiring distress funding during 2018/19

ii) The Trust receiving an overall CQC rating of 'Requires Improvement'

At the same time, the Trust commissioned an external review of its governance arrangements using the Well-led framework.

During 2018/19, the Trust has been actively discharging the undertakings and providing regular updates to NHSI on the steps taken to improve our position, including:

i) A comprehensive review of all services and their sustainability, undertaken in collaboration with commissioners, which in turn informed a decision approved by the Board of Directors in December 2018 to refocus its service portfolio and concentrate on the provision of mental health and learning disability services
ii) A review of our structure, capacity and capability, overseen by a Transformation Programme Board, to inform the development of a sustainability plan and long-term strategy, for approval by the Board of Directors and finalised in line with national timescales
iii) The Trust was rated 'Requires Improvement' by the CQC in 2018 and has been participating in the 'Moving to Good' programme and paired with Tees, Esk and Wear Valley NHS Foundation Trust.

Additionally, in June 2018 the Trust agreed a revised Control Total of £6.4m deficit for the financial year ended 31 March 2019. The year-end outturn position was a surplus of £60k, supported by the receipt of £6.97m Provider Sustainability Funding. This improved financial position, along with the actions taken above, has led to the Trust proposing removal of the enforcement undertakings pending submission of the strategic sustainability plan.

Initial enhanced oversight meetings were held with NHSI on a monthly basis but these have now been reduced in frequency to quarterly.

A review of the Trust's governance arrangements was undertaken in March 2019 in line with the 2018/19 Audit Plan, as approved by the Audit Committee. The review of 'Governance – Well-led' was awarded a rating of 'Substantial Assurance'.

The organisation has five strategic objectives – Quality, People, Partnerships, Money and Infrastructure. For each there is an overarching strategy, supported by a suite of delivery plans.

The Trust's People and Workforce Strategy was approved by the Board of Directors in 2018. The five-year strategy focuses on the national context and challenges, GM position and local workforce challenges. Underpinning the strategy is the People and Workforce Delivery Plan, which supports the implementation of short, medium and

long term workforce strategies that seek to address having the right people, with the right skills, at the right place and time. Outputs from the strategy and delivery plan are monitored and governed by the People and Workforce Committee, which is a sub Board committee; updates on progress are reported to Board on a monthly basis.

In line with the NHSI 'Developing Workforce Safeguards' recommendations the Trust is committed to implementing these standards. The Trust has started the journey to implement the recommendations outlined in this guidance as follows:

A) Effective Workforce Plan that is updated annually

To ensure progression of the People and Workforce Strategy delivery plan at an operational level a Trust-wide People and Workforce Steering Group has been established, and is chaired by the Executive Director of Workforce. The purpose of this group is to focus on the four key domains set out in the strategy, underpinned by our approach to Equality Diversity and Inclusion.

The four domains are:

1. Effective and sustainable workforce:

   (Expectation 1/2/3: evidenced based workforce planning/professional judgement/compare staffing with peers, working as a multi professional team, recruitment and retention, efficient employment and minimising agency)

   The group focus on ensuring that we have the right staff, with the right skills to support services, whilst simultaneously looking at the gaps in services relating to clinical roles, developing new models / ways of working to address this challenge. There is also a strong emphasis on addressing the challenges with recruitment and retention, with the group leading on the NHSI retention programme. The Trust currently has a relatively low retention rate of 10% and was in cohort 4 of the programme, work is underway to reduce this further.

2. Capable and Skilled Staff:

   (Expectation 2: mandatory training development, and education, working as a multi professional team)

   The group focuses on implementing and continually improving interventions to ensure we meet Health Education England (HEE) quality standards required for learners through:

   - The development of proposals to make effective use of the apprenticeship levy, reviewing current provision and future proposals;

- Developing proposals for the implementation of technological solutions for learning activity and the development of health informatics skills;
- Ensuring that work to embed service improvement skills and knowledge development is aligned to the provision of Education, Learning and Development in the Trust. Frameworks for the recording of education, learning and development activity both at Trust and individual level, including monitoring and reporting for inclusion purposes and systems for recording;
- Agreeing standards for the provision of and commissioning of education, learning and development to ensure quality.

3. Effective Leadership:

The group is currently undertaking the development of a leadership development strategy for the Trust through a talent management and succession planning framework and supporting interventions.

4. Health, Wellbeing and Staff Engagement:

(Expectation 2: retention)

Focussed work is underway to:

- Understand the reasons for sickness and absence relating to Seasonal Affective Disorder (SAD) and musculo-skeletal conditions (MSK) and we are developing proposals for interventions that are designed to reduce the levels of SAD and MSK
- Identify trends of bullying and harassment in the Trust and complete a diagnostic to understand the root causes
- Develop proposals for interventions that are designed to reduce the levels of bullying and harassment identified in the staff surveys and the actual numbers
- Provide a forum for the health and wellbeing champions and engagement champions to sharing best practice, highlight issues and propose areas for escalating to the steering group
- Develop a staff engagement strategy to include a reward and recognition framework
- Complete a diagnostic of medical engagement using the medical engagement tool and develop appropriate interventions.

Working groups have been established for each key work stream, each group membership includes key stakeholders from across both Clinical and Corporate services. This allows for a multi-disciplinary informed approach to decision making to develop a sustainable future workforce. Activity against the delivery plan is reported

through the People and Workforce Steering Group on a monthly basis with regular reports to the People and Workforce Committee.

B) Measure and Improve

The organisation has agreed local quality dashboards that cross-check comparative data.

Pennine Care has a governance structure that includes a Quality Committee that reports directly to the Board. This committee exists on behalf of the Board of Directors to:

- Seek assurance that effective and appropriate systems are in place to drive quality improvement
- Seek assurance the Trust is delivering high quality care

The Quality Committee receives a report that presents 58 quality indicators within three domains: patient safety, patient experience and clinical effectiveness. This report not only presents the data but provides a narrative against each of the indicators to provide assurance around each of the indicators presented (i.e. action plans, lessons learnt etc.). Key metrics from the three committees that report to the Board of Directors (Quality Committee, People and Workforce Committee and Performance and Finance committee) are then brought together in the Integrated Performance Report to provide an integrated view of the organisation. This allows the Board to see the quality outcomes, against performance outcomes, alongside financial and workforce information.

C) Develop local quality dashboards for safe sustainable staffing

(Expectation 3: Productive working and eliminating waste, efficient deployment and flexibility, efficient employment and minimising agency).

As well are reports that are presented to Board and the committees, operational managers and newly appointed Quality Leads have access to live reports via the Trust Business Intelligence system (Tableau). Tableau provides them with access to data from both clinical and corporate systems (this includes performance measures, patient experience, incidents information, workforce, agency spend etc.) which is updated on a daily basis with the latest information to help them manage any issues, such as nursing establishment and skill mix across wards to ensure safe services.

To support our Quality Leads and Operational Managers to ensure that our inpatient units are staffed safely and flexibly to support the needs of the changing patients a Tableau quality performance dashboard has been developed that presents staffing levels alongside activity information, sickness patterns, patient acuity and incidents

information. This allows them to see at a glance, by day, whether staffing levels are having an impact on the quality of care on the wards by seeing the incidents details presented alongside it. This allows Quality Leads and Operational Managers to react quickly, make professional judgement to any emerging issues that might not have been obvious without the data triangulated and readily available.

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

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.

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

The Trust has a statutory obligation to address climate change, with carbon emission reduction targets set out in the UK's Climate Change Act (CCA 2018). We are currently revising and expanding our sustainable development management plan (SDMP) involving the wider stakeholders in responding to this obligation and other requirements placed on the Trust to manage and reduce our environmental impact. It is important to ensure that the SDMP plan reflects the needs and ambitions of the organisation, and empowers staff to contribute and embed sustainable healthcare within their roles and departments.

d) Capacity to handle risk

As Chief Executive, I have overall responsibility for ensuring arrangements exist to allow the effective management of risk, with the Board of Directors ensuring that robust systems of internal control and management are in place. The responsibility for leading the management of risk throughout the organisation is delegated to the Executive Directors and strategic risks are aligned to their respective areas of responsibility.

The Executive Director of Service Development and Delivery is responsible for the overarching risk management systems and processes, whilst the processes for ensuring appropriate management of clinical risks rests with the Executive Director of Nursing, Healthcare Professionals and Quality Governance.

The RMS provides a clear, structured and systematic approach to the management of risks from 'ward to Board' and ensures that risk assessment is an integral part of clinical, organisational and financial processes across the organisation.

Divisional Business Units / boroughs are responsible for the operational management of risks. An escalation process is in operation to ensure that, where necessary, risks are referred / escalated through the Trust's governance structures, as detailed in the RMS.

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.

Following the well-led review, the Trust recognised the need to streamline and ensure consistent understanding of effective risk management at service and directorate level. We have refreshed the RMS to allow escalation via our governance structures to be based on the risk score and will continue to monitor the effectiveness of the new process. The Trust is undertaking further work to realign the responsibility within the Executive Team portfolios, with each of the Trust's delivery priorities and any risks to their achievement being assigned to an Executive Director.

Staff employed within the Trust received mandatory training and role specific training, in line with policy and targets, ranging from basic risk awareness to more specific training to support clinical delivery e.g. STORM training (skills training in suicide prevention and self-harm).

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.

Public stakeholders are involved in identifying risks and providing assurance that they are mitigated in a variety of ways, including the Council of Governors; Joint Health Overview and Scrutiny Committee; Healthwatch meetings; patient satisfaction surveys; complaints; claims and Patient Advice and Liaison (PALS) concerns.

e) 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 the financial operational plan, including the annual budget, by the Board of Directors prior to the commencement of the financial year / in line with national timescales.
- Monthly reporting to the Board on key performance indicators that include finance, governance, activity and workforce and organisational development targets. This is supplemented by monthly meetings of the Performance and Finance Committee, a committee of the Board and chaired by a Non-Executive Director, which provides a more in-depth review.
- Monthly performance reports to the divisions and heads of service including finance, governance, activity and workforce and organisational development targets.
- A risk based approach to the annual internal audit plan approved by the Audit Committee and regular review of progress against the plan by the committee throughout the year.
- Monthly reporting to NHS Improvement and quarterly review meetings to ensure compliance with the terms of authorisation.

In its role as regulator of all NHS provider organisations, NHSI uses the Single Operating Framework to consider how efficiently a provider uses its resources, how financially sustainable it is over the longer term, and ultimately the level of support and intervention required. Part of this framework includes a monthly finance score.

The monthly finance score is calculated by scoring providers on a scale of 1 (best) to 4 (worst) against five key metrics, and averaging these scores to derive an overall figure known as the Use of Resources rating.

Based on actual performance delivered in 2018/19 the final Use of Resources rating was ‘2’. The final operational plan submitted for 2019/20 forecasts an overall rating at year end of ‘2’ also.

In addition to the Annual Plan submission, and in response to national directive, the Trust is working on developing a five-year long term financial model (LTFM) outlining a framework to return the Trust to a sustainable financial platform over a 3-5 year period. Further work will take place during 2019/20 to have a detailed, co-produced and deliverable LTFM in place by autumn 2019.

As highlighted in the section on strategic risks, based on the assessment of the Trust's ability to continue as a going concern, the directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. The directors have approved the preparation of the financial statements on a going concern basis as they consider that the majority of the services currently provided by the Trust will continue to be provided in the foreseeable future.

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 action plans signed off by the Quality Committee, a committee of the Board, and also the Board.

Independent assurance is provided by the Trust's internal and external auditors. Internal Audit undertakes a review and reports on the risk management processes annually, reporting to the Audit Committee. This Committee has a timely reporting process in place to ensure that identified actions from audit reports are progressed to satisfactory conclusion through the implementation of the agreed recommendations.

In terms of deterrents against fraud, the Trust has a very proactive nominated Anti-Fraud Specialist who is fully accredited by the NHS Counter Fraud Authority. The Audit Committee approved the Annual Anti-Fraud Plan for 2018/19 and received regular updates on progress of anti-fraud work during the year. Areas of work during the year have included: proactive anti-fraud activity to raise awareness of policies, systems and controls; reactive investigations where potential fraud areas have been identified; and wider intelligence gathering through NHS Counter Fraud Authority bulletins and alerts.

f) Information governance

During 2018/19, following the principles outlined in the NHS Digital guidance document *'Guide to the Notification of Data Security and Protection Incidents'* the Trust submitted the following incidents to the Information Commissioner's Office (ICO) and/or Department for Health and Social Care via the *Data Security and Protection Incident Reporting Tool*:

Date of incident (month)	Nature of incident	Number affected	How patients were informed	Lesson learned	ICO action taken (where applicable)
November	Inappropriate referral regarding a patient's symptoms and perceived safeguarding concern	1	Face to face	Review of Department procedures Review of relevant training compliance	ICO closed with No further action Required
November	Due to a technical error, a batch of records was scanned under the incorrect patient names.	106	Patients not informed as issue was identified and resolved with no anticipated detriment to patient care	Increased monitoring of provider's quality assurance and contract. Provider to undertake more frequent data audits	ICO closed with No further action
August	A water leak at a health centre caused water damage to records	65	Affected records are currently undergoing a restoration process. Records are historical and relate to inactive patients, therefore no anticipated continuity of care issue. Decision made not to inform patients.	Scoping exercise of all records storage locations. All records to be moved to offsite storage as soon as is practically possible. Raise staff awareness about restricted use of storage rooms.	Currently with the ICO for consideration
August	Set of paper clinical notes inadvertently seen by a patient's relative.	3	Face to face	Incident discussed in house with staff in the team by management Review of relevant training compliance	Currently with the ICO for consideration

Date of incident (month)	Nature of incident	Number affected	How patients were informed	Lesson learned	ICO action taken (where applicable)
August	Patient information sent to the wrong patient.	2	Telephone and in writing	Members of staff formally reminded of IG responsibilities in supervision Review of relevant training compliance	Currently with the ICO for consideration
July	A member of staff accessed an electronic record of a person who was not currently a patient of Pennine Care.	1	Patient informed in writing	Access to systems removed Member of staff suspended pending HR investigation	Currently with the ICO for consideration
July	Unable to locate records	1	In writing	Trust Missing Records Procedure followed. Reminder to all staff re management of records.	Currently with the ICO for consideration

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

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 Executive Director of Service Development and Delivery, who is also the Trust Senior Information Risk Owner (SIRO).

The Performance and Finance Committee, a committee of the Board, has delegated authority to oversee the management and performance of Information Governance, receiving reports, risks, issues and assurance from the Information Governance Assurance Group and Data Protection Officer, and providing risk and/or assurance to the Board.

The Information Governance Assurance Group (IGAG) supports and drives the broader information governance agenda to provide the Board (via the Performance and Finance Committee) 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 i.e. the Data Security and

Protection Toolkit. The Assurance Group is supported operationally by the Information Governance Manager.

The Caldicott Guardian and the SIRO jointly chair the IGAG, and ensure that issues arising from the group are escalated to appropriate committees or the Board.

The Trust has self-assessed against the Data Security and Protection Toolkit, which assesses annual performance against and compliance with Department of Health information governance policies and standards. For 2018/19 the Trust achieved a submission of ***Standards Met*.**

The Trust's Data Security and Protection Toolkit compliance is reviewed by our internal audit provider, who for 2018/19 has provided ***substantial assurance*** that there is a sound system of control in place.

During 2018/19, the Trust has embedded the new and revised information risk management framework, and is rolling out the new information asset and data flow register tool.

The Trust continues to monitor its compliance against the requirements of the new data protection legislation (including GDPR) post its implementation in May 2018.

g) Annual Quality Report

The directors are required under the Health Act 2009 and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The 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 for the year ahead. In developing the report the Trust has engaged with staff, patients and carers, Council of Governors and Board of Directors.

The Quality Account details progress against the Trust's quality improvement initiatives across our mental health and community services in 2018/19 and sets out the Trust's key priorities for quality improvement in 2019/20. The four initiatives chosen by our stakeholder groups for the next 12 months are:

- Care Planning (this will be the third year of a three-year initiative)
- Learning Library (a five-year initiative)
- Just Culture (a five-year initiative)

The Quality Account presents a picture of people's commitment and skills to ensure that quality will always be central to service delivery.

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 2018/19 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, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance.

The external auditor's review of the Quality Report, prepared for the Council of Governors for the period 2017/18 issued an adverse qualification on the two mandated indicators as a result of data quality issues. The Trust instigated an improvement plan to address those issues, which has seen a generally improved position.

The report for 2018/19 reports an improved position in that the testing of the inappropriate out of area placement indicator found no evidence that this indicator is not reasonably stated, in all material respects, in accordance with the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance, however noted that the testing of the Early Intervention in Psychosis (EIP) indicator identified errors in five of the 25 cases tested, which resulted in this indicator being qualified due to data errors. Whilst it was recognised that these errors did not impact on the overall reported achievement of the standard, the external auditor has raised a recommendation for improvement to the compilation procedures for the EIP indicator. The Trust acknowledges that ongoing work is required to support further improvements in this area and will continue to provide training and support to all teams on a routine basis to ensure it becomes an embedding of practise issue.

h) Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust refreshed its governance structures in early 2018 to improve the flow of assurance throughout the organisation up to the Board and continues to monitor the effectiveness of these arrangements. Each sub-Board level assurance committee assesses its own performance annually, in line with best practice guidance, ensuring its terms of reference, annual work plan and agendas focus their discussion appropriately.

The Audit Committee supports the Board by critically reviewing and reporting on the relevance and robustness of governance structures, assurance processes and systems of internal control, on which the Board places reliance.

The Trust's internal audit programme is planned annually using a risk-based approach and is overseen and reported through the Audit Committee. The Committee receives ongoing reports on the progress of the audit plan and evidence on the implementation of audit recommendations.

Conclusion

As outlined above, the Trust is working closely with NHS Improvement with a view to removing the enforcement undertakings upon submission of the strategic sustainability plan and hence I can confirm that there are no significant control issues in the Trust in 2018/19.

I have drawn on the content of the Quality Account attached to this Annual Report and other performance information available to me. The Trust has committed to address the issues identified around EIP data recording and will implement and monitor the robust improvement plan put in place.

My review is also informed by assurance and evidence to support its development from the Trust's External Auditors.

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.

My review concludes that Pennine Care NHS Foundation Trust has generally sound systems of internal control that support the achievement of its policies, aims and objectives.

Signed

Claire Molloy
Chief Executive
24 May 2019

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 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; 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.

Material uncertainty related to going concern

We draw attention to note 1.2 ‘Going Concern’ in the financial statements, which indicates the Trust has a planned breakeven position for 2019/20 after the anticipated receipt of £12 million of Provider Sustainability Funding (PSF) and Financial Recovery Funding (FRF). The receipt of PSF and FRF is dependent on the Trust meeting the £12 million deficit target set for it by NHS Improvement. Despite planning to meet this target, the Trust still forecasts that it will need to obtain a revenue loan from the Department of Health and Social Care (DHSC) in 2019/20. As stated in note 1.2 DHSC has not, at the date of our report, confirmed that this loan will be provided.

These conditions, along with the other matters as set forth in note 1.2 to the financial statements, indicate that a material uncertainty exists that may cast significant doubt about Trust’s ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Overview of our audit approach

Financial statements audit

- Overall materiality: £4,650,000, which represents 1.64% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
- Going concern material uncertainty
- Occurrence and accuracy of contract variations and other operating revenue.
- Valuation of land and buildings.

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

- We identified two significant risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (see Report on other legal and regulatory requirements section).

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 Occurrence and accuracy of contract variations and other operating revenue and existence of associated receivable balances Approximately 90% of the Trust's income is from patient care activities and contracts with NHS commissioners and other NHS bodies. These contracts include the rates for and level of patient care activity to be undertaken by the Trust. We have considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue. We have rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We have determined these to be income from: • contract variations • other operating revenue. The block contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust recognises patient care activity income during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in these contracts (e.g. contract variations) are subject to verification and agreement by the commissioners and may include estimates. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognition of income from patient care activities for appropriateness and compliance with the Department of Health and Social Care (DHSC) group accounting manual 2018/19 • updating our understanding of the Trust's system for accounting for income from patient care activities and evaluate the design of the associated controls • agreeing on a sample basis income from contracts with commissioners to signed contracts • agreeing a sample of any contract variations to supporting evidence • assessing the Trust's estimates and judgments taken in order to arrive at the income recorded in the accounts • examining variances in income and expenditure and receivables and payables between the Trust and other NHS Bodies of £300k and above • agreeing income to NHSI notifications in respect of Provider Sustainability Funding. Key observations We obtained sufficient audit evidence to conclude that: • the Trust's accounting policies for recognition of contract income and other operating revenue comply with

Key Audit Matter	How the matter was addressed in the audit
We have therefore identified the occurrence and accuracy of contract variations and other operating revenue and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement and a key audit matter. Risk 2: Valuation of land and buildings The Trust re-values its land and buildings on a regular basis to ensure that the carrying value is not materially different from current value in existing use. This 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.	the DHSC group accounting manual 2018-19 and have been applied appropriately • income from patient care activities and other operating income and the associated receivable balances are not materially misstated. Our audit work included, but was not restricted to: • Evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work; • Evaluating the competence, capabilities and objectivity of the Trust's valuation expert; • Discussing with the Trust's valuer the basis on which the valuations were carried out and challenging the key assumptions applied; • Challenging the information used by the valuer to assess completeness and consistency with our understanding; • Testing, on a sample basis, revaluations made during the year to ensure they have been recorded accurately in the Trust's asset register; • Evaluating the assumptions made by management for any assets not revalued during the year and how management has satisfied themselves that carrying value is not materially different to current value in existing use. The Trust's accounting policy on valuation of land and buildings is shown in note 1.6 to the financial statements and related disclosures are included in note 16. Key observations We obtained sufficient audit evidence to conclude that:

Key Audit Matter	How the matter was addressed in the audit
	• the basis of the valuation of land and buildings 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.

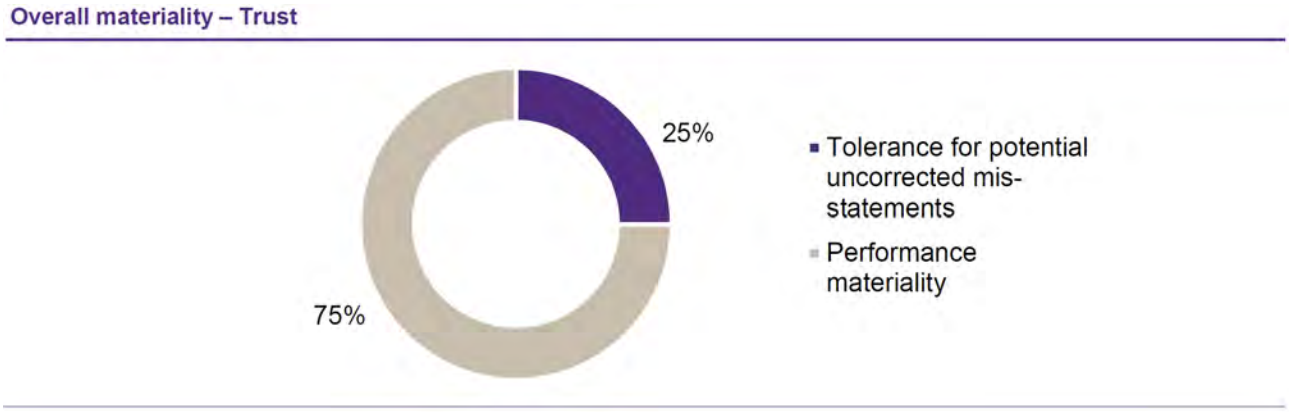
Our application of materiality

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	£4,650,000 which is 1.64% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is lower than the level we determined for the year ended 31 March 2018 to reflect our view that the financial challenges and risks for the Trust and the wider NHS sector have increased in 2018-19.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	The senior officer remuneration disclosure in the Remuneration Report has been identified as an area requiring specific materiality of £5,000 based on the disclosure bandings, due to its sensitive nature.
Communication of misstatements to the Audit Committee	£233,000 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, its environment and risk profile. It included an evaluation of the Trust's internal controls including relevant IT systems and controls over key financial systems.

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile. It included an evaluation of the Trust's internal controls including relevant IT systems and controls over key financial systems.

The scope of our audit included:

- obtaining supporting evidence, on a sample basis, for all of the Trust's material income streams;
- obtaining supporting evidence, on a sample basis;
- obtaining supporting evidence, on a sample basis, for property plant and equipment and the Trust's other material assets and liabilities.

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 obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a

material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the 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
- 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 2018/19 or is misleading or inconsistent with the information of which we are aware from our audit. 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 2018/19 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 issue a report 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 refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take 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 the Chief Executive's responsibilities as the accounting officer, 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 2018/19, 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 Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in respect of the above matter.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Key Audit Matter	How the matter was addressed in the audit
Risk 1: Financial sustainability The Trust continued to operate under significant financial pressures. A deficit control total of £6.4m was been agreed with NHSI for 2018-19 which included £1.9m of Provider Sustainability Funding (PSF) funding. The Trust was expecting to carry an underlying deficit into 2019-20 and was likely to forecast a break even position. The Trust was expected to require cash support during 2019-20 to meet its operational responsibilities. We continued to monitor the Trust's financial position and considered the year end outturn position to secure PSF funding. We will also considered the adequacy of cash resources in the context of the 2019-20 budget position and associated levels of CIP required to be achieved in the coming year.	Our audit work included, but was not restricted to: • monitoring the Trust's financial position throughout 2018/19 • evaluating the delivery of the Trust's cost improvement programme for 2018/19 and the viability of its 2019/20 programme • assessing the adequacy of the Trust's cash resources in the context of its 2019/20 budget. Key findings No issues have been identified that would suggest that the Trust does not have adequate arrangements in place for delivering economy, efficiency and effectiveness in the use of its resources
Risk 2: Community Services transfer In December 2018, the Trust took the decision to work with partners to support the move to a new locality- based service model for community services. In doing this the services will be transferred to new providers who are most able to deliver integrated care. Discussions were ongoing with commissioners, however, it was anticipated that the transfers for all four localities will be completed by September 2019. We considered the implications of this on the Trust's immediate financial reporting and its medium to long term financial sustainability. We considered the extent to which the financial plan for 2019-20 was aligned with the baseline funding and productivity assessment that was underway and the implications that this had for the longer term transformation programme.	Our audit work included, but was not restricted to: • Reviewing the implications of this transfer reflected in the 2018/19 financial statements • Reviewing the progress of the baseline data review (single version of the truth) and the progress and current status of the development of a phased transformation plan and aligned contracting plans • Review of the status of the Corporate Services Transformation. Key findings No issues have been identified that would suggest that the Trust does not have adequate arrangements in place for delivering economy, efficiency and effectiveness in the use of its resources.

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 2019, 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.

Use of our report

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.

Gareth D Mills

Gareth Mills, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Leeds

24 May 2019

Pennine Care
NHS Foundation Trust

2018-19

QUALITY ACCOUNT

Pennine Care NHS Foundation Trust

CONTENTS

Part One: Quality Aspirations

1.1 Welcome Statement from the Chief Executive on Quality

Welcome to our Quality Account for 2018/19. This document provides an overview of the quality of the services we provided over the past twelve 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.

The past twelve months have been momentous in terms of transition as we develop an ambitious new Trust strategy, with a greater emphasis on quality.

We have spent time appreciating where we have been and what we have learned; recognising where we are now; and determining where we want and need to be in the future.

This has been an extremely valuable piece of work which has allowed us to identify our strengths and weaknesses and better understand the opportunities and challenges which may face us in the future.

We can be proud of our achievements in 2018/19 and positive about the future.

Our future Trust strategy will focus on improving and enhancing our mental health, learning disability and wellbeing services in their broadest sense, within our available resources. It will also allow us to capitalise on the national focus on mental health.

In order to ensure we provide the highest quality services in the years ahead, we need to concentrate on where we add the greatest value to the communities we serve.

As part of this new strategy, our community (physical health) services in Bury, Oldham, Rochdale and Trafford will transfer to new NHS provider organisations. We have been very proud to run these services over the last seven years and there have been significant achievements, but we believe other provider organisations are better positioned to enable community health services to achieve more for the benefit of local people.

We know that to achieve all we want we need an organisation that is built on trust and empowerment; a team that is respectful of each other and driven by individuals at all levels.

To support such a culture, a lot of work is taking place on refreshing our vision and values.

I’m also proud that we have become one of the first NHS Trusts in the country to adopt a *Just Culture* approach.

The *Just Culture* initiative is already being used in the airline and nuclear industries for example, and is based on an approach where staff are not blamed for honest errors, but instead feel supported and encouraged to come forward and share experiences to allow lessons to be learned. It aims to get to the heart of what, not who, was responsible for the error. This will form part of the wider piece of work around culture and values.

Our improvement journey to a CQC ‘good’ rating continues.

We received an overall ‘requires improvement’ rating from our CQC inspection in September 2018; and, whilst the overall and five domain ratings did not change from the previous inspection in 2016, the report felt very different. It recognised the significant improvement we have made in many areas and that we are on a positive journey towards ‘good’.

Our quality strategy has been refreshed and we have improved our quality governance through a number of ways, including investment in clinical and professional leadership, clinical presence visits and shared learning.

We have also revised our patient experience strategy. Quality is not a dashboard of statistical measurements; it is also the perception of our patients and their families and carers, and how they feel about their experience whilst under our care.

An extensive mental health integrated programme is underway, as well as extensive work to deliver on improvement priorities such as safer staffing, mixed sex accommodation, crisis care and use of informatics.

We recognise our challenges, especially around recruitment and financial sustainability. As well as showcasing some of our strengths, importantly this report also highlights areas we are clear we need to improve.

High quality can only be achieved if everybody is pulling in the same direction, and we recognise that this includes building excellent relationships with our partners and through our clinical networks, as these are vital to our success.

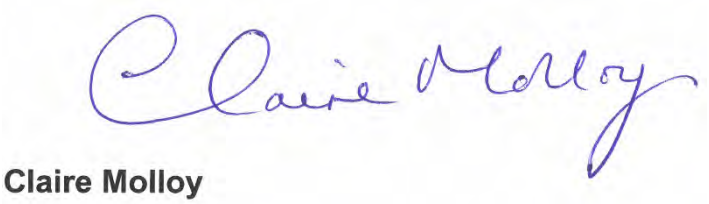
We have an exciting time ahead of us and our new strategy will provide us with a clear, focussed direction for the future. Quality is at the heart of this and our key driver for all the developments and improvements we wish to make.

Through using data from the analysis of our services, along with maximising feedback opportunities and building on what we learn from our patients and their families, we will be continuously improving our quality standards.

Our staff continue to be our most valuable asset and we could not achieve all we have, or want to in the future without their commitment, dedication and loyalty. I would therefore like to close by thanking them for their tremendous dedication and outstanding contribution.

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.

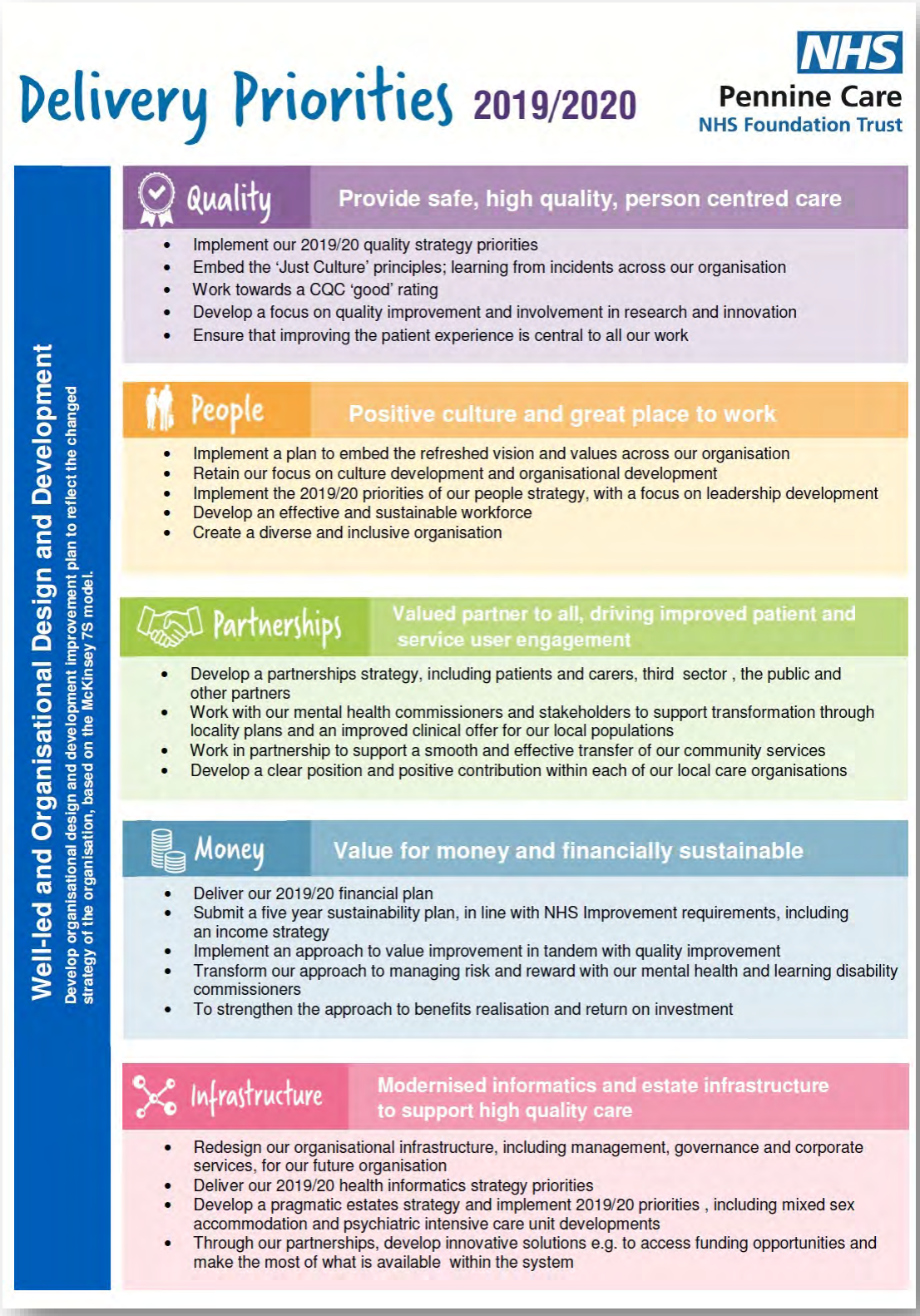


Claire Molloy

Chief Executive

24 May 2019

1.2 Our Vision and Strategic Goals



Part Two

2.1 Priorities for Quality Improvement

Priority One: Quality Improvement Programme

Two years ago, the 2016/17 Quality Account introduced the Quality Improvement Programme as a two-year quality priority. The Quality Improvement Programme details fifteen emerging themes from the CQC report published following inspection of Pennine Care NHS Foundation Trust in summer 2016.

Four of those emerging themes were chosen through a voting campaign engaging 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. The Quality Account 2017/18 reported the work undertaken and the progress made during that year.

These four workstreams are now discussed in detail, telling our reader why we consider each is important, what we aimed to achieve over the two-year project life, the progress made, how we have tracked performance and improvement, how we have shared 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, and we have been working on this area as a quality improvement initiative.

The CQC inspection conducted in 2018 recognised some of the positive work undertaken but did highlight further areas for improvement in relation to collaborative care planning.

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

In 2016 we set the Care Planning initiative as a quality priority and reported to the Trust's Quality Committee on the developments. As the second year comes to an end, we have decided to extend this initiative for a further year to ensure new documentation is embedded into practice.

We stated a Trust Lead would be identified to facilitate the second phase of the initiative, this has been a small project team rather than one identified person.

What we have achieved this year

We have moved to the second phase of this quality initiative. Care planning is included in the Trust's Clinical Audit Programme. A clinical audit proforma has been developed by the project team and that includes a set of five minimum core standards, supported by best practice standards.

Core Standards

1.	Care plan is present
2.	Care plan is up to date
3.	Service user individual needs are recorded
4.	Evidence of service user involvement in the plan
5.	Service user preferences are recorded

Six inpatient wards are audited on a monthly basis; two each from Adult, Older People and Rehabilitation & High Support services, and six health records per ward are audited. The fieldwork for this roll out of the audit has been undertaken by our Modern Matrons.

A monthly report is produced to support the results published in the Quality Report for the Quality Committee, and individual reports are generated for each ward area to ensure actions are taken in relation to improvement.

To support staff and help to share best practice ideas, the clinical teams have been issued with a best practice handbook. This initiative was recorded in the CQC report 2018 as outstanding practice.

What we plan to do next

The CQC report, published in January 2019 articulates two "should do" recommendations.

1) Ensure care plans are completed to meet individual needs and take into consideration the communication needs of patients with Learning Disabilities.

The Trust plans to hold a workshop with Managers and Clinicians from Adult wards and Learning Disability Services to explore how reasonable adjustments can be incorporated into care planning for people who have a learning disability on Adult wards and Psychiatric and Intensive Care Unit, sharing best practice examples.

2) Consider an appropriate audit tool, to provide assurance that collaborative care planning is fully implemented and that care plans are produced to meet individually assessed need.

The CQC found our care plans were easily identifiable in the records and that families and friends were given the opportunity to be involved in patient care if the patient wished it, but they noted inconsistencies. The report stated the plans were not always personalised, holistic and recovery orientated.

Pennine Care NHS Foundation Trust's care plan audit will continue to measure compliance against the five core standards and best practice standards, across six wards per month (six records per ward audited). This is a rolling cycle. The next step, the third phase of our care planning work will be to expand the audit to six records per ward per month, across all inpatient wards, creating a larger spread to allow more effective reporting and targeted improvement.

How we track performance and improvement

- Audit results included in the Quality Report for the Quality Committee
- Wards receive individual reports
- Reporting to local Integrated Leadership Groups (ILG)

How we share lessons learned, good practice and improvements

We will share lessons learned, good practice and improvements through effective reporting; with targeted improvement plans, supported by a range of communication processes for sharing best practice.

How we plan to sustain quality

The Clinical Audit Programme will support this on-going quality initiative, testing compliance. Learning will be both targeted and shared wider.

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

The aim of this quality improvement initiative is to 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 during 2018/19

We have continued to develop and deploy clinical forms for use in Community Services including Paediatric Speech and Language Therapy, Community Paediatric Consultants, Falls team, Community Physiotherapy, Paediatric Occupational Therapist, Community Paediatric Teams, Looked After Children, IV Therapy Services, School Nursing, Health Visiting, and Child Protection Service, enabling these teams to move away from paper records. We have successfully migrated four child health information systems into one to ensure that immunisations and vaccinations are appropriately tracked. The Out of Hours services in Bury are now live with the Child Protection Information System (CPIS). The Audiology service across Rochdale, Oldham and Bury have been migrated to a single electronic system and all the Healthy Young Minds and Psychological Medicine teams are working electronically. In February 2019, thirty nine teams and several hundred staff in Learning Disabilities and Access services (RAID, HTT, HIT), were migrated to a single electronic record. All of these developments allow the services to work electronically with a single record and decommission paper records.

The Greater Manchester Street Triage Team is accessing systems across all three mental health providers in Greater Manchester to allow them to support police colleagues. In addition, we have completed technical work that allows all public sector employees to use the internet in Pennine Care NHS Foundation Trust buildings (govroam).

We have had three independent reviews completed within the last six months:

- Greater Manchester Health and Social Care Partnership commissioned a review on Pennine Care NHS Foundation Trust and Greater Manchester Mental Health to understand the opportunities for collaboration within Health Informatics between the organisations. This has made a number of recommendations where the Trusts could collaborate.
- Greater Manchester Health and Social Care Partnership commissioned an independent review (across all Greater Manchester organisations) of twenty five systems by a consultancy to understand whether we could gain quality and/or financial improvements by moving our applications to the cloud. This found that the organisation has invested very shrewdly in its data centres and servers, which means there is no compelling financial case to move services to the cloud currently.

- The Information Team have had a follow-up audit on improvements they were asked to make three years ago which has found they have made excellent progress.

We have engaged a consultancy to advise us on how to manage the wide diversity of clinical paper records that the Trust has and we have drafted a business case for the purchase and deployment of a system to do this.

We are working with colleagues across all localities to ensure that an Integrated Digital Care Record is available to all clinicians for the purposes of direct patient care. This is part of the Share For You initiative and we will go-live in Heywood, Middleton and Rochdale with our first set of data.

We will build within the Trust, a robust and reliable Clinical Safety Officer function to ensure good quality risk assessments are completed for all Health Informatics implementations and changes.

What we plan to do next

2019/20 will be a very exciting year for the technology initiatives and includes:

- The use of PARIS as an electronic record across all our inpatient departments
- The purchase and deployment of an electronic prescribing and medicines administration system
- Enabling electronic referrals from GP into our mental health services
- Supporting the Greater Manchester electronic record across all six of our localities, by sharing our clinical data from community and mental health systems

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. Sponsors are senior leaders within operational and clinical management, who ensure a close alignment between Pennine Care NHS Foundation Trust objectives and the deployment of technology.

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 won an award at this conference in September 2018 for workforce development.

Our Head of Information won a national award as a Future Digital Leader and our e-rostering project manager won a Rising Star at the Women in Information Technology (IT) Excellence awards.

We were shortlisted for the following National Information Technology awards:

- UK IT Industry Awards - Best Not Profit IT Project of the Year - Improving Community Clinical Recording and Information Exchange
- UK IT Industry Awards - Chief Information Officer of the Year

- Women in IT Excellence - Digital Leader of the Year - Head of Information
- Women in IT Excellence - Software Engineer of the Year - Systems Developer

How we aim to sustain quality

Our ambition is to complete the next level of Informatics Skills Development Accreditation, which helps us to bench mark ourselves against our peers and ensure we are keeping up to date with the latest developments.

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 aim of this quality improvement initiative is to 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 during 2018/19

Each locality across the North East sector; Bury, Oldham and Heywood, Middleton and Rochdale (HMR), has committed investment to implement a safe haven service, using the Greater Manchester allocation funding to support ‘enhanced crisis care’ options, with a view to support a reduction in the number of short-stay admissions and a strengthened community offer for people who experience a mental health crisis out of hours.

The service will operate from 5pm-8am five nights (Monday to Friday) in Bury and Oldham, and seven nights a week in Heywood, Middleton and Rochdale. The delivery model in Oldham and Bury is a partnership approach with the third sector. In Heywood, Middleton and Rochdale, the safe haven will be supported by third sector enhanced pathways.

A business case has been developed by each Clinical Commissioning Group and agreed through governance processes. Programme implementation plans have been developed for all three Boroughs which will be delivered through locality mobilisation groups.

The planned start dates reported in October 2018 were anticipated as December 2018; however, delays have been encountered due to recruitment difficulties; i.e. recruiting the number of qualified practitioners required to safely support the service model across all three localities, together with the need to undertake work to the estate to develop an appropriate environment for the service (relevant to Heywood, Middleton and Rochdale and Bury).

The Oldham Safe Haven service is now operational 5 nights per week and the HMR Safe Haven service is operational 7 nights per week. The mobilisation of Bury Safe Haven service is still to be confirmed.

Recruitment has been a significant risk, both in managing to recruit external candidates and the impact of internal applications to the posts. The majority of staff recruited to the new safe haven posts have come from other mental health services such as Inpatients, Home Treatment Teams and Community Mental Health Teams. The impact of this on core services have had to be carefully managed locally and contributes to some of the delay in mobilising the safe havens; e.g. the time taken to release staff from substantive posts.

The service specification is in development and will be a common specification across the three localities, with locality specific sections where required.

The Stockport Borough was an early adopter of this approach and has had the Stockport Team for Early Management (STEM) service in operation for approximately two years. This has been evaluated to have a positive impact on short-stay admissions within the Borough. The Clinical Commissioning Group has committed to extending the working hours through a business case process. Stockport Clinical Commissioning Group has also progressed plans to develop a day-time crisis offer / one stop shop with the Greater Manchester transformation funding. This model in still in development and is being designed through a partnership including the Trust, Local Authority, Stockport Homes, the Police, third sector and people with lived experience.

Tameside & Glossop Clinical Commissioning Group have yet to confirm their investment in a safe haven offer within the locality; however, they are engaged with the Trust in discussions about developing it in conjunction with investment in Home Treatment and Mental Health All Age Liaison. This proposal is currently being developed and costed.

What we plan to do next

We need to fully mobilise the safe haven services across the North East Sector and then work to evaluate their impact on the crisis pathway within the locality.

There are on-going discussions with all five Clinical Commissioning Groups in terms of the local benchmarking of Crisis Resolution and Home Treatment Teams against the national core fidelity model. Whilst the safe haven developments will go some way to supporting 24/7 services, they do not address some of the outstanding skill-mix issues within the teams or the numbers of staff required to support intensive home treatment (as described in the core fidelity guidance). The Clinical Commissioning Groups have until 2020/21 to address these short falls.

How we track performance and improvement

The Crisis Resolution and Home Treatment Team developments, which include the safe haven model, are encompassed within the ‘Alternatives to Admission’ work stream which forms part of the Integrated Mental Health & Learning Disability Programme; which is the governance framework for managing and monitoring all transformation work happening across the Trust. All performance and improvement is reported through the Programme Board which is chaired by the Medical Director. The programme of work is overseen by the Managing Director for Mental Health Services, who also acts as Senior Responsible Officer for delivery of the programme.

Once fully mobilised, the safe haven models will need on-going evaluation and performance monitoring to ensure that they impact on activity flows in the way that they were intended to impact. These services are new and previously un-tested, so this will be crucial to ensuring on-going investment and support for the model. The key performance indicator will be the impact on short-stay admissions (less than five days) and we envisage that this will reduce over time. However, the evaluation will also take into account service user feedback and seek to evidence positive clinical outcomes for patients.

How we will share lessons learned, good practice and improvements

As outlined above, this will be via the Integrated Mental Health & Learning Disability Programme Board at a senior level within the organisation, as well as through the Trust Quality Group. Lessons learned and good practice will also be shared within the Mental Health Integrated Leadership Group and through to the Borough Integrated Leadership Groups to ensure synergy with operational services. The work streams within the programme are also being shared regularly through the Trust’s Service User and Carer Forum and via the new Mental Health and Learning Disability Intranet page, where there is a specific section on transformation and service development.

How we will sustain quality

We will work to sustain the quality of the service through regular reviews of staffing levels and through adopting a quality improvement approach locally. This will be supported by the Associate Director for Mental Health within the Borough, the new ‘Acute Service Manager’ roles which are being created and funded through safer staffing investment; with an operational management responsibility for inpatients and Crisis Resolution and Home Treatment Teams, together with the locality Quality Lead. Quality will also be regularly monitored through service user and carer feedback mechanisms within the locality.

Externally to the organisation, the locality Urgent Care Boards are very keen to understand the impact on both urgent care demand / activity, as well as service user experience, with the introduction of the safe haven models. The impact and quality of the services will also be monitored and reported through this external partnership forum.

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.

Bed Occupancy Older People	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
	90%	89%	89%	97%	96%	97%	95%	97%	90%	94%	88%	86%	85%*

Bed Occupancy Adult Wards	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
	90%	99%	99%	98%	98%	97%	97%	96%	98%	98%	99%	96%	96%*

*Data to be refreshed on 30 April 2019 following validation checks and end of quarter submissions

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

This quality improvement initiative aims to enable the Trust to 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 during 2018/19

A new bed management function has been developed now called the Patient Flow Hub which will cover all adult and older people's inpatient beds. A 30 day consultation has concluded and all jobs are currently being advertised. The service is expected to be operational by July/ August 2019 based on successful recruitment.

The Patient Flow Hub will operate out of a centralised hub office in Bury; however, will be an outreach service and will have visible presence in all localities. The bed management protocol has been reviewed and is in operation and has a section regarding placing people close to home and also repatriation guidelines have been reviewed. Repatriation is focussed on clinical appropriateness.

The positive improvements realised from the Delayed Transfer of Care (DTOC) work programme has been maintained; however, as expected there have been fluctuations in performance across the patch.

A Delayed Transfer of Care escalation procedure has been developed with Greater Manchester principles and local timescales and escalation hierarchy based on organisational form. This is to be agreed with our Clinical Commissioning Group and Local Authority colleagues over April 2019.

The Trust continues to work with Commissioners on the Mental Health Integrated Programme and sustainability, led by the Greater Manchester Health and Social Care Partnership, one of the key workstreams being focussing on inpatient services and the sustainability. A key objective of which is to improve patient flow and eradicate any identified unwarranted variation and a key objective is to effectively reduce occupancy rates working towards the nationally identified best practice of 85% as recommended by the Royal College of Psychiatrists. This workstream is far reaching and covers all parts of the inpatient and community acute and crisis care pathway, including review of gatekeeping. The workstream is led by a dedicated clinical project lead.

A locality workstream meeting has been convened in each Borough. The local group will review Trust wide data presented at the Consultants and inpatient away days to identify and implement sustainable improvements.

The Trust continues to experience high demand for inpatient services and is working in collaboration with The Priory Group to manage demand. This includes continuing to commission 8 acute beds (reduced from 10) and newly commissioned 4 female Psychiatric and Intensive Care Unit beds on behalf of the Clinical Commissioning Groups.

The Trust continues to work to deliver the Greater Manchester 10 point plan to eradicate inappropriate out of area placements by 2021, in collaboration with Commissioners and other Greater Manchester mental health providers and has successfully reduced the number of out of area placements in year.

Alternatives to admission transformation schemes are mobilised in two of the three Boroughs, with Bury mobilisation planned for late April 2019. The key outcome is to provide an alternative to, and therefore reduce admissions (in particular short stay admissions). These schemes are designed to positively impact on occupancy rates on the inpatient units and support longer term sustainability of secondary care mental health services.

The Trust has operated a daily patient flow/ bed management call since the start of the calendar year. The purpose of the call is to support whole system patient flow across all boroughs and adult and older people’s beds. The call facilitates timely escalation and resolution of patient flow issues.

The Trust has worked with the North East Sector Clinical Commissioning Group and V4 consultancy to develop a first draft Operational Pressures Escalation Level framework for mental health that will contribute to the overarching locality Operational Pressures Escalation Level score.

What we plan to do next

Continue to mobilise the patient flow hub and to mobilise/evaluate the safe havens. Work with commissioners regarding the plan for investment in core services that support alternative to admission as per the requirements of the Five Year Forward View to have a CORE compliant Crisis Resolution and Home Treatment Team by 2020/21.

The Trust will continue to work with commissioners to maintain and further improve the Delayed Transfer of Care rates across all services.

Undertake significant focussed work in each Borough to make improvements in the inpatient Mental Health Integrated Programme workstream, including development of agreed standards and processes.

The patient flow daily phone calls are being reviewed and expanded to include a broader range of services that can impact on flow.

How we track performance and improvement

Continue to review a range of inpatient indicators such as occupancy and Delayed Transfer of Care rates.

How we will share lessons learned, good practice and improvements

Lessons and good practice will be shared through a number of forums including the Ward Manager Forums, Acute Care Forum and the Mental Health Integrated Programme Board. The Trust will also share good practice across Greater Manchester via the Greater Manchester Out of Area Placement Group.

How we will sustain quality

Sustained quality will be led through the Borough inpatient workstream meetings and over seen by the Acute Care Forum and Mental Health Integrated Programme Board.

Priority Two: Mixed Sex Accommodation

Why we consider this is important

National guidance from the NHS Operating Framework (2011/2012) 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 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.

What we aimed to achieve

The aim of this initiative is to achieve an improved Quality and Safe Care and to be regulatory compliant.

What we have achieved during 2018/19

In June 2018, an engagement and involvement programme was commenced by the Trust. This included a three stage process:

1. Ward Managers having informal conversations with staff, patients, carers and families as regards to the issues around Mixed Sex Accommodation and potential changes to Same Sex Accommodation. This process also included recording views and extending invitations to attend facilitated group sessions with patients and staff on the wards.
2. Facilitated sessions from end of July 2018 through to September 2018 asking patients questions about experiences around privacy, dignity and safety, as well as their views on potential moves from Mixed Sex to Same Sex Accommodation. Feedback from the 18 sessions on older people and adult wards has been used to inform development of an on-line survey as part of the final stage of the engagement process. Follow-up sessions during visiting times on the wards were also facilitated.
3. On-line survey was launched 23 October 2018 and ran through to 26 November 2018. This survey was sent direct to all Pennine Care NHS Foundation Trust staff, Commissioners, service user groups, local authority partners, CQC, third sector groups etc.

   Feedback from this survey was combined with feedback from all three stages described earlier to inform an independent analyst report. This feedback report was presented to the Trust Board on the 11 February 2019 as well as the Joint Health and Scrutiny Committee on 26 February 2019.

   - Stage 1 of the process resulted in **327 response forms** being returned.
   - Stage 2 involved a total of **197 participants in the focus groups**.
   - Stage 3 on-line survey to **wider stakeholder groups** resulted in **640 responses**.

A number of presentations have also taken place with Governors and Pennine Care NHS Foundation Trust Service Users Group to update on progress. A presentation was also given to the CQC inspection team.

As part of the learning process, on 6 November 2018, the Executive Director of Nursing, Service Manager, Director of Estates and Assistant Director of Operations visited Redwoods Centre in Shrewsbury as an example of best practice, (highlighted in the CQC Report on Sexual Safety on Mental Health Wards, September 2018).

Other activities includes a review and update to the Bed Management Protocol and mixed sex accommodation algorithms, new signage being deployed onto wards and a mixed sex accommodation poster and leaflet has been designed and is being printed for all wards.

What we plan to do next

Findings from the feedback report highlighted the following which are now being considered by the organisation, some of which are in the process of being actioned:

- The Trust needs to provide on all wards at all sites Single Sex Accommodation with En-Suite facilities.
- There should be separate wards for Functional and Organic patients.
- Involve patients, carers and staff more in design of services.
- Continue to empower staff.
- Increase levels of Continued Professional Development to equip staff with appropriate skills to offer patients better quality of care.
- Provide greater number of Occupational Therapists on wards to increase therapies and activities for patients.
- Provide more activities and if possible access to quiet outside space.
- Location is important; however, more important is safe patient care.

The Trust Board is now considering these findings as well as comments from the Joint Health Overview and Scrutiny Committee (JHOSC) members. The Board has committed to having a clear picture of how a solution to the mixed sex accommodation issue is taken forward by the end of May 2019. This will involve a prioritisation exercise for:

- Delivering and managing mixed sex accommodation.
- Eradication of dormitories.
- Delivering services that are specifically separate for functional and organic patients over the age of 65.

How we track performance and improvement

- We report all breaches using the National Unify System.
- We collate feedback from patients, carers and staff.
- We monitor the number of incidents linked to mixed sex accommodation and mixing of functional and organic patients.
- Reduced spend directly linked to increased observations for the purposes of managing mixed sex accommodation.

How we will share lessons learned, good practice and improvements

We will share lessons learned from the programme of works and the implementation plan as we roll out the work across the Trust through the mixed sex accommodation regulatory group.

How we will sustain quality

- By being regulatory compliant, and reporting any breaches.
- Including in the Trusts Quality and Safety inspections.

Priority Three: Learning From Deaths

Why we consider this is important

In December 2015, the Secretary of State for Health commissioned CQC to carry out a review of how acute, community and mental health trusts across the country investigate and learn from deaths to find out whether opportunities for preventing deaths have been missed, and identify any improvements needed. (CQC 2019; Learning from Deaths A review of the first year of NHS Trusts implementing the national guidance). https://www.cqc.org.uk/sites/default/files/20190315-LfD-Driving-Improvement-report-FINAL.pdf

In March 2017, the national guidance on learning from deaths set clear expectations for how NHS Trusts should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death. It also described Trust Board's responsibilities for ensuring this happened. In July 2018, additional guidance for NHS Trusts on working with bereaved families and carers was published by the National Quality Board. It was developed by NHS England in collaboration with families who have experienced the death of someone in NHS care and have been involved in NHS investigations, as well as with voluntary sector organisations. Pennine Care NHS Foundation Trust is committed to following the National Guidance and believes that it is consistent with our values to learn from deaths.

What we promised to do

- Deliver a Learning from Deaths policy
- Join the Royal College of Psychiatrists pilot study for employing the Structured Judgement Review (SJR) tool as a method to review deaths in addition to investigations occurring under the Serious Incident framework
- Establish a Greater Manchester Mortality Review Group whereby we join other local NHS mental health providers in reviewing data and lessons to be learned from deaths not meeting serious incident criteria; we also agreed to set up a joint suicide prevention forum.

- Embed the governance process for Structured Judgement Review within our clinical governance processes.
- Recruit five additional Band 8a Quality Lead posts to support this agenda.
- Establish a Non-Executive Director Lead for learning from deaths.
- Embed involving families directly in the construction of the terms of reference for deaths meeting the serious incident framework.

What we have done so far

- Have a Learning from deaths policy.
- Have a nominated Non-Executive Director Lead for deaths.
- Formed and contributed to the joint provider mortality review groups.
- Established and filled the Quality Lead posts.
- Embedded the governance processes of Structured Judgement Review into a range of methods for reviewing deaths within the Trust's options.
- Routinely involve families now in delivering the Terms of Reference for investigations into the deaths of loved ones.
- Invested in STORM v.4 as training package.
- Invested in Band 8a Persons Affected and Bereaved By Suicide training (PABBS).

How we tracked performance

We track the numbers of deaths reviewed via our Board dashboard and via the Quality metrics that form part of the Quality Committee. This is also replicated and reviewed in more detail at the Mortality Review Group.

We use the Continuous Learning Forum to theme deaths by service line for review with clinical and executive colleagues.

We also track performance via contract reporting to clinical commissioning colleagues and to Quality Committee and Quality Group.

How we shared lessons, good practice and improvements

The Trust uses a range of methods to share lessons to be learned, lessons learned, and good practice, these include 7-Minute Briefings, Continuous Learning Forums, clinical bulletins and the development of quarterly transformative learning events with individual clinical teams to review either specific deaths or themes arising from deaths.

The Patient Safety Lead has worked with Dr Ng Man Kwong Georges (RW6) Pennine Acute Hospital NHS Trust at the Royal Oldham Hospital to deliver a shared presentation at a Grand Round[1] for mortality reviews for shared care patients; this is going to be taken forward by Pennine Care NHS Foundation Trust liaison psychiatrists and colleagues to deliver two initiatives initially; support for Pennine Acute (Northern Care Alliance – Royal

[1] Grand rounds are methodology of medical education and inpatient care, consisting of presenting the medical problems and treatment of a particular patient to an audience consisting of doctors, residents, and medical students.

Oldham Hospital site) to develop a *no-force first* rapid tranquilisation policy and secondly, a protocol and standard for patients with dementia to arrive on medical wards with standardised care plans and clarity of instructions for their dementia-care.

What we plan to do next

Deliver a Learning from Deaths workshop to widen the perspective on learning from deaths to include alternative uses of the Structured Judgement Review tool.

Develop post-vention standards for families and workforce following a death of a patient

The patient safety lead has been invited with Greater Manchester Mental Health colleagues to discuss how providers support both families after bereavement by suicide and through the investigation process at the next Greater Manchester STORM Conference 2019.

How we aim to sustain quality

We have our Quality Strategy within which there is a clear work-stream for Learning from Deaths and this is a clear mandate that remains a priority for the Trust.

In partnership with Greater Manchester colleagues and wider stakeholders we will review and renew our clinical governance processes to reflect intelligent changes that bring about positive-change for patients and their families.

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

The Trust is planning a piece of work using the Quality Strategy to review how we learn as a Trust and this will involve a new Learning Library where lessons learned, good practice and improvements will be showcased.

The Risk Department are continuing to work with the Performance Department to develop bespoke Tableau reporting for deaths in real time and accessible at clinician and team level.

Introducing our new Quality Priorities

We'd like to now introduce our new quality priorities, Just Culture and Learning Library. These initiatives will run over five years and will support and enable us to continuously improve and learn.

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.

Just Culture

Why we consider this is important

NHS Improvement promotes the Just Culture Framework as “a powerful tool to promote cultural change”. The framework supports staff to be open about mistakes and allows valuable lessons to be learnt. Their guide encourages managers to treat staff involved in a patient safety incident in a consistent and constructive way, claiming that fair treatment of staff supports learning by making staff feel confident to speak up when things go wrong rather than feeling blamed.

Pennine Care NHS Foundation Trust is working hard to change the culture in the organisation and embedding the Just Culture Framework will help us on our change journey. We want our staff to feel that they can be open and feel supported.

Pennine Care NHS Foundation Trust held a conference on 8 March 2019 to launch the Just Culture with approximately 170 guests, staff from the Trust, Board Members, Clinical Commissioning Group, Colleagues, CQC representation and Trade Union representation. We had guest speakers to help the day be a success, Dr Bill Kirkup, CBE known for his work in the Morecambe Bay investigation, Hillsborough Panel and many more investigations helped us with our thinking and commitment to launching the framework.

What we aim to achieve

We aim to achieve a visible shift in what our staff tell us. The 2019 staff survey reported that 3% of our staff had seen errors, near misses or incidents that could have hurt patients. 58% reported that they felt they had been treated fairly when involved in an error, near miss or accident, leaving 42% of our staff not feeling supported. 45% told us that they are not given feedback about changes made in response to errors, near misses or incidents.

A short staff survey conducted ahead of the Just Culture conference asked a small cohort of staff what they felt about investigations. Their feedback included those investigations where the police had involvement and attendance at Coroners Court, not just an incident investigation.

Feedback from our staff was emotive and supports the need to change culture, change our approach.

What are the benefits of the initiative

- Treats staff in a fair, consistent and constructive way
- Supports a culture of fairness
- Promotes learning by supporting staff to speak up
- Learning from incidents
- Supports a cultural change
- Does not replace HR advise, but supports Trusts to use the framework in conjunction with policy

- Will not act as replacement for investigations, but allows this investigation process to “feel” different for our staff
- The feedback from quick successes will allow staff to believe the Trust is committed
- Improved staff feedback – Staff survey, experience surveys
- Potentially improvements in recruitment and retention.

NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - **Q1. deliberate harm test**

1a. Was there any intention to cause harm?

→ **Yes** → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. → **END HERE**

No go to next question - **Q2. health test**

2a. Are there indications of substance abuse?

→ **Yes** → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. → **END HERE**

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

→ **Yes** → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. → **END HERE**

if **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

→ **If No to any** → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → **END HERE**

if **Yes to all** go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

→ **If Yes to any** → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → **END HERE**

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?

→ **Yes** → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → **END HERE**

if **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → **END HERE**

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

Academy of Medical Royal Colleges · avma · BMA · CareQuality Commission · National Guardian Freedom to Speak Up · General Medical Council · NHS England · NMC Nursing & Midwifery Council · Royal College of Nursing · Royal Pharmaceutical Society · UNISON Health Care · Unite

collaboration trust respect innovation courage compassion

How we plan to do it

Pennine Care NHS Foundation Trust will establish a task and finish group to drive the initiative, with Executive sponsorship from the Executive Director of Nursing. There will be a project plan outlining the next steps and milestones; agreed “pause” points where we check if we are being just or not.

How will we track performance and share lessons learned, good practice and improvements

Pennine Care NHS Foundation Trust Just Culture Project will clearly outline all the methods for:

- Tracking if we are moving to a more Just Culture
- Sharing our learning
- Implementing new approaches.

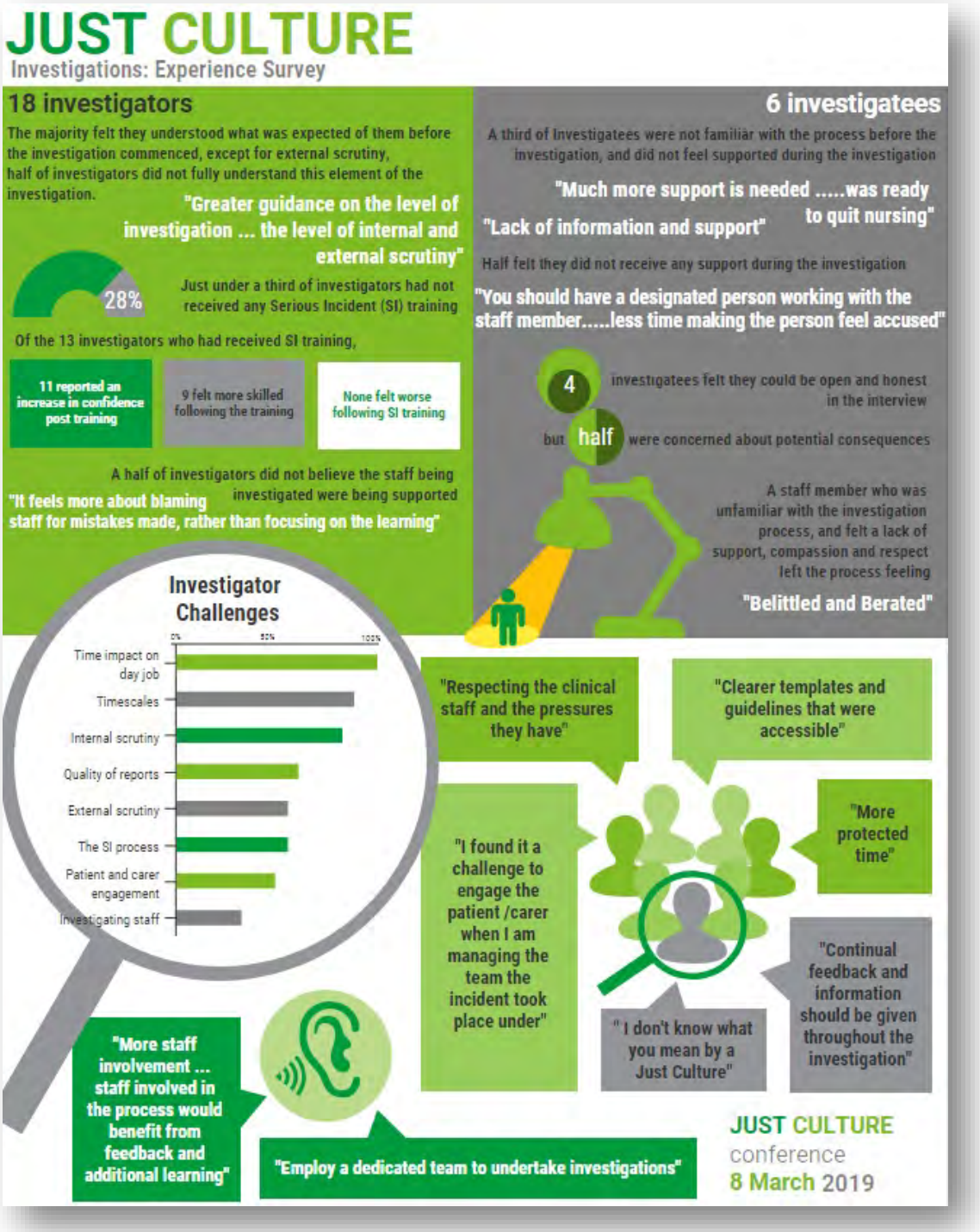
We will work with our Communications Department to ensure wide coverage across our footprint, reporting on progress and sharing feedback from surveys, focus groups and other feedback loops.

How we will sustain quality

The Trusts governance structures allow and encourage frontline to Board reporting. This initiative is a key component in the implementation of the Trust’s Quality Strategy.

The Just Culture Task and Finish Group will report in at all levels of this Governance Framework, including:

Local Integrated Leadership Groups
Integrated Leadership Groups
Quality Group
Quality Committee
Trust Board



Learning Library

Why we consider this is important

Pennine Care NHS Foundation Trust's Quality Strategy (2018/2023) articulates our ambitions and ways in which we will achieve continuous improvement over a five year period.

The five domains of safety, experience, effectiveness, quality improvement and well led will only have the successful implementation of the projects to support strategic delivery if we are successful in sharing learning. Our improvement journey can only be a success if we nurture, develop and support our staff ensuring they are highly skilled and working in an environment that fosters positive attitudes and a desire to improve.

Recent engagement events held with staff, service users, carers, volunteers, governors and Board members have highlighted the need to have a robust programme of learning lessons and sharing best practice.

The recent CQC inspection highlighted this, and we have an improvement action for this.

The Trust is going to develop an approach called our “learning library”.

What we aim to achieve

We aim to review current methods used to share learning and best practice and ensure they meet our requirements. We will ask staff what works for them.

In addition we will introduce new methods for learning and sharing, building our library into a portfolio of different tools and resources.

What are the benefits of the initiative

A workforce that has a variety of methods for sharing learning. An approach that allows our workforce to access the library at any time, encouraging individuals, teams, and services to help build our library.

Our library will be a repository for all ideas and actions generated from Quality Improvement initiatives, clinical audits, feedback from those who use services and from when things have not gone to plan and we have actions from incidents.

How we plan to do it

A delivery group will be tasked with developing the programme for the library.

This delivery group will have a project plan and will report to the Quality Group and Quality Committee.

How we will track performance, share lessons learned, good practice and improvements

We will use staff feedback mechanisms and evaluation tools for the variety of learning approaches in our library.

How we will sustain quality

We will implement a bi-annual staff survey to check we are sustaining the challenge of learning.

2.2 Statements of Assurance from the Board

This section describes activity during 2018/19 on specific workstreams and uses the exact form of each statement specified by the Quality Accounts Regulations. Activity is aligned to the three domains of quality, patient safety, clinical effectiveness and patient experience.

During 2018/19 Pennine Care NHS Foundation Trust provided and/or sub contracted four NHS 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 four of these NHS services.

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by Pennine Care NHS Foundation Trust for 2018/19.

Participation in National Clinical Audits and Confidential Enquiries

During 2018/19 thirteen national clinical audits and two national confidential enquiries covered NHS 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 2018/19 are as follows:

National Clinical Audit of Anxiety and Depression Core Audit

National Clinical Audit of Anxiety and Depression - Psychological Therapies Spotlight Audit

National Diabetes Footcare Audit

National Clinical Audit of Psychosis - Early Intervention into Psychosis Spotlight Audit

Sentinel Stroke National Audit Programme
National Audit of Intermediate Care
National Audit of Care at The End of Life
National Audit of Pulmonary Rehabilitation
National Audit of Inpatient Falls
POMH-UK 16b - Rapid Tranquillisation
POMH-UK 18a - Prescribing Clozapine
POMH-UK 6d - Assessment Side Effects of Long Acting Injectable Depot Antipsychotics
POMH-UK 7f - Monitoring Patients Prescribed Lithium
Learning Disability Mortality Review Programme (LeDeR programme)
National Confidential Inquiry into Suicide and Homicide

The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust participated in during 2018/19 are as follows:

National Clinical Audit of Anxiety and Depression Core Audit
National Clinical Audit of Anxiety and Depression - Psychological Therapies Spotlight Audit
National Diabetes Footcare Audit
National Clinical Audit of Psychosis - Early Intervention into Psychosis Spotlight Audit
Sentinel Stroke National Audit Programme
National Audit of Intermediate Care
National Audit of Care at The End of Life
National Audit of Pulmonary Rehabilitation
National Audit of Inpatient Falls
POMH-UK 16b - Rapid Tranquillisation
POMH-UK 18a - Prescribing Clozapine
POMH-UK 6d - Assessment Side Effects of Long Acting Injectable Depot Antipsychotics
POMH-UK 7f - Monitoring Patients Prescribed Lithium
Learning Disability Mortality Review Programme (LeDeR programme)
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 2018/19, 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
National Clinical Audit Of Anxiety And Depression core audit	93 %
National Clinical Audit Of Anxiety And Depression - Psychological therapies spotlight audit	100%
National Diabetes Footcare Audit	100%
National Clinical Audit of Psychosis – Early Intervention into Psychosis spotlight audit	100%
Sentinel Stroke National Audit Programme	77%
National Audit of Intermediate Care	100%
National Audit of Care at The End of Life	100%
National Audit of Pulmonary Rehabilitation	Currently in data collection
National Audit of inpatient falls	Currently in data collection
POMH-UK 16b - Rapid Tranquillisation	100%
POMH-UK18a - Prescribing Clozapine	100%
POMH-UK 6d - Assessment of Side Effects of Long Acting Injectable Depot Antipsychotics	100%
POMH-UK 7f - Monitoring of patients prescribed lithium	100%
Learning Disability Mortality Review Programme (LeDeR Programme)	Cases not yet identified
National confidential inquiry into suicide	56%

The reports of five national clinical audits were reviewed by the provider in 2018/19 and Pennine Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audit of Psychosis (Core Audit)

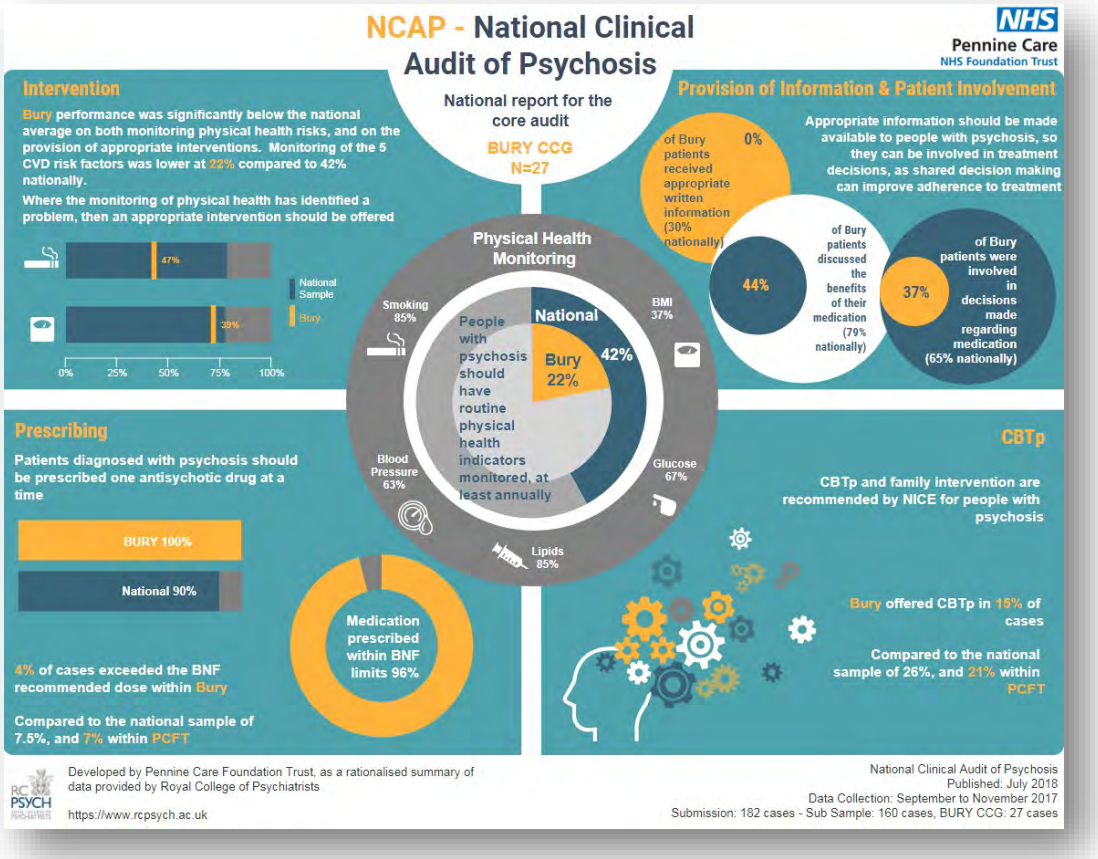
Key Findings

- Monitoring of the 5 Cardio-Vascular Disease risk factors was significantly below the national average, at 21%, compared to 42% nationally.

- The benefits of medication had been discussed with patients in 69% of cases compared to 79% nationally.
- 56% of patients had been involved in decisions made regarding medication compared to 65% nationally.
- 95% of patients diagnosed with psychosis had been prescribed one antipsychotic at a time, compared to 90% nationally.
- 7% of antipsychotic drugs had been prescribed outside of the BNF recommended range compared to 10% nationally; however, a rationale had been provided in 100% of cases compared to 56% of cases nationally.
- Cognitive Behaviour Therapy for psychosis (CBTp) had been offered in 21% of cases, and family intervention in 4% compared to the national sample of 26%, and 12% respectively.

Key Actions

- A local infographic summary and slide set was produced and shared alongside the National Report at a focussed clinical audit forum, and the findings used to generate discussion.
- The Clinical Effectiveness Team to work with local services to review local outputs and develop action plans to address any areas for improvement.



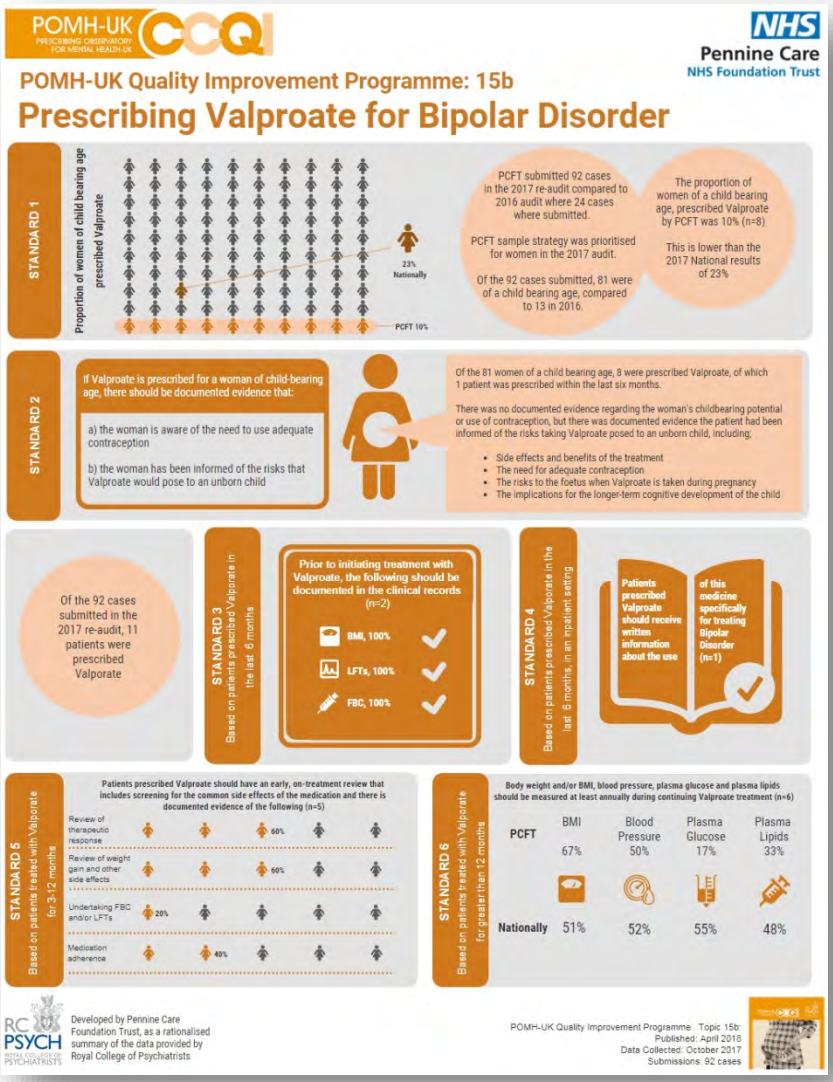
POMH-UK Topic 15b: Prescribing Valproate for Bipolar Disorder

Key Findings

- The findings suggest that women of child bearing age included in the sample were not routinely prescribed valproate.
- There was no documented evidence regarding the woman's childbearing potential or use of contraception; however, there was documented evidence the patient had been informed of the risks taking valproate posed to an unborn child.
- Two female patients who had commenced on valproate in the previous 6 months had their Body Mass Index, Liver Function Tests and Full Blood Count assessed prior to treatment with Valproate.

Key Actions

- The results were used to develop a local infographic summary which was presented at the Trust's Drugs and Therapeutics Committee in July 2018.
- Details of the Medicines and Healthcare products Regulatory Agency, Pregnancy Prevention Programme have been disseminated to all clinicians across all Trust services including Mental Health Services.
- All clinicians reminded that valproate is contraindicated in the absence of completed and signed Pregnancy Prevention Programme paperwork.



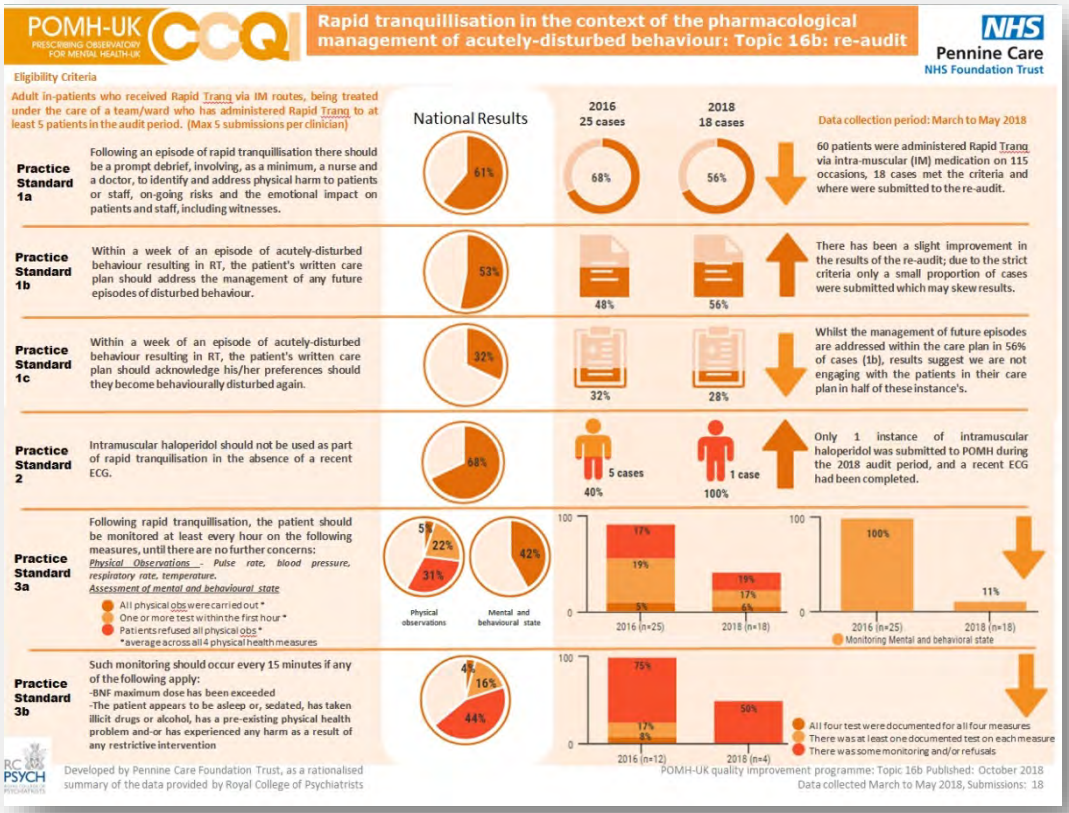
POMH-UK Topic 16b: Rapid Tranquilisation

Key Findings

- A prompt debrief to identify physical harm to the patient or staff, following an episode of rapid tranquillisation, was carried out in 56% of cases compared to 61% of cases Nationally.
- The patient's written care plan addressed the management of future episodes of disturbed behaviour in 56% of cases compared to 53% Nationally.
- Patient preferences in case of future episodes of disturbed behaviour were considered in 28% of cases compared to 32% Nationally.

Key Actions

- The results were used to develop a local infographic summary which was presented at the Trust's Drugs and Therapeutics Committee in March 2019.
- It is anticipated that the findings will generate local review, discussion and action planning.



UK Parkinson's Audit

Key Findings (local)

- 100% of patients were seen within 18 weeks from time of 'routine' referral to initial assessment.
- All patients assessed during the audit period were in the 'maintenance' phase of Parkinson's.
- Patients are offered a physiotherapy assessment to determine the best fit treatment, as group and individual physiotherapy is offered:
    - Individual sessions can address more complex phases of Parkinson's and can be home based.
    - Group sessions include exercise and educational needs.
- 78% of patients say they are able to contact their physiotherapist between sessions.
- 80% of patients felt the Parkinson service was either 'good' or 'improving'.
- 90% of patients felt their concerns and cultural needs were taken into account.
- 91% of patients felt listened to, and that the service involved them in decisions about their care.

Key Actions

- A local infographic summary was produced and shared alongside the National Report to the Parkinson's team.
- The findings were used to generate local discussion.

POMH-UK Topic 18a: The use of Clozapine

Key Findings

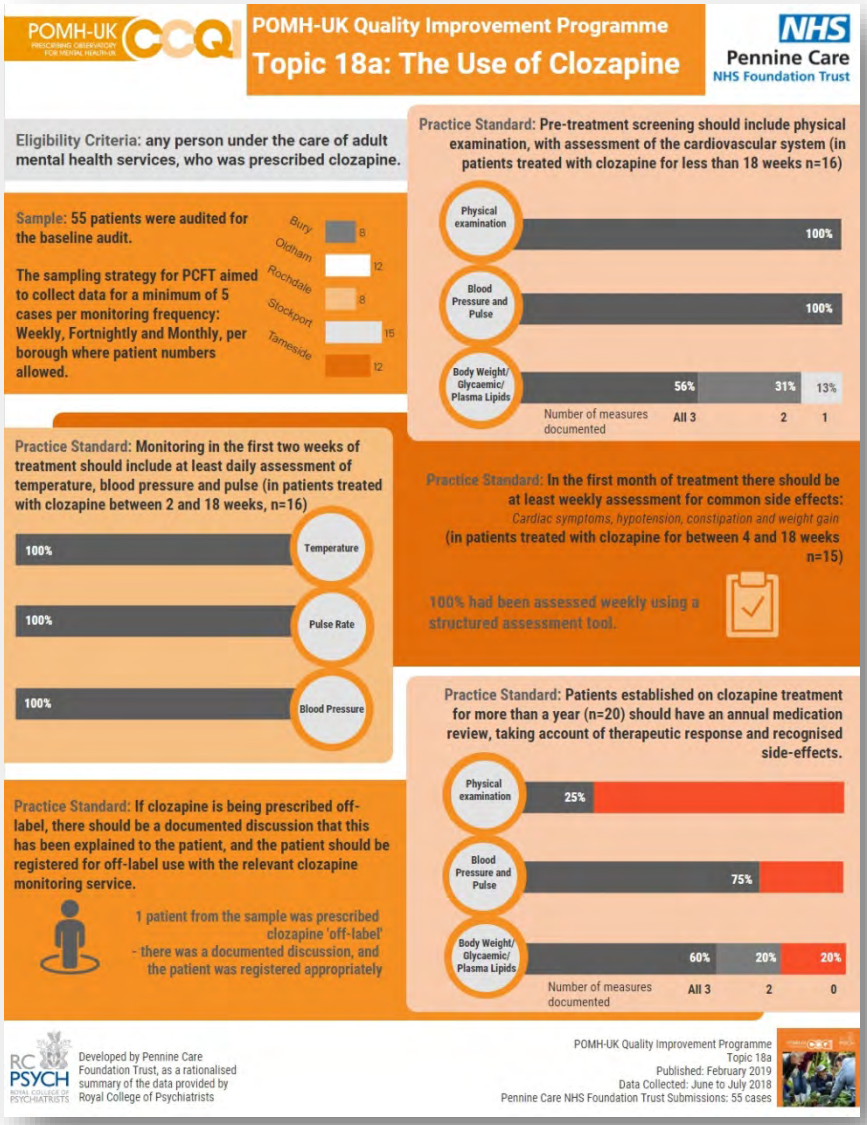
- Monitoring in the first two weeks of treatment included daily assessment of blood pressure, temperature and pulse in 100% of cases.
- People are generally only prescribed Clozapine for the licensed indication, occasionally it is prescribed to treat other indications not specified in its summary of product characteristics (off-label). Only one patient in the sample was prescribed

Clozapine off-label; there was evidence of documented discussion, and the patient had been registered appropriately.

- 100% of patients included in the sample, who had been treated with Clozapine between 4 and 18 weeks, were assessed for common side effects on a weekly basis.
- Not all patients established on Clozapine for more than a year had an annual medication review, taking account of therapeutic response and recognised side-effects.

Key Actions

- The results were used to develop a local infographic summary which was presented at the Trust's Drugs and Therapeutics Committee in March 2019.
- It is anticipated that the findings will generate local review, discussion and action planning.



The reports of 27 local clinical audits were reviewed by the provider in 2018/19 and Pennine Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

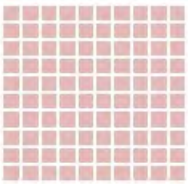
Clinical Audits reviewed in 2018/19

Driver	Clinical Audit Title and clinical audit period /quarter where applicable
Medicines Management	Antimicrobial prescribing (Community Service inpatient) Q1, Q2, Q3, Q4
	Antimicrobial prescribing (Non-Medical Prescribers) Q1, Q2, Q3, Q4
	Antimicrobial prescribing (dental) Q2
	Antimicrobial prescribing (Mental Health inpatient) Q2, Q4
	Safe and secure handling of medications mental health services
	Safe and secure handling of medications community services

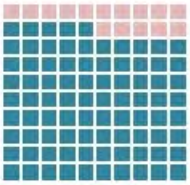
Trust Concern	Dental risk assessment and recalls
	Female Genital Mutilation enquiry
	Record keeping (paper health records)
	Resuscitation Equipment
	Blanket restrictions
Infection Prevention and Control	Infection Prevention and Control (IP&C) Environmental inpatient areas Q2, Q4
	Infection Prevention and Control (IP&C) Environmental community buildings Q3
	Infection Prevention and Control (IP&C), Dental environmental Q2, Q4
	Infection Prevention and Control (IP&C), Hand hygiene Q1, Q2, Q3, Q4

Key Actions of Clinical Audits Reviewed in 2018/19

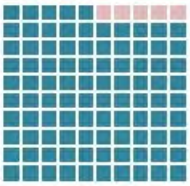
Clinical Audit Title	**Blanket Restrictions**



Standard 1: There should be a written formal process in place for applying Blanket Restriction(s) on a ward *(n=19)*.



Standard 2: There should be information available about the Blanket Restriction on the ward for staff, service users and visitors. *(n, number of blanket restrictions= 110).*



Standard 3: There is an appropriate rationale for applying a Blanket Restriction on a ward. *(rationales for the blanket restrictions had not been validated in 34 cases therefore n=76).*

The results of this audit were discussed at the Blanket Restrictions Steering Group and a number of actions have been agreed to develop and deliver an improvement plan.

A Task and Finish Group will agree a strategy to develop and implement a Trust wide Policy in relation to blanket restrictions.

Services will use and share learning from an improvement project that was recently completed in the Rehabilitation and High Support Directorate.

Borough level Acute Care Forums will agree their local blanket restrictions and pathways, and these will be ratified at the Task and Finish Group.

A further cycle of clinical audit will be planned following publication of the Policy.

Clinical Audit Title	**Dental Risk Assessments and Recalls**

* All 3 risk factors assessed for patients 16 years and over

* Carries risk assessed for patients under 16 years of age

Standard 1:
The recommended interval between oral health reviews should be determined specifically for each patient and tailored to meet his or her needs, on the basis of an assessment of disease levels and risk of or from dental disease.

Patients aged 16 years and over should be risk assessed for caries, perio and cancer.

Patient under 16 years of age only need to be risk assessed for caries disease.

Standard 2:
During an oral health review, the dental team (led by the dentist) should ensure that comprehensive histories are taken, examinations are conducted and initial preventive advice is given.

Standard 3:
The dentist should discuss the recommended recall interval with the patient and record this interval, and the patient's agreement or disagreement with it, in the current record-keeping system.
**excluding patients discharged or in receipt or off on-going treatment.*

Standard 4:
Prevention of caries disease advice given and action taken.

**excluding patients risk identified as N/A*

Standard 5:
Prevention of periodontal disease advice given and action taken for patients aged 16 and over.

**excluding patients risk identified as N/A*

Standard 6:
The recommended shortest and longest interval between oral health reviews are as follows:

- The shortest interval between oral health reviews for all patients should be 3 months.
- The longest interval between oral health reviews for patients aged 18 years and older should be 24 months.

** excluding patient status of "discharged" and "Treatment" from standard as they do not need a recall present*

Nice CG19 1.1.7 states "the dentist should discuss the recommended recall interval with the patient and record this interval, and the patients agreement or disagreement with it, in the current record-keeping system". The results of this clinical audit suggest this is not always happening or if it is, is not being documented in the record-keeping system (as this was the lowest score) and therefore suggests a prompt could be placed on the template to remind staff to have and record this conversation.

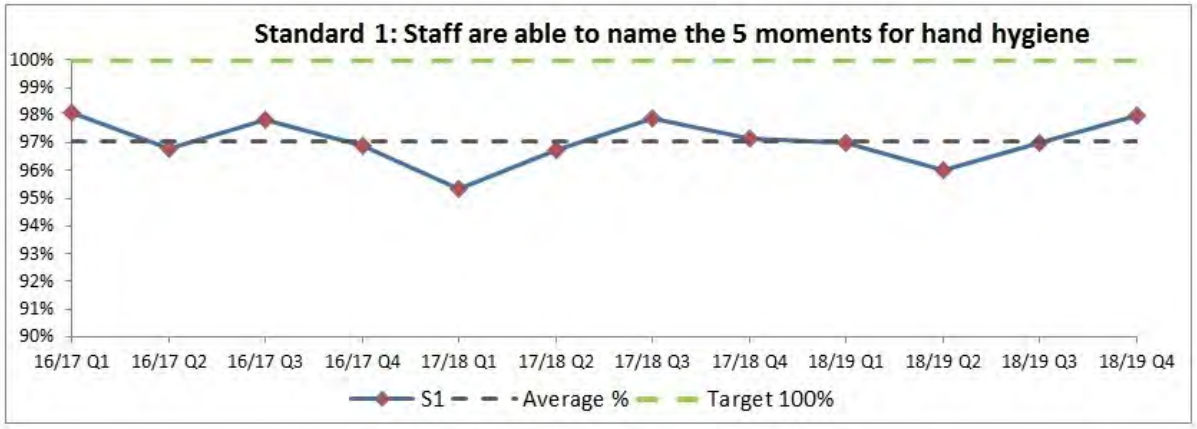
NICE CG19 1.1.3 recommends that initial preventative advice is given on "the effects of oral hygiene, diet, fluoride use, tobacco and alcohol on oral health, and is discussed and documented". Dietary advice (if given) needs to be recorded explicitly within the records, as the audit results could not evidence information or advice on diet being given.

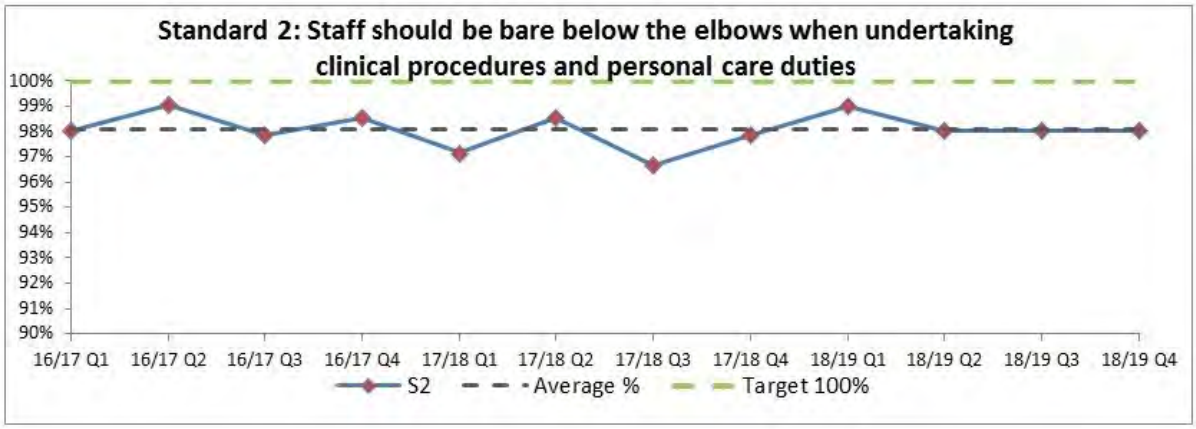
The audit grouped cases into age ranges, this is to be discussed with clinicians to agree appropriate age ranges for recording of carries risks, periodontal risks and oral cancer risks, to ensure consistency across the directorate.

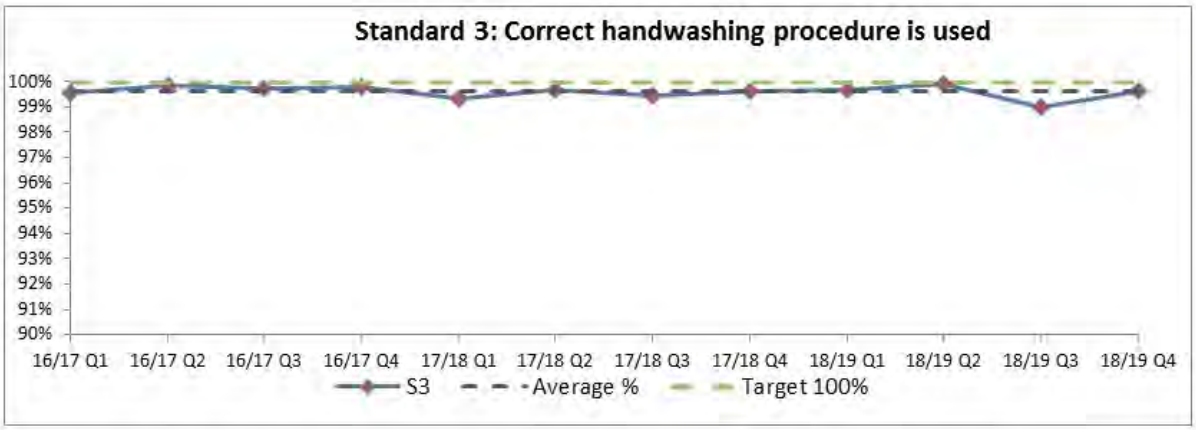
The clinicians should discuss and form a reasonable consensus of the recall intervals for each category of risk profiles.

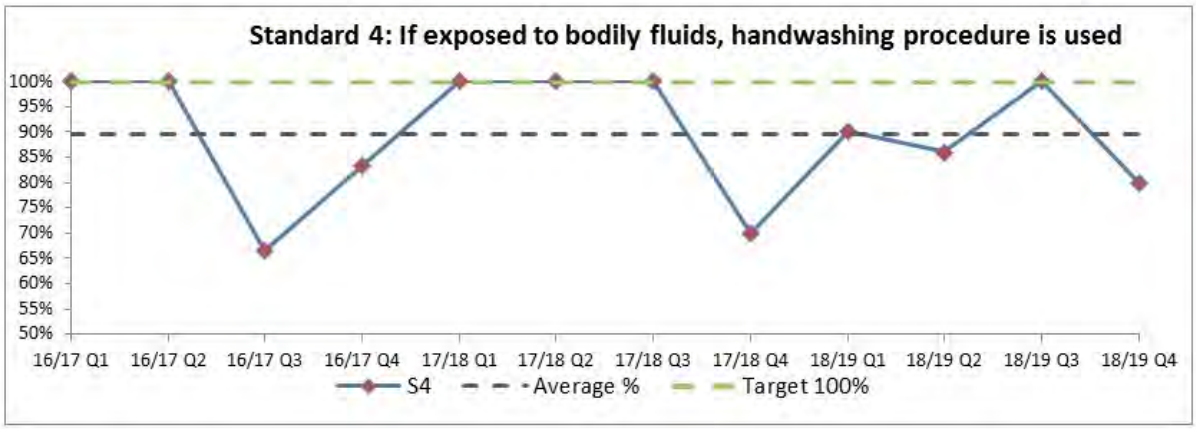
Correlation of information with other departmental audits published this year regarding record keeping standards and fluoride prescriptions may benefit the directorate in understanding the needs of the patient, risk profiles, as well as help identify areas for improving delivery of preventative care.

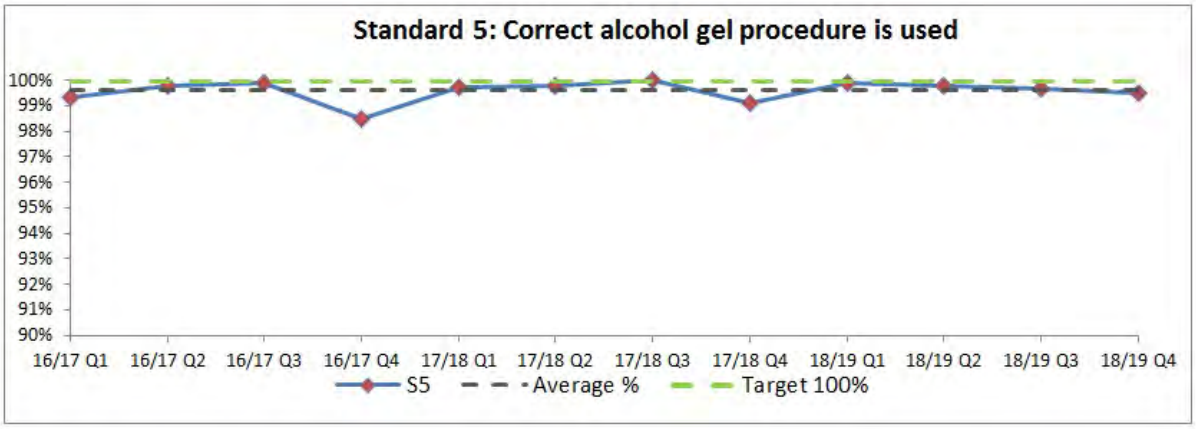
Clinical Audit Title **Hand Hygiene Observations**











Compliance to standards for hand decontamination practices has remained consistently good, with little variance over the last 3 years.

Auditable measures are reviewed annually, and the Clinical Effectiveness Team recently reviewed the current standard measures we use for hand hygiene observation audits against NICE Guidance (CG139 and Quality Statement 61).

Current measures for hand hygiene observations are based on the World Health Organisation (WHO) Five Moments for Hand Hygiene, which do not fully reflect NICE guidance; as reference to cleaning hands after removal of gloves is omitted from the WHO guidance. As the hand hygiene observation clinical audit tool is based on the WHO Five Moments, it has not previously included removal of gloves in the criteria.

A review of Trust Policies verifies that relevant Policies do reflect the NICE guidance, and direct staff to clean their hands after removal of gloves.

Subsequently the hand hygiene observation audit tool has been updated to include measures to ensure hands are cleaned following removal of gloves.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Pennine Care NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 714.

During 2018/19, Pennine Care NHS Foundation Trust was involved in the conduct of over 50 clinical research studies. This represents our most research active year to date.

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 2018/19 Pennine Care NHS Foundation Trust has reached and surpassed the recruitment set by the National Institute of Health Research (NIHR).The overall recruitment figure is likely to be our best ever. 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 help 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 2018/19 Research and Innovation Department have approved 23 new studies, 14 of which are on the National Institute for Health Research (NIHR) portfolio.

New Portfolio Projects 2018/19

Resilience to Suicidal Thoughts and behaviours in people with schizophrenia (ReST)

Investigating the long-term relationship between resilience and suicidal ideation and behaviours in people with mental health problems on the schizophrenia spectrum.

Online Remote Behavioural Intervention for Tics (ORBIT)

Therapist-guided, parent-assisted remote digital behavioural intervention for tics in children and adolescents with Tourette Syndrome: an internal pilot study and single-blind randomised controlled trial.

WOUNDCHEK Bacterial Status Benefits Evaluation

Clinical and Economic Effectiveness of Testing Chronic Wounds for BPA (bacterial protease activity) using WOUNDCHEK™ Bacterial Status: A Pragmatic Randomised Clinical trial.

Enhancing the quality of psychological interventions delivered by telephone (EQUITy)

Telephone-delivered psychological interventions, based on cognitive behavioural therapy (CBT) principles, are NICE recommended treatments for mild-moderate anxiety and depression. They represent 20% of appointments in the NHS's 'Increasing Access to Psychological Therapies' (IAPT) programme. However, practitioners lack confidence and training in this delivery method. When telephone treatments are used, patient engagement is often not sustained.

Our programme aims to increase engagement in telephone-delivered psychological interventions for mild-moderate depression and anxiety in primary care, and improve clinical and cost-effectiveness.

Therapeutic Relationships within Inpatient units: Carers, Adolescents and Nursing staff (TRI-CAN)

The aim of the programme is to develop a theoretically-driven, tailored and publicly-informed intervention that will support the development and maintenance of helpful therapeutic relationships between nursing staff, young people and carers within inpatient CAMHS.

Can smartphone TechnolOGy be used to support an EffecTive Home ExeRcise intervention to prevent falls amongst community dwelling older people? The TOGETHER feasibility RCT.

Strength and balance exercise programmes are effective in reducing falls (Gillespie et al., 2012). However, older adults do not always maintain their exercises, nor do them regularly enough to gain the benefits. Healthcare services do not offer adequate support to enable older adults to achieve the evidence-based dose of exercise. This study aims to explore whether smartphone technology can be used to support patients to adhere to an evidence based exercise programme.

Assertive Outreach following the Manchester Arena attack

Mixed-method work in advance of a full-scale process evaluation of a screen-and-treat intervention for psychological trauma.

Adverse drug events in NHS mental health hospitals - 2nd V

To determine the frequency, nature, preventability and severity of Adverse Drug Events in three English NHS Mental Health Trusts.

Investigating the long-term relationship between resilience and suicidal ideation and behaviours in people with mental health problems on the schizophrenia spectrum

Suicide deaths in people with serious mental health problems, such as schizophrenia, represent a main health care concern. Suicidal thoughts and behaviours can have a deleterious impact on individuals' wellbeing. However, research has shown that some people are able to counter the impact of these experiences. Resilience has been defined as abilities or skills which help people achieve positive outcomes despite adversity. Previous research has shown that resilience can buffer or moderate factors which lead to suicidal thoughts and acts in people with schizophrenia. However, cross-sectional and prospective studies which assess the buffering role of resilience in pathways to suicidal thoughts and acts, and how it may change over time, are relatively sparse. It is important to understand the mechanisms underlying resilience to suicide.

Cognitive-Behavioural versus cognitive –analytical guided self-help for anxiety, a patient preference clinical trial.

The Improving Access to Psychological Therapies (IAPT) service follows the NICE guidelines for anxiety and depression and therefore offers evidence-based psychological interventions for adults aged 16+ years with common mental health problems in a stepped-care service philosophy. Patients receiving psychological therapies in the service are typically seen at local GP surgeries, NHS health centres and other community based clinics. At step 2, at the present time the typical intervention consists of 6-8 sessions with a Psychological Wellbeing Practitioner using CBT-GSH. PWPs would receive clinical and case management supervision to ensure the fidelity and quality of both forms of GSH as a part of their routine practice during the trial. The CAT-GSH has been produced to dovetail with typical Psychological Wellbeing Practitioner work and does not need specialist clinical supervision to support it. Nevertheless, participating Psychological Wellbeing Practitioners will be offered a once

per month group clinical supervision facilitated by the Principal Investigator and the Chief Investigator to support their delivery of either CBT-GSH or the CAT-GSH intervention during the duration of the trial.

Prevalence of neuronal cell surface antibodies in patients with psychotic illness

To establish the prevalence of neuronal cell surface antibodies including NMDAR, LGI1, GABA-A and others in patients with a diagnosis of psychosis.

Increasing access to Cognitive Behavioural Therapy (CBT) for psychosis patients: a feasibility randomised controlled trial evaluating brief, targeted Cognitive Behavioural Therapy for distressing voices delivered by Assistant Clinical Psychologists

Psychosis is a type of mental health problem. People with psychosis usually experience distressing delusional beliefs and/or voice hearing. The National Institute for Health & Care Excellence (NICE) recommends Cognitive Behavioural Therapy as one of the best treatments for psychosis. But only 10% of people with psychosis have the chance to receive Cognitive Behavioural Therapy. Cognitive Behavioural Therapy is scarce because it can be quite long and needs to be delivered by highly trained therapists. We want to see if a shorter version of Cognitive Behavioural Therapy that is delivered by therapists with less training will be helpful for people who hear voices.

Supporting Memory Services to enable people with dementia and their families timely access to Assistive Technology.

Assistive Technology (AT) could potentially support people with dementia to live independently for longer. Research has highlighted a complex system surrounding the provision of AT. GPs and families living with dementia do not know where to get information on or how to access AT. Pathways need to be clarified to support people with dementia to obtain AT. This project focusses on the provision by Memory Services (MS) as they are the first service providing information after diagnosis.

Development of an occupational therapy intervention to improve sleep in people with schizophrenia spectrum disorders using Delphi study methodology.

Sleep problems are very common in people with schizophrenia and related disorders (including schizoaffective disorder and delusional disorder). This impacts on these people's quality of life, affects their recovery, can affect their social life or work, and worsens isolation.

Cognitive behavioural therapy for insomnia (CBT-i) has been found to be effective in some groups, but is not widely available in practice. Experts have called for briefer alternatives to CBT-i to be created.

People with schizophrenia have more irregular, broken and un-refreshing sleep, often combined with being less active in the daytime. Theories of sleep processes suggest addressing daytime activity may help, by increasing tiredness at bedtime, and improving light exposure (light is important for our biological sleep rhythms (circadian rhythms)).

We will develop a brief alternative to CBT-i, with increased focus on daytime activity, for delivery by an occupational therapist.

The CQUIN Framework

A proportion of Pennine Care NHS Foundation Trust income in 2018/19 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 NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at https://www.penninecare.nhs.uk/quality/performance/ and from Pennine Care NHS Foundation Trust, 225 Old Street, Ashton-Under-Lyne, OL6 7SR.

In 2018/19, £5,208,807 was conditional upon achieving quality improvement and innovation goals. The associated payment in 2017/18 was £4,364,218.

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 & Wellbeing 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 & Wellbeing 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 & Wellbeing a) Staff Health & Wellbeing c) Improving uptake of Flu Vaccinations for frontline staff
National	Oldham Community Services	Improving the assessment of wounds
National	Oldham Community Services	Personalised care and support planning
Local	Oldham Community Services	Quality outcomes for Children and Young People who may have SEND (Specialist Education Needs and Disability)
Local	Oldham Community Services	Sustainability and Transformation Plan Engagement
Local	HMR Community Services	Audiology – Patient/service feedback to improve patient/service experience
Local	HMR Community Services	CAONS (Children's Acute Ongoing Needs) Patient and Carer Pathway
National	Trafford Community Services	NHS Staff Health & Wellbeing a) Staff Health & Wellbeing c) Improving uptake of Flu Vaccinations for frontline staff)
National	Trafford Community Services	Improving the assessment of wounds
National	Trafford Community Services	Personalised care and support planning
National	Trafford Community Services	Preventing ill health by risky behaviours
National	Trafford Community Services	Sustainability and Transformation Plan Engagement
Local	Trafford Community Services	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 2018/2019.

Pennine Care NHS Foundation Trust has not participated in any special reviews by the Care Quality Commission during the 2018/2019.

Pennine Care NHS Foundation Trust has participated in investigations by the Care Quality Commission relating to the following areas during 2018/19.

- Pennine Care NHS Foundation Trust is currently under Care Quality Commission criminal investigation into concerns of a suspected breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – potential breach of Regulation 12; safe care and treatment.

Pennine Care NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission:

- Further information regarding any actions to be taken by the provider will be identified when the investigation process by the Care Quality Commission has concluded.

Pennine Care NHS Foundation Trust has made the following progress by 31 March 2019 in taking such action:

- Investigation on going.

Service	Overall rating	Safe rating	Effective rating	Caring rating	Responsive	Well-led rating
Community Dental Services	Good	Good	Good	Good	Good	Good
Urgent Care	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement
Adult Wards and PICU	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Older Peoples Wards	Good	Requires improvement	Good ↑	Good ↑	Good	Good ↑
Crisis Services and HBPoS	Requires improvement	Requires improvement	Requires improvement	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 2018/2019 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 2018/19 was Standards Met:

- 100 of 100 mandatory evidence items provided
- 40 of 40 assertions confirmed

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; Data Protection Privacy Impact Assessments; and hosting the Trust Data Protection Officer function; in 2019/20 the Information Governance Department will be looking to maintain and improve on the Data Security and Protection Toolkit assessment achievement in 2018/19.

The Trust will also continue to monitor its compliance against the requirements of the new data protection legislation (incorporating GDPR); requirements from the National Data Guardian Review and NHS Cyber Security programme; and any required actions as a result of the Brexit process.

For the 2018/19 Internal Audit review of the Trust's information governance compliance, a rating of ***substantial assurance*** was given.

The Information Governance function will continue to support the transition, transformation and 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 Health Informatics; Business Planning and Procurement; Performance and

Information; Human Resources and Risk Management, to review processes and Information Governance assurance, including rolling out the new Information Risk Management processes throughout the Trust, and externally working with partner agencies, Commissioners and other external bodies.

Payment by Results & 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 Payment by Results, 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 2018/19 by NHS Improvement and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary diagnosis 2%
- Secondary diagnosis (treatment coding) 5%
  (Scores provided following verbal feedback from Auditors.)

The sample size for the audit was 100 records out of a total of 3,277 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 of the Data Protection Security Toolkit in which it states that an annual audit by an external provider is undertaken and a sample of records across our Mental Health Inpatient Services is used. The sample includes Adult Mental Illness; Old Age Psychiatry; Child and Adolescent Mental Health Services and Forensic Psychiatry from across all Boroughs in the Trust. The scores above relate only to the actual audit sample and should not be extrapolated further. The audit was undertaken at the end of February 2019 and we are awaiting the draft report.

Data Quality

During the production of the Quality Account 2017/18, Grant Thornton were engaged by the Council of Governors of Pennine Care NHS Foundation Trust and performed limited assurance procedures 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 two indicators substantively against supporting documentation and reported issues which came to their attention causing them to believe that these two mandated indicators had not been prepared in accordance with applicable criteria.

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 three of the six dimensions of data quality in the following respects:

- **Accuracy** - testing identified seven errors in the ten cases tested where either the clock start or stop date was incorrectly set.
- **Timeliness** - testing identified one error in the ten cases tested where the data was recorded in the wrong month.
- **Validity** - 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 three of the six dimensions of data quality in the following respects:

- **Completeness** - testing identified two errors in the twenty-four cases tested. These were patients that each had separate placements which were not recorded.
- **Accuracy** - 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** - 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.

The External Auditors reported an **Adverse Conclusion** based on the results of their procedures.

Pennine Care NHS Foundation Trust will be taking the following actions to improve data quality:

Action Taken by the Trust

Early Intervention in Psychosis

As an immediate response to the issues raised regarding early intervention in psychosis data quality, guidance was reissued to all teams followed up by visits to each team to ensure the requirements and data capture processes where fully understood.

Weekly conference calls, led by the Performance Department, were established with each team to review the data recorded on the system and monitor overall performance. This intensive and extensive programme of work has resulted in a significant improvement in both the performance and the local awareness and recognition for healthy data.

An internal review, using the new internal Data Health Framework, has also been commissioned, the results of which are currently being assessed.

Inappropriate out-of-area placements (OAP) for adult mental health services

Following the auditors finding in relation to out of area placements, services were contacted to reiterate the need to ensure data was recorded accurately. A programme of work was also established to review the current systems and processes used to capture data and undertake a full Data Health Review.

This identified that, due to the lack of an electronic system, services were utilising local spreadsheets to capture data with limited ability to robustly monitor and validate data. To address this, and pending roll out of PARIS to these areas, work has been carried out by the Information Department to standardise the spreadsheets with a view to linking these into the data warehouse and developing routine reports in Tableau which can be used to validate data and monitor performance. This work is expected to be completed for Psychiatric and Intensive Care Unit and North Adult Acute, where the majority of out of area placements take place, within the next month, before being rolled out to the South Acute bed managers. Work to develop processes within PARIS will be aligned to the establishment of the new Bed Management Bureau.

Data Health Programme

As a Trust we report against over 1000 measures, collecting information from over 40 systems and processing these in to circa 5000 datasets totalling 209 million rows of data per day. Furthermore, as there is not yet a fully implemented Electronic Patient Record across the Trust, the effectiveness of data capture is variable across our services presenting significant challenges in relation to Data Quality.

In recognition of these challenges the ‘establishing an information culture’ project was mandated in October 2017 by Pennine Care NHS Foundation Trust’s Health Informatics Strategy. The primary aim of this project is to establish an improved information culture; whereby the organisation recognises the value of information and has high levels of confidence in its data. The project is sponsored by Keith Walker, Executive Director of Operations, and is supported by all areas of Corporate Services and representatives from Operational Services.

There are three workstreams within the project:

- **People development:** Get staff to promote and use data to support decision making
- **Infrastructure:** Ensure we have a strong and well managed infrastructure to support the organisations need for data/information
- **Data Quality Standards and Compliance:** Provide assurance as an organisation/ service/ individuals that we have good data quality (All systems - clinical and corporate).

All the workstreams have been established with terms of reference, identified membership and work has begun in all areas.

As part of the Data Quality Standards and Compliance work stream and in response to the Auditors finding in May 2018, a specific working group was established, co-chaired by the Director of Operations and the Medical Director and tasked with developing both a framework and sustainability model to data quality audit and assurance across Pennine Care NHS Foundation Trust.

Over a period of 6 months this group has devised and tested a comprehensive Data Health Review Framework and has discussed the sustainability options to ensure the Framework can be utilised across the Trusts information sets.

The group also oversaw a Risk Stratification exercise which identified and agreed the critical must do's measures for the Trust. This includes the national standards within the NHS Improvement Single Oversight framework and the key contractual standards and requirements.

The working group reported to the Performance & Finance Committee, providing regular updates on the progress of the activities, and presented its final recommendations to the Executive Directors in November 2018.

These recommendations included the formal adoption of the Review Framework and formal pledges of time from across Operational and Support Services to undertake reviews across the 26 Level 1 Risk measures (our critical must do's).

Following this a schedule of routine Data Health Reviews is now being developed which will be monitored centrally within the Performance Department. The outcome of the Data Health reviews will be used internally to provide assurance within dashboards and internal reports in relation to the reported performance against key measures.

Actions plans arising from the review will be owned by the Integrated Leadership Groups and assurance on delivery sought.

The Data Health Review Framework will also be embedded across the organisation as a self-assessment tool for services to test data quality within teams.

Learning from Deaths

During 2018/19 453 of Pennine Care NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 116 in the first quarter
- 110 in the second quarter
- 107 in the third quarter
- 120 in the fourth quarter

By 26 March 2019 10 case record reviews and 65 investigations have been carried out in relation to 453 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:

- 3 case record reviews and 16 investigations in the first quarter
- 2 case record reviews and 20 investigations in the second quarter
- 3 case record reviews and 19 investigations in the third quarter
- 2 case record reviews and 10 investigations in the fourth quarter

1 representing 0.22% 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:

- 1 representing 0.86% for the first quarter
- 0 representing 0% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for the fourth quarter

These numbers have been estimated using root cause analysis methods and the pilot structured judgement review process.

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. From our investigations under the serious incident framework similar themes occur year on year with 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.

In relation to learning from the structured judgement review processes the following has been highlighted:

- Men are over-represented for early morbidity.
- Consistent with Public Health England findings patients face a rate of mortality 3.7 times the rate of general population.
- Reasons for the loss of life are consistent with British Medical Journal findings (Highest risks of premature death, from both natural and unnatural causes, are for substance abuse and eating disorders. Risk of death from unnatural causes is especially high for the functional disorders, particularly schizophrenia and major depression.)
- Schizophrenia likely to be the diagnosis (People with schizophrenia have a mortality risk that is two to three times that of the general population). Most of the extra deaths are from natural causes. The apparent increase in cardiovascular mortality relative to the general population should be of concern to anyone with an interest in mental health; smoking prevalence in the general population is 14.9% versus 40.5% in adults with severe mental illness [Public Health England; GP lists with patients with schizophrenia; bi-polar affective disorder or other psychoses].
- Life-style and co-morbidity of drug use.
- Lack of engagement in primary physical health care.

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

- Delivered face to face learning lessons training as a result of the common themes arising from suspected suicides to front-line colleagues.
- Invested in Band 8a Quality Leads across the Trust's Borough footprint to improve our offer around Quality to front-line colleagues with support from dedicated Band 4 administrators.
- Planned workshop for colleagues and stakeholders around Learning from Deaths – 'closing the gap'.
- Developed and developing shared care incident reporting, investigating and learning lessons platforms with acute hospital trust sites.
- Significant investment in the train the trainer approach for STORM v.4 and post-vention modules.
- Working with Greater Manchester and other North-West provider colleagues to consider the case record review tool as a potential method for learning from the living with a view to 'closing the mortality gap' for our secondary care mental health patients.

What impact do we envisage the actions will have

The assessment of the impact of the actions taken will be measured via the Trust's groups and committees.

- **Quantitative** - we will review the number of deaths that we consider arising from a problem in care against previous year's data and the root cause for this; the numbers will form part of the report seen and given scrutiny and review by the Mortality Review Group and the Trust's Quality Committee.
- We will review the uptake of the numbers of workforce accessing the STORM v.4 training.
- We will track the numbers of shared care incidents, investigations and learning that we have with acute provider colleagues.
- **Qualitative** – we will continue to develop quarterly transformational learning events with front-line workforce and assess the impact of the new support offer by the Quality Leads and evaluate the feedback provided by those in attendance.
- We will review and analyse the evaluation forms from those attending STORM v.4 training.
- We will review the comments and suggestions from colleagues in attendance at the Learning from Deaths – 'closing the gap'.

7 case record reviews and 26 investigations were completed after 31 March 2018 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the structured judgement review process that the Trust Board agreed on the 18 December 2017 in preparation for the Nationally mandated tool which came 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 agreed to be in the pilot (test and evaluate) phase (April 2018 – June 2018).

0 representing 0% of the patient deaths during 2017/2018 are judged to be more likely than not to have been due to problems in the care provided to the patient using the Structured Judgement Review.

Freedom To Speak Up

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS Trusts and NHS Foundation Trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of such legislation, NHS Trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

Ways in which staff can speak up

Freedom To Speak Up is one element of a wider strategic approach to cultural transformation and improvement. The values that underpin it are mirrored in those of the Just Culture framework, work towards resolution rather than grievance, and behaviour standards.

By viewing it and using it in this context we have an opportunity to lead the way in demonstrating our commitment to embedding the values that create a positive culture change.

Policy

The Freedom to Speak Up policy encourages staff to speak up to their line manager if they can, but it recognises that this is not always possible and so where staff don't feel able to speak up to their line manager or they have already tried to speak up to their line manager and they have not had a satisfactory response, they are asked to go to the Freedom to Speak Up Guardian.

The Freedom to Speak Up Guardian is independent and impartial and they can speak to her in confidence. Since the appointment of the Freedom to Speak Up Guardian in September 2017, 88 staff have spoken up to the Guardian.

Communication Plan

The Freedom to Speak Up Communication plan aims to ensure that the Freedom to Speak Up message is communicated widely to all staff groups. We acknowledge that 100% of staff are not aware of the Guardians role and there remains much to do.

It is often when staff have an opportunity to meet the Guardian that they chose to speak up. There has been an increase in the number of Freedom to Speak Up presentations, including input on the junior doctor professionalism training, team leadership programme, team meetings and general induction market place, and clinical skills training. In addition there are plans to increase the number of visits to services, and have input on the planned managers induction.

Improvement work

We aim to continually improve and so work is currently underway to map the Freedom to Speak Up process, identify standards of manager's response and appropriate measures of success.

Triangulating Information

Freedom to Speak Up information is shared as part of the Quality Summit, where information relating to patient safety, complaints and friends and family test are triangulated. This supports the identification of areas in need of support and improvement and the transferring of lessons learnt across the organisation.

Speak Up Ambassadors

We intend to expand staffs access to support to speak up by launching a network of five Speak Up Ambassadors in May 2019. The Ambassadors will have one day a week ring fenced time and will nurture a culture of openness, honesty, transparency and learning, where staff are valued for speaking up. They will work directly to support staff, volunteers, bank staff and governors to speak up.

Ambassadors will be recruited from all staff in substantive posts across the Trust. Staff will be expected to attend two days initial training, one days update training a year and quarterly network meetings. Training will include the national Freedom to Speak Up Course, Mental Health First Aid training, Difficult Conversations and Just Culture training. There will be a values based recruitment process. Staff from groups with additional barriers to speaking up, such as LGBT and BME will be particularly encouraged and supported to apply.

Backfill cost will be paid to services and managers are expected to commit to supporting staff in the role and commit to releasing staff for one day a week.

How feedback is given to those speaking up

Feedback is given via the Freedom to Speak Up Guardian or directly by the Managing Director, of the service concerned, the relevant Executive Director or Chief Executive. Feedback includes how concerns have been investigated or responded to, any changes that have been made to processes and systems as a result, lessons learned for individual services and lessons that are transferable across the organisation.

Quarterly reports to Board identify themes from the issues staff are speaking up about and provide assurance that staff are fed back to appropriately.

How we ensure staff who do speak up do not suffer detriment

The Trust policy clearly states that the organisation will ensure that staff who speak up will not suffer detriment as a result. Staff who fear victimisation by colleagues can speak up anonymously via the Freedom to speak up guardian. They are offered assurance that their identity will not be revealed and their confidence kept. 46 people whose cases have been closed and where asked would they speak up again, 43 said they would.

Different ways staff can speak up if they have concerns over quality of care. Patient safety or bullying and harassment.

In addition to the Freedom to Speak Up Guardian staff can speak up via the usual routes, Safeguarding, Trade Unions, Human Resources, or their line manager. If staff have not received an appropriate response they can speak up to the Freedom to Speak Up Guardian.

There has been a significant increase in the numbers of staff speaking up within the Trust. Since the appointment of the Freedom to Speak Up Guardian in September 2017, 88 members of staff have contacted the Freedom to Speak Up Guardian to speak up. Things that staff have spoken up about include; patient safety, staff safety, failure for follow correct process, understaffing, wrongdoing, sexual harassment, racist bullying, biased recruitment and bullying.

Time period	Numbers of staff speaking up
April 2015 – March 2016	6
April 2016 – March 2017	4
April 2017 – March 2018	19
April 2018 – March 2019	69

What is it?

Freedom to speak up is about supporting the creation of an open, honest, transparent and safe working culture where staff feel able to speak up and are valued for doing so.

This is vital to help us to keep improving the quality of the services we provide to our patients and ensure a positive, healthy working environment for staff.

Who can speak up?

All staff, including bank staff and volunteers can speak up about safety, malpractice or wrongdoing, this can include patient /staff /visitor safety, professional conduct, bullying culture, cover ups.

If in doubt, raise your concern anyway. Do this even if it turns out to be untrue.

Our Freedom to Speak Up policy is available on the intranet and recommends that where possible to speak up to your line manager. Where this isn't possible you can contact the person they report to or the Freedom to Speak Up Guardian.

Who is the Freedom to Speak up Guardian?

Our Freedom to Speak Up Guardian is Lisa Ryder. Lisa's role is to support staff to speak up. You can speak to Lisa in confidence. She is independent and impartial.

You can contact Lisa on:

Tel: 07825 425410

Email: lisa.ryder@nhs.net

"It is important that we create a culture of speaking out and continue to improve service quality and safety."

Claire Molloy
Chief Executive

Evelyn-Asante-Mensah
Chair

"The trust is committed to working towards an open culture where staff who speak up are valued and supported."

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: 97.3%

	2016/17	2017/18	Trust Actual 2018/19		National Average 2018/19		National Range 2018/19	Thresh-old 2018/19
Patients on CPA who were followed up within 7 days after discharge	97.6%	97.7%	Q1	96.5%	Q1	95.8%	74.4% - 100%	95%
			Q2	98.8%	Q2	95.7%		
			Q3	98.0%	Q3	95.5%		
			Q4	95.8%	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 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 continues to work to reduce the risk of suicide and any problems in the immediate post discharge period as per national evidence and best practice.
- To show that all relevant 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:

- CPA follow up breaches are reported through Tableau for the purposes of monitoring and following up breaches. Tableau is accessible for 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 with Commissioners has launched the mental health improvement programme. The key workstreams include inpatient services, alternative to admissions and crisis service provision. This workstream includes all disciplines working collaboratively to review current service provision, best practice and consider service redesign, staffing portfolios and commissioning opportunities to reduce inconsistencies and improve quality of service provision and patient outcomes whilst supporting the financial sustainability of the organisation.
- The Trust continues to mobilise safer staffing resources including a range of new posts on inpatient services and strengthening existing staffing portfolios.
- The bed management function is being mobilised and the revised bed management protocol is fully embedded.
- This will involve the implementation of a new skill mix on wards and also the creation of a central bed management function.
- All schemes described above will also focus on releasing time to care to facilitate improved performance regarding 7 day follow up.

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: 98.4%

	2016/17	2017/18	Trust Actual 2018/19	National Average 2018/19	National Range 2018/19	Threshold 2018/19

Patients who were admitted to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.	99.9%	99.6%	Q1 Q2 Q3 Q4	99.1% 99.0% 98.7%*** 96.8%	Q1 Q2 Q3 Q4	98.1% 98.4% 97.8% **	78.8% - 100%	95%

**Quarter four national averages had not been published at the time of writing.
*** Following the identification of an error in the Q3 Gatekeeping national submission a revision request is pending with NHS Digital, the figures provided reflect the correct performance and match the revised data awaiting resubmission.

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 and strengthened night management function which will provide consistency across all Pennine Care NHS Foundation Trust sites and one point of entry for inpatient support increasing the robustness of gatekeeping.
- The inpatient and alternative to admission workstreams have a programme of work focusing on the gatekeeping function across the Trust. The programme is considering current inconsistencies, barriers to effective gatekeeping to consider if a new or revised approach is required to ensure consistent and effective gatekeeping for all admissions, this will also address the quality of gatekeeping.
- The developments of the safe haven approaches provide clinicians a new alternative in some Boroughs to consider at the point of gatekeeping.
- The Trust is working with the Clinical Commissioning Groups to review the current Home Treatment and Crisis provision in the context of the core fidelity model to understand the gap in staffing compliance and service offer to work with Commissioners to develop their commissioning intentions to work towards a core fidelity model by 2020/21 as per the requirements articulated in the Five-Year Forward View.

Mental Health 28-day emergency readmission rates

		2016/17	2017/18	2018/19		National Range 2018/19	Threshold 2018/19
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	10.7%	10.7%	Q1	9.9%	n/a	n/a
				Q2	7.6%		
				Q3	10.7%		
				Q4	11.8%		

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:

- A threshold for readmissions is included in each Clinical Commissioning Group contract. A breach of the threshold triggers a clinical review of the cases to understand the reasons and identify themes and trends.
- As part of the Mental Health Integrated Programme inpatient workstream, each locality has established a small working group to consider the inpatient admissions and develop systems and processes to address the areas of concern. In some localities this includes a review of readmissions/ short stay admissions to identify the rationale for readmission and alternative solutions that could be mobilised to prevent further readmissions.
- All data in relation to admissions is now readily available through Tableau for locality consideration.
- The Trust continues to review the Community Mental Health Team provision as part of the Mental Health Integrated Programme. This is a comprehensive review of systems and processes which will ensure a consistent Community Mental Health

Team offer across the Trust's footprint and a shared approach to support between in-patient and community services.

- The Crisis Resolution and Home Treatment and alternative to admissions workstream will also support in reducing readmissions.
- The development of the safe havens in each locality as designed to prevent unnecessary admissions.
- The Trust is working with the Clinical Commissioning Groups to review the current Home Treatment Teams provision in the context of the core fidelity model to understand the gap in staffing compliant and service offer to work with commissioners to develop their commissioning intentions to work towards a core fidelity model by 2020/21 as per the requirements articulated in the Five-Year Forward Plan.

Patient Experience of Mental Health Services

	2016/17	2017/18	2018/19	National Average 2018/19*
Patients experience of Community Mental Health Services with regards to contact with a health or social care worker	8.0	7.7	7.2	"about the same"
Listening	8.4	8.2	8.0	"about the same"
Time	7.8	7.7	7.4	"about the same"
Understanding	7.8	7.2	6.9	"about the same"

* There is no data to indicate the national average; however, information received from the CQC indicates 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 Friends and Family Test data and promote service areas to remind service users to complete continuously.
- A new crisis out of hours service has been launched to provide help and support to anyone aged over 18 years of age and their carers who are experiencing a mental health crisis and or emotional distress.

Patient Safety Incidents

	Local Rate			National Rate		
				Total No of incidents reported within the 54 Mental Health Trusts**		
Patient Safety Incidents*	**2017/18 Q1 & Q2**	**2017/18 Q3 & Q4**	**2017/18 Q1 & Q2**	**2017/18 Q3 & Q4**	**Median**	**Mean**
Number of Incidents	3554	3020	167,477	166,787	-	3,287
Rate per 1000 bed days**	42.31	35.49	-	-	-	39
Number resulting in: Severe Harm	2 (0.1%)	1 (0.03%)	532 (0.3%)	569 (0.3%)	-	2
Death	22 (0.6%)	59 (2.0%)	1212 (0.7%)	1331 (0.8%)	-	41
Total No incidents resulting in severe harm or death	24 (0.7%)	60 (2.0%)	1744 (1.0%)	1900 (1.2%)	-	42

* 2017/18 data reflects six monthly reporting periods quarter one and quarter two (incidents occurring between 1 April 2017 and 30 September 2017 and reported to the NRLS by 30 November 2017) and quarter three and quarter four (incidents occurring between 1 October 2017 and 31 March 2018 and reported to the NRLS by 31 May 2018) 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 National Reporting and Learning System (NRLS) of incidents reported between 1 April 2017 and 30 September 2017, and 1 October 2017 and 31 March 2018.
- To show the number and where available the 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 reporting procedures against the National Reporting and Learning System Incident Type Coding List for Dataset, to ensure that all patient safety incident reported within the Trust are appropriately reported.
- Robust and timely review of incidents by appropriate subject matter experts.
- Networking with local Mental Health Trusts to identify any further strategies to improve incident management and investigation processes.
- 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, 7 minute briefings to share lessons learned from serious incidents, and team presentations in regards to learning from suicide and mental health homicide incidents.
- Continued liaison processes with the CQC and NHS Improvement to highlight patient safety incidents and respond to information requests.
- Appointed dedicated Quality Leads to each of our Boroughs including a Specialist Services divisional lead for Quality with a brief to support improvements in patient safety through transformative learning rather than traditional transactional.
- Holding a *'Making Families Count'* conference in October 2017 held to promote the status of families in investigations, ensuring they are central to the process.
- Most recently the Trust has:
    - Appointed Quality Leads and administrators Teams within each of our six Mental Health Boroughs and specialist services.
    - Launched the *'Just Culture'* approach at a Trust conference in March 2019. A focus on systems issues instead of blame for errors, to improve incident reporting and learning.
    - Developed a comprehensive Quality Strategy with robust Patient Safety Delivery plan.

During 2018/19 a total of 4812 incidents have been uploaded to date (26 April 2019) on the National Reporting Learning System. The details of these patient safety incidents will be reported in the 2019/20 Quality Account and the table below is for information only.

Month	Total
Apr-18	469
May-18	500
Jun-18	422
Jul-18	377
Aug-18	388
Sep-18	411
Oct-18	438
Nov-18	404
Dec-18	344
Jan-19	357
Feb-19	346
Mar-19	356
TOTALS	**4812**

Part Three

This section provides an overview of care offered by Pennine Care NHS Foundation Trust based on performance in 2018/19 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 2017/18 are signposted and the rationale for the change is explained. Any inconsistencies between the data provided in this report and that reported in 2017/18 are signposted and explained.

3.1 Performance Showcased

All initiatives showcased in this section were selected by a panel representing all key stakeholder groups; patients and carers, staff and Council of Governors and our thanks are extended to the panel for their valued contribution and ongoing support to endeavour to showcase high quality improvement projects and initiatives that staff are engaged.

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.

Showcasing Panel

- Sara Barnes, Deputy Managing Director Mental Health and Learning Disability
- Lynette Whitehead, PALS/Volunteer Service Manager
- Wendy Hartley, Public Governor, Tameside and Glossop
- Mary Foden, Public Governor, Stockport
- Linda Chadburn, Clinical Effectiveness and Quality Improvement Lead (Chair)

Therapy Hub

By: TracyLee Gilbride, Service Lead, Therapies; Vicki Elcock, Head of Service, Urgent Care

Patient Experience, Clinical Effectiveness

Aim of the initiative

Health and Social Care Services are under pressure due to an ageing population, limited resources and an increase in the acuity and complexity of patient conditions. To ensure we continue to provide continued quality care services have recognised the need to integrate - not just within our own areas but across the whole system of health, social and third sector provision in order to make most effective use of existing resources, reduce duplication and ensure a seamless quality service for the patient.

Why we did it

When the Integrated Health and Social Care clusters were first discussed and planned, it was recognised that given the small numbers of staff in some of the Therapy teams it was maybe not as feasible or effective to split the therapies up into the five clusters. An options paper was presented to the Senior Leadership Team and it was decided that the preferred option for the therapy teams was to find a location that could accommodate all the staff (approx. 75) – the Therapy Hub. This Therapy Hub would then link closely with the five

Health and Social care locality based Cluster teams to ensure a seamless quality service for all our patients.

At this time the Therapy teams were located at several sites across Oldham; The Link Centre, South Link, Glodwick and Leesbrook. We considered the therapy service provision across Oldham and came up with the idea of the co-location and integrated working in line with the wider integrated model of care. The idea was to improve access for our patients and service users to refer into the therapy services. There were many referral routes into therapy services which caused confusion to patients and referrers. The idea to have one single point of referral for therapy referral made sense and the Oldham community embraced the idea.

Who was involved

The service leads looked at the integrated staffing model and the importance of co-locating staff to help improve patients pathways and experience. Initially the service leads visited other areas that had embarked on co-located therapy teams; some with other nursing and social care staff and some where they had remained separate (Sandwell and Calderdale). This formed the basis for an options paper and the decision to co-locate all the therapy teams together. Premises were then identified; The Link Centre in Oldham town centre, a council owned building that was at that point being underutilised and consideration being given to its future.

The teams across the Borough were involved in the service redesign and were fantastic contributors to help the project on its way. Stakeholders across Oldham contributed to the project plan and shared their ideas regarding the referral process. It was agreed that the one referral route would improve the experience for the patient and referrers and also make it easier for users to understand the offer within the community.

What we did and how we did it

Once it was agreed that the Therapy teams would be moving to The Link Centre and a date was agreed as July 2018, a project group was established to ensure the move went to plan. There were several other Oldham Metropolitan Borough Council (OMBC) and Miocare teams that were part of the move so the group consisted of representatives from all these groups. Pennine Care NHS Foundation Trust was represented by the Oldham Estates Manager and one of the Therapy Service Leads. Meetings were held fortnightly and looked at the proposed layouts of the rooms, communication issues around Information and communications technology, costings, furniture etc. to ensure a smooth move to the premises.

It was decided that Muscular Skeletal (MSK) Physiotherapy would remain at Werneth because of the requirement to use the gym and specialist clinic facilities that were not available at The Link Centre.

The Therapy teams that have co-located to the Link Centre are Community Occupational Therapy team, Adult Community Physiotherapy team, Falls prevention team, Stroke rehabilitation team, Community Neurorehabilitation team, Adult Nutrition and Dietetics team, Adult Speech and Language Therapy team and the MacMillan Allied Health Professionals.

Existing clinic rooms at The Link Centre previously only used by the Community Occupational Therapy team, are now available for other teams to utilise; which is a more effective use of clinician's time where appropriate.

Alongside the practical issues as detailed above there were regular meetings with the teams involved, staff workshops and regular communication updates to ensure everyone was kept up to date with the move. Once the move had occurred regular meetings with team leaders were held to update them on any practical issues and snagging lists were regularly addressed and updated.

The vision for the Therapy Hub and how all the teams thought this could work was addressed initially through a Polarity Thinking workshop led by a representative from NHS England and staff from Pennine Care NHS Foundation Trust's Organisational Learning and Development Department; where staff explored how they thought the Hub could evolve and what they wanted to work on as priorities. This was followed up by two staff workshops where staff further developed the vision, objectives and priorities for the Hub. Further workshops are planned with all staff. The vision, developed by the teams, is *to provide the best possible integrated care to enable the people of Oldham to live good quality, healthy lives closer to home.*

We have already implemented an electronic referral system for GPs and are looking to extend this to Acute Services and other referrers as soon as possible. We are working on an improved triage process where referrals into the Hub are triaged by a Multi-Disciplinary Team to ensure 'right team – right time'.

Team members have already started to attend the West Cluster Inter-Disciplinary Team meeting to ensure the Therapy Hub is linked in with the clusters; and we will attend other cluster Inter-Disciplinary Team meetings as they become established.

How we monitored progress and the measure we used

In the first few months of the project staff felt it was important to gain patient feedback. The initial comments were based around ease of access and referral pathways. Following the redesign, the staff and patients have fed back that there is a coordinated approach to the services they receive. Staff share their experiences and knowledge which can help management of individual cases. The team have received feedback from stakeholders who feel that the co-location has assisted in streamlining services and has helped with easier access to the therapy services.

Use of Family and Friends test
Team Specific Key Performance Indicators (KPI)
Feedback from staff in Cluster teams
Showcase day on March 6th – GPs, Oldham Clinical Commissioning Group (CCG)
Clusters, third sector agencies and others invited to event where all teams showcased their team and the work they carried out. Excellent feedback from all attendees.
Feedback from teams within the Hub

We are currently providing a high level report looking at the patients' experiences and data across Oldham. The main focus of this report is to capture patients' experiences and outcome measures for each individual.

Evaluation of the impact upon service, patients, staff and carers

Early evaluation has already identified many benefits.

Benefits of the co-location to date
One contact number for the public
Easy access to all teams - central location in Oldham
Shared professional expertise
Shared business support across all team - more productive and sharing of skills and knowledge
Introduction of new clinics- Neuro and Speech and Language Therapy clinics
Multi-Disciplinary Team - use of clinical rooms
One approach to triage - Right team-Right outcome
Release time to care - time saved not having to ring teams in other locations
Joint visits/car sharing more productive and efficient
Joint training sessions - building of skill base/shared competencies
Reduced number of meeting - increase in professional support across the teams
Cluster teams have one contact number and are developing specific links within the Hub

Living and working with The Therapy Hub

Background

The client has a brain injury resulting in post-anoxic cerebellar ataxia myoclonus. He has dysphasia and is a full time wheelchair user. He has also had a pacemaker fitted and has prostatectomy and right ulnar nerve entrapment. The client's wife has been his sole carer for some time; however, over time it has become clear that she needs additional support as his needs have increased. She also has her own health issues. The client is not eligible for disabled facilities grant funding and would be eligible to pay for formal carer support. They now have a privately funded Personal Assistant to assist with transfers / cares as there was a risk of carer breakdown due to the increased level of support required.

Referral

The client was initially referred to the service by his wife who was having difficulties turning him in the bed at night and supporting him if he needed the toilet at night. At the time of the initial referral he was able to stand to transfer using a self-bought non powered stand aid. Over the time of the input the clients standing ability has declined and all his equipment needs have had to be reviewed on an ongoing basis to meet his needs and enable him to continue to stand for as long as possible, as is his and his wife's wishes, and also from a physical health benefit.

Assessment and Input

Assessment has been ongoing to accommodate for the clients changing physical abilities and ensure that his functional abilities have been facilitated at all times. It has been necessary to review all equipment needs and refer to other services.

The following has been completed

Assessment with stock standing equipment Nothing suitable and special funding panel request sought to provide suitable stand aid initially. This has met his needs for a year in order to keep standing. It can now be reissued to other suitable clients.

Bed mobility Equipment fitted (bed slide sheet system) and referral to continence team to look at options to reduce the need to transfer at night.

Referral to Community Neurology Rehabilitation Team Physiotherapy input requested to review standing tolerance to assist with transfers.

Provision of Specialist Seating Client had no suitable seating. He was sitting in his wheelchair at risk of pressure injuries and postural deformities. He was experiencing high pain levels and was going back to bed throughout the day. There was no suitable seating in stock and a funding request was required for suitable seating with postural support and integral pressure relief. This now allows him to sit out safely and in comfort. This was also designed to allow him to continue with his standing transfers for as long as possible however it also still meets his needs now he is fully hoisted.

Support letter to Wheelchair Services The wheelchair issued did not offer a safe level of pressure relief or postural support therefore a review was requested and a support letter provided to ensure that these risks were reviewed.

Provision of a Shower Chair A non-stock tilt in space shower chair was required to allow him to continue to use the toilet and safely shower as his postural needs increased. His other shower chair no longer offered a safe level of support and he was leaning heavily to the side and at risk of injury to himself, his wife and his Personal Assistant, by having to reposition him regularly.

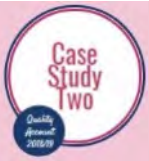
Hoisting Provision of mobile hoist as clients standing ability has reduced to the point the only option now is for full hoist, this is not suitable for single handed care long term. Client's wife has long been against having this in the home; however, she consented to the idea after seeing for herself how difficult moving and handling had become. Client and wife were not eligible for Disabled Facility Grant funding and Occupational Therapy offered to source other funding. However they decided to self-fund ceiling track hoist in the home. Stock slings provided; however, these are not working in this instance for

single handed care and they restrict the client when he needs to access the toilet. A non-stock sling has been identified and is to be issued that the carer can use singlehandedly The client is well supported and he is still able to access the toilet throughout the day.

The Outcome

The client is no longer standing despite Physiotherapy input and supportive equipment. However, his wishes have been met at all times. He is now fully hoisted by one Personal Assistant. All equipment is in place to facilitate single handed care safely and advice has been given. He will now be on the review list to ensure his seating is still meeting his needs; however, there is no further planned input once specialist sling has been issued and written information provided. It has taken some time to achieve this; however, the clients and his wife's wishes were respected at all times and his standing ability was facilitated for as long as was safe. As we worked with the client and his wife throughout, they were more accepting of equipment and support when needed. This would not have been the case if full hoist was suggested initially while there was still potential to stand and maintain some independence.

Living and working with The Therapy Hub



Background

N is a 75 year old male. He lives with his wife and she is his main carer. He has a diagnosis of cerebrovascular disease with left side hemiparesis and he has chronic pains along with a history of Anxiety and Depression. His mobility is impaired with a distinct ataxic gait; he mobilises indoors with a walking frame.

Referral

N was referred to the Community Occupational Therapy Team from the Community Matron at the GP surgery for difficulties accessing the showering facilities and negotiating the front access.

A member of the Community Falls Prevention Team was also involved with N, and had already provided a toilet frame and a shower chair. I was approached by H, the Occupational Therapist in the Falls Prevention team, to attend a joint visit with her to provide an assessment for the access, as she was unsure what recommendation would meet N's long term needs and required advice.

Assessment and Action

During the assessment I identified N had difficulty pushing up from the sofa; although he preferred to sit on the sofa due to comfort. The Occupational Therapist, H, was reviewing N's bed transfers. During this assessment, I observed N was struggling with sit to stand transfers from the bed. N's feet were also slipping during the bed transfers. He was

finding it difficult mobilising to the commode that H had provided, which was positioned beside the bed. He had fallen recently during this task. The space beside the bed was narrow, however N preferred to sleep on this side of the bed and expressed if he moved to the other side he would become confused and this could increase the risk of further falls. The bedroom was a small room and the double bed was not able to be re-sited to create more space. The bedroom door opened inwards making it difficult for N to mobilise with his walking frame to his side of the bed. N had problems negotiating the front access step. The front had double doors that opened outwards. This prevented the provision of rails being fitted.

H was unsure what minor adaptations could be done at the front access for N. A recommendation was made for a single door to be fitted with a platform step and rails. The bedroom door could be re-hung to enable N to mobilise safer into the bedroom with his walking frame. I discussed with N and H regarding the provision of a bed lever that was suitable for his bed type.

During the assessment I shared my moving and handling skills and knowledge with H and was able to inform her of equipment that would support N with the sofa and bed transfers. H was made aware regarding the use of a non-slip mat to prevent N's feet from slipping. We were able to determine a solution to the problems with the front access together sharing our skill mix and knowledge.

The Outcome

N was able to transfer in and out of his bed safer and mobilise to his bed with his walking frame, this reduced the episodes of falls. He could negotiate the front access without holding onto his wife's arm with the minor adaptations provided. The overall impact of the joint visit demonstrated a positive outcome for N and his wife. N's wife provides informal care support and has her own health needs. Our intervention has reduced the risk of carer breakdown and also the moving handling risks to the client and his wife. The emphasis of the joint visit has also prevented the client being placed on a separate waiting list. His needs were met effectively with a timely response.

DESMOND (A Diabetes Structured Education Programme)

By: Janette Daeth, Diabetes Specialist Dietitian; Alexis Halloran; Val Little, Head of Service for Adult Managed Care

Patient Experience, Clinical Effectiveness, Patient Safety

Introduction

The Oldham Diabetes Service is a partnership organisation between the Pennine Acute Diabetes Service based at the Royal Oldham Hospital and Pennine Care NHS Foundation

Trust's Oldham Community Diabetes Service. Based at our community service site we have 0.8 whole time equivalent, Band 7 Diabetes Specialist Nurse and Team leader, 1.8 whole time equivalent, Band 6 Diabetes Specialist Nurses, 0.8 whole time equivalent, Band 7 Diabetes Specialist Dietitian and Education Lead, 1.0 whole time equivalent, Band 4 Assistant Practitioner, 1.0 whole time equivalent, Band 3 Administrative support and 0.6 whole time equivalent, Band 3 Healthcare Assistant support. We work as an integrated team and Consultants and Diabetes Nurses from the hospital team deliver clinics on a weekly or two-weekly basis within the community setting.

We care for patients with Type 1 and Type 2 Diabetes on a variety of insulin regimes and other complexities including kidney disease, pancreatitis, cardiovascular, peripheral neuropathy and obesity. Currently we have a caseload of 1021 patients that have been in the service for six months or more.

Aim of the initiative

DESMOND is delivered in Oldham for patients who can speak and understand English and have been diagnosed with Type 2 Diabetes within the last 12 months. We are aware of the need to make the education session more accessible to patients who don't speak or understand English and have been diagnosed with Diabetes.

Why we did it

There is a high percentage of ethnic groups living in Oldham and of the increased risk of developing and being diagnosed with Diabetes.

According to the 2011 Oldham census, the most commonly spoken languages after English were Bengali and Urdu with 8502 and 4338 patients speaking these languages respectively. This project focussed on patients from these communities.

Who was involved
The lead DESMOND educator and DESMOND Co-ordinator
Urdu and Bengali speaking DESMOND educator
Local GP practices who had a high percentage of these population groups on their patient list (information obtained from the predicated prevalence rates for primary care practice registers for Long Term Conditions, Oldham Council June 2015) and Type 2 Diabetes diagnosis rates in the last 12 months by language spoken in Oldham GP's- (data source Oldham Clinical Commissioning Group, 2016)
Interpreters
Leaders of local ethnic community groups i.e. Pakistani Community Centre and Fatima Women's Group
Patients with Type 2 Diabetes that spoke Urdu and Bengali.

What we did and how we did it

We firstly attended a one-day course run by DESMOND, titled Cultural Adaptation; then conducted a needs assessment using the 2011/2012 Joint Strategic Needs Assessment and information from the 2011 census to support identification of Urdu and Bengali as the most commonly spoken languages in the area after English.

We then established focus groups to be delivered in Bengali and Urdu and used these groups to discuss the DESMOND programme; the style of delivery of the programme, the resources to be used and asked for comments on how we could best adapt the current programme to meet the needs of these ethnic groups.

All suggested changes were then reported back to DESMOND head office and pilot courses were designed and delivered in Bengali and Urdu; both in mother tongue and using interpreters.

We obtained feedback from the pilot sessions from the educators, the interpreters and the patients attending; before a final report was written and shared with the DESMOND head office, detailing all adaptations we had agreed upon.

How we monitored progress and the measures used

Notes taken during the focus group sessions and pilot sessions, as well as the feedback received from educators, interpreters and patients attending the focus and pilot sessions were used to monitor progress.

A pictorial evaluation form was designed and used with the pilot group; with the interpreters and mother tongue speaking DESMOND educators being able to explain to patients how to complete the evaluation.

How we evaluated the impact upon service/patients/staff/carers

We discussed the huge amount of time and effort it took from staff within the Oldham Diabetes Service to go through the whole cultural adaptation pathway and set up the focus groups and pilot sessions and make the necessary adaptations suggested.

We evaluated the impact from a patient perspective and the educators and interpreters perspective; with all comments and discussions being reported in a Cultural Adaptation report.

What the outcome was

DESMOND head office agreed and confirmed that the work we have completed meets their criteria to move forward and roll out the culturally adapted programme. We are currently having ongoing discussions about how to roll the programme out, including the costs attached.

Costs to run the culturally adapted version of DESMOND are greater than the standard DESMOND programme due to language support required; as well as Estates costs due to the time to deliver and resource the course. Costs are approximately £600 per course with additional bi-lingual administration support required for reminder calls.

A business case will need to be developed and discussed with the Clinical Commissioning Group. Meanwhile further information regarding the direction of structured education programmes in relation to the Greater Manchester Diabetes strategy are being sought.

Tailoring Literature Searches

By: Laura Jeffreys, Knowledge Specialist: Quality Lead, Knowledge Management Service

Clinical Effectiveness

Introduction

Healthcare knowledge and library services provide NHS staff with access to knowledge and evidence for decisions that support exceptional healthcare.

The Knowledge Service at Pennine Care NHS Foundation Trust offers several core services including: journal article and book supply; access to electronic resources via OpenAthens; literature searching; supporting staff in keeping up-to-date in their area of interest; and training in a range of information skills, from searching for healthcare information, to evaluation of research or online resources.

The team is currently comprised of two knowledge specialists and an administrator and is a freely available service for all staff, students on placement, and volunteers within the Trust. The Knowledge Service supports wide-ranging activities across the Trust from direct patient care, research projects, development of clinical services, non-clinical decisions, Continuing Professional Development (CPD) and learning. The Knowledge Service has scored over 90% in the Library and Quality Assurance Framework (LQAF) for the past several years.

Aim of the initiative

The aim of the project was to add value to the literature search offer from the Knowledge Service to ensure that the product was fit-for-purpose for all staff utilising the service rather than a one-size-fits-all approach. Literature searching is a core knowledge service and aims to facilitate access to the evidence-base for both clinical, non-clinical and managerial decisions made within the organisation.

A side aim was also to increase the productivity of the Knowledge Specialists.

Why we did it

All customers requesting a literature search are invited to provide feedback via an online survey; and some customers are invited to provide verbal feedback via a semi-structured telephone interview, to monitor the quality and value of the searches from a customer perspective. From feedback from these surveys and interviews, some staff told us they received too much information for their requirements which led them to either not understanding the results, or not using the results at all. Others said the information was too brief and led to ineffective decision-making. Equally where under- or over-delivery was encountered, this proved an unproductive use of the Knowledge Specialists' time.

As such we wanted to tailor literature searches to better suit the requirements of the staff requesting literature or evidence and thereby improve access to the evidence-base.

Who was involved

Key members of the Knowledge Service Team were involved in this initiative; including Dr David Low, Knowledge Service and Innovation Programme Manager, and Project Lead, Lucy Anderson BA MCILIP, Knowledge Specialist, Project Delivery and Evaluation, Laura Jeffreys (née Drummond) MA, Knowledge Specialist, Project Delivery and Evaluation, and Matt Johnston, Knowledge Service Administrator, Evaluation Support.

What we did

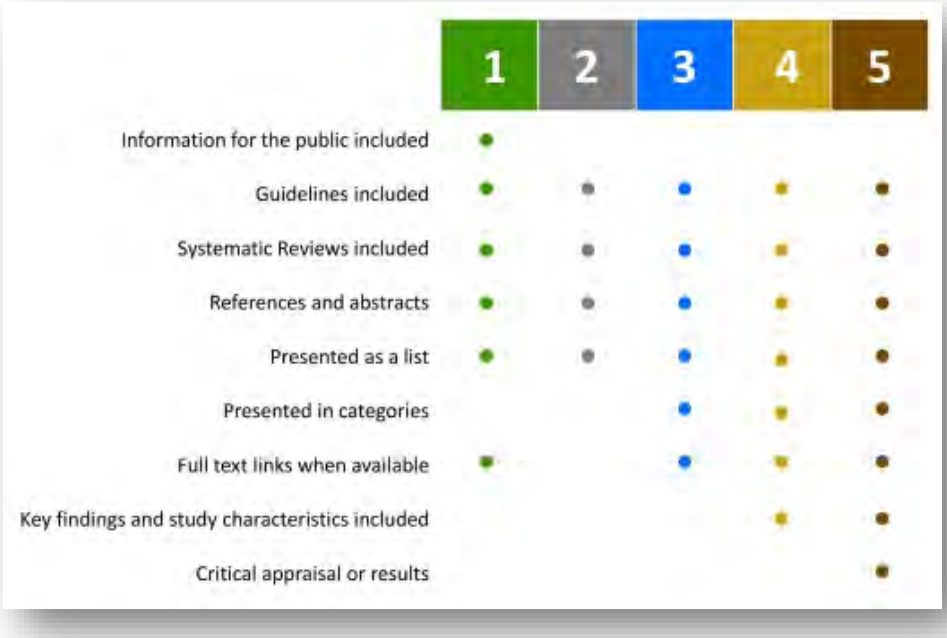
Knowledge Service Team formalised their literature search process and separated the search types into distinct categories or 'levels', each with a structured criteria.

Our structured criteria
Level One: Scoping search
Level Two: Bibliographic list
Level Three: Categorized bibliographic list
Level Four: Tabulated results with key findings and study characteristics highlighted
Level Five: As number 4 plus some critical appraisal and literature overview or summary

What we did and how we did it

Knowledge Service Team looked at existing research evidence on maximising the value of literature searches and contacted other NHS knowledge and library services to identify good practice. We found that some services in other NHS Trusts were already offering varying product outputs to positive effect.

Following the production of a new process for literature searching, the team spoke to each staff member who requested a search to determine their information need, for what the results were to be used, with whom the results would be shared and to negotiate time-scales. When this wasn't possible, information was clarified by email. This enabled them to follow the process and select the level of search required and to let the staff member know what to expect when they received their results.



How we monitored progress

Knowledge Service Team recorded the details of each search with the relevant information into a database including:

- Date requested and date delivered to identify turnaround times
- Time taken to complete the search. Every search is accurately timed, accounting for initial administrative support, planning, and delivery.
- We also discussed searches each week at the team meeting including:
- Assigning searches
- Support needed from the team
- Issues
- Good and critical feedback.

Measures we used

The Knowledge Service Team worked towards a turnaround time of 10 working days per question, unless otherwise agreed. Deadlines for those staff members who required a higher-level literature search are negotiated on an ad-hoc basis.

How we evaluated the impact upon service/patients/staff/carers

The team followed up searches with either a telephone interview or with an evaluation survey two months after the delivery of the literature search. In some cases both methods were completed. The information gathered identified how information from the search was used, how it helped support evidence-based practice and how these reflect the Trust values and goals.

What the outcome was

Positive Outcomes

Staff requesting searches now know exactly what product (i.e. level of literature search) they are receiving

Search reproducibility between specialists has improved

Searches can be more effectively prioritised

In quarter four of 2017-18 before introducing the new literature search process, it took on average 3.7 hours to conduct and deliver each search with little variation in the data. In the following quarter, after introducing the new levels, it took the knowledge specialists between 1.3 hours for level one search to 10.7 hours for a level four search (yet to deliver a level five). This enabled the knowledge specialists to be more productive and create value-added products. The average time per search was 2.4 hours which is a reduction of 35% from the previous quarter.

However, during January and February 2019, the average time per search extended to 4.5 hours due to an increase in searches assigned at levels four and five. Further analyses highlighted that this is a reflection that staff are increasingly recognising the benefits of using the evidence-base for higher-impact or higher-reach pieces of work.

The most recent evaluation survey results collected covered the period from April to July 2018. All feedback was positive and staff said that the literature provided by the Knowledge Service had an immediate contribution or probable future contribution on improved patient safety, quality of patient care, more informed decision-making, service development, collaborative working and personal development.

My Experience

One of the stroke nurses contacted the Knowledge Service for information to provide accurate and up to date guidance to a patient who was experiencing sudden onset of menopause following her stroke. The Knowledge Service carried out a level 3 search for up to date guidelines, patient information and research articles.

> "I didn't feel I had sufficient knowledge myself. The [service] was really great. I was able to give up to date advice to the patient and advise them what to expect from their GP".
>
> "It was really helpful. There were two sides to it. One was the information and education of the patient, the second was my education and updating. I was able to do both with the information, so thank you for that."
>
> Lydia Palmer, Stroke Nurse.

Eye Movement Desensitisation and Reprocessing Therapy

By: Dr Emma Shlosberg, Consultant Clinical Psychologist; Rebecca Knowles, Community Psychiatric Nurse

Patient Experience, Clinical Effectiveness, Patient Safety

Introduction

The Secondary Care Older Peoples Psychological Service consists of approximately 2.5 full time staff, and provides services across Tameside and Glossop, for older adults with complex psychological difficulties.

Aim of the initiative

The aim was to offer a course of structured evidence based psychological therapy to a patient experiencing high levels of distress; specifically high levels of anxiety, depression and anger characterised by frequent suicidal thoughts and ideas of self-harm.

The patient had previously received input from the Healthy Minds Service (approximately 2011) but due to the level of risk was transferred to Adult Services; specifically Access and Liaison Team and Crisis Resolution Team. Following assessment within this team, the patient was referred to Alcohol and Drug Services to focus on his alcohol misuse. A recommendation was made by the Advance Practitioner to re-refer the patient for psychological therapy following his involvement with Alcohol Services.

Following successful engagement with Alcohol Services, the patient, now aged 67 years old, was referred to Older People's Secondary Care Service and later the Older People's Secondary Care Psychological Therapy Service by his Community Psychiatric Nurse.

Why we did it

There is substantial evidence base indicating the effectiveness of delivering psychological therapies to older people. A wide range of difficulties are receptive to change, after the application of psychological therapies, including depression, anxiety disorders, including Obsessive Compulsive Disorder, Post Traumatic Stress Disorder, generalised anxiety disorder, panic disorder, and agoraphobia; as well as Personality Difficulties (Woods, 2015; Laidlaw, 2003.)

The value base underpinning the development and delivery of Secondary Care Clinical Psychology Services for Older People follows those of the Trust, namely to be Compassionate, Accountable, Responsive, Effective and Safe.

Its own additional values have always been to be:

Client centred	Carer sensitive
Culturally sensitive	Community orientated
Continuity of care	Collaborative
Communicative	Cost effective

The values of the service are informed by a model of community psychology; in particular the psychotherapy and social action model (Holland 1982), which aims to aid clients in overcoming mental health problems through personal psychotherapy, group coping and collective social action.

The services are delivered in line with national guidelines and best practice. This case study includes reference to the following:

DH Guidelines, including: Organising and Delivering Psychological Therapies (DH, 2004)
Everybody's Business (2005)
BPS Guidelines, including Generic Professional Practice Guidelines (BPS, 2008)
BPS Good Practice Guidelines on the use of psychological formulation (2011)

The case study illustrates extremely effective multidisciplinary team work in a patient with a long history of contact with mental health services. Following the intervention with the Older People's Secondary Care Service the patient was successfully discharged from services.

What we did and how we did it

The Clinical Psychologist met with patient to initially conduct a detailed biopsychosocial assessment. Biopsychosocial assessments are routinely offered which take a comprehensive, systematic perspective to integrating the psychological, biological and sociocultural influences on human development and functioning. Depending on the client's needs and the nature of their difficulties, a range of evidence based psychological

interventions can be offered including behavioural, cognitive behavioural, psychosocial, interpersonal, compassion based approaches along with systemic and narrative approaches.

At the time of assessment, the patient reported experiencing extremely high levels of distress characterised by frequent negative and intrusive thoughts related to previous traumatic life experiences explaining *'I carry so much hurt and rejection and I'm always beating myself up'*. So distressed with the nature of his intrusive thoughts he stated, *'My mind never stops, it's like 70mph, I want to rip my brain out'*.

The patient also reported regular intrusion symptoms in the form of both flashbacks and nightmares and a persistent inability to experience positive emotions; specifically holding negative beliefs about himself and the future. Throughout assessment, the patient voiced suicidal ideas with a specific plan of taking medication and alcohol. Risk was monitored closely with my colleague, a Community Psychiatric Nurse from the Community Mental Health Team requiring close multidisciplinary team working.

It emerged from the assessment that the patient had a poor attachment to his parents; particularly his father and an extensive history of childhood negligence and abuse. Assessment revealed a history of the patient engaging in distraction based coping styles, including alcohol misuse. At the time of assessment, the patient had a tendency to 'overanalyse' the past, searching for an understanding as to 'why' it happened. This ruminative style of thinking resulted in the patient feeling 'overwhelmed', 'stuck' and unable to move on with his life. At the time of assessment, the patient reported infrequent alcohol misuse and after a brief behavioural activation intervention he began to structure his week with various values guided activities.

Considering all the above, the patient's presenting difficulties were conceptualised within a complex trauma framework.

The Community Psychiatric Nurse worked intensively to prepare the ground for the psychological therapy whilst the patient was on a waiting list. This involved psychoeducation and skills based work for guided relaxation and breathing techniques and trauma specific grounding and safety work informed by The Post-Traumatic Stress Disorder Workbook (Williams & Poijula, 2001). When psychological therapy commenced the Community Psychiatric Nurse stepped back to minimise distractions from that process. The Community Psychiatric Nurse continued to provide risk assessment and review process. The patient was reassured to know that the Community Psychiatric Nurse would be there to support beyond the ending of the therapy process and to manage a patient led discharge from specialist mental health services.

Detailed biopsychosocial assessment was conducted by the Clinical Psychologist which allowed a detailed psychological formulation to be developed. Following this, an individually tailored evidence based psychological intervention was delivered based on the patient's unique clinical needs. Specifically, the following psychological interventions were offered:

- Skills based interventions designed to teach ways to manage psychological distress including Mindfulness, distress tolerance techniques, self-soothing and self-compassion strategies.

- Eye Movement Desensitisation and Reprocessing (EMDR), a Nice Guidance recommended structured psychological intervention designed to address psychological distress that is rooted in previous trauma.
- Values guided behavioural activation designed to increase the patient's engagement in meaningful activity.
- The patient attended weekly sessions with the Clinical Psychologist.
- Regular review from the Community Psychiatric Nurse supporting and consolidating therapeutic work.
- Regular/close liaison with Community Psychiatric Nurse to monitor risk.

How we monitored progress

The Psychologist worked closely with the Community Psychiatric Nurse and progress was closely monitored during each session, initially weekly reducing to monthly once therapeutic gains had been achieved.

The Community Psychiatric Nurse repeated cognitive assessment following the psychological treatment; concerns had been raised about possible impairment prior to therapy. At that time the patient was experiencing high levels of distress, suicidal impulses and intrusion symptoms related to past adult and childhood trauma: see below for results. Additionally the patient was content that they no longer wished to seek out support from specialist mental health services as they had developed a sustainable and positive range of social roles and activities in their local community. The Community Psychiatric Nurse conducted mental health and risk assessments as part of the discharged process and no signs or symptoms of significant mental illness or risk of harm to self or others could be identified.

Measures used

Measure	Before Therapy	After Therapy
Impact of Events Scale – Revised. The IES-R is a 22-item self-report measure that assesses subjective distress caused by traumatic ***events***.	Avoidance symptoms - 26 Intrusion symptoms - 32 Hyperarousal symptoms - 23 **Total IES-R score- 81** **(a score of 33 and above represents the best cut-off for a probable diagnosis of PTSD**)	Avoidance symptoms - 3 Intrusion symptoms - 5 Hyperarousal symptoms - 0 **Total IES-R score- 8** **(NON CLINICAL)**
DASS 21 The Depression, Anxiety and Stress Scale - 21 Items is a set of three ***self***-report scales designed to measure the emotional states of	**Extremely severe** Depression (18) **Extremely severe** Anxiety (17) **Extremely severe** stress (17)	**'Normal'** range for Depression (2) **'Normal'** range for Anxiety (0) **'Normal'** range for stress (3)

depression, anxiety and stress.		
WHO 5 Wellbeing Questionnaire A short self-reported measure of current mental ***wellbeing***. Scores range from 0-100, with higher scores indicating greater wellbeing.	12	84
ACE III A cognitive assessment administered by a trained practitioner (Community Psychiatric Nurse).	81/100	93/100

We evaluated the impact upon service, patients, staff and carers

Service user feedback questionnaires were used to evaluate the impact of the work we had undertaken. Qualitative feedback was gathered over the course of therapy.

A review of referral data for the patient revealed repeated presentations to services over the 6 years prior to the combined Community Psychiatric Nurse Psychologist interventions described. Subjective reports from the patient following this suggested a very successful treatment outcome resulting in a well-equipped individual who no longer felt they needed any support from mental health services and is therefore much less likely to be referred back with the same problems in future.

What the outcome was

Quantitative assessment All outcome measures showed significant clinical improvements with all psychological indicators falling in the non-clinical range, post therapy.

Qualitative assessment The following comments were received:

The patient reported a significant reduction in intrusion symptoms explaining *'I'm in a much better place, I don't over think things now, I take every day as it comes along';* describing a renewed ability to live in the present moment reflecting *'this is good enough!'* The patient described feeling more assertive and stronger explaining *'if things happen – they happen'.*

The patient also stated *'previously the memories harmed me – they can't harm me now!'*

By the end of therapy, the patient had re-engaged in life; attending the gym, organising short holidays with friends and volunteering at a local cancer charity shop.

Feedback received from the service user end of therapy form:

'When you took me on, I was broken; I felt I was a hopeless person'.

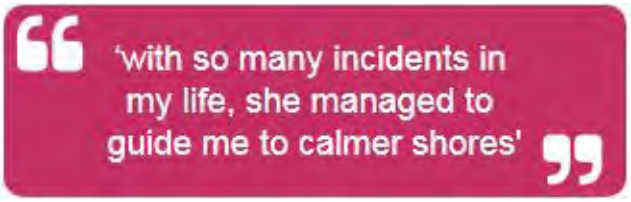
'you stayed with me even though at times I thought I was going insane, with so many incidents in my life, she managed to guide me to calmer shores. By using the tools she has given me I can control the issues by blocking them, I can now sleep better, laugh, smile. I now no longer take myself back to my past'.

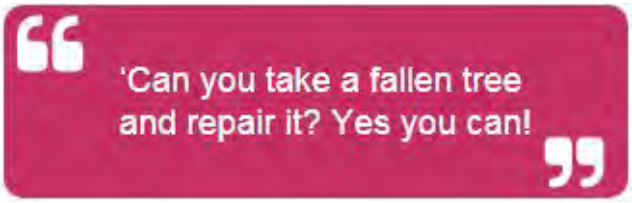
'EMDR to me helped me control my emotions. Things can't hurt me now',

'I found it calmer'.

'The boxes have lids with names on. I know what is inside them. I don't need to open them'.

'Can you take a fallen tree and repair it? Yes you can!'





Cognitive Stimulation Group

It's like the moon…a light shining down on dementia

By: Lynne Turton, Whittaker Day Unit

Patient Experience, Clinical Effectiveness

Aim of initiative

The aim of this initiative was to provide the individuals whom had received a diagnosis of dementia, access to a therapeutic group. At this time it was also recognised that individuals given a diagnosis of Vascular Dementia received less services than those with a diagnosis of Alzheimer's Disease. It was identified as a clinical need by staff working in the Older People Mental Health Service. This would aim to improve their cognitive abilities as well as improving their social skills and preventing social exclusion. By providing the Cognitive Stimulation Therapy it was hoped to improve the general cognitive function and engagement in mentally stimulating activity for our clients. The aim was to improve the learning, cognitive functioning, concentration, mood, confidence, memory, language, comprehension and orientation of the service users. All of the goals stated above were achievable and evidenced based (Hall et al., 2012, Orrell et al., 2014).

Why we did it

Informal cognitive stimulation and reminiscence intervention was routinely delivered as part of the therapeutic activity group programme at Whittaker Day Unit. The National Institute For Health and Clinical Excellence, NICE Guidance on the Management of Dementia (2006) and NICE Dementia: assessment and support for people living with dementia and their carers (2018) recommend that structured group cognitive stimulation therapy should be offered to people living with mild to moderate dementia, providing opportunities for engaging in a range of activities and discussion that are aimed at the improvement of cognitive and social functioning. This is also reflected in the Memory Services National Accreditation Programme (MSNAP) Standards for Memory Services (5th Edition, March 2017) which states that a timely diagnosis must be followed by quality timely post diagnostic care, including psychological treatment. They specify access to a local programme of age appropriate Cognitive Stimulation Therapy should be available. It was decided in 2017 to run a pilot of a formalised Cognitive Stimulation Therapy Group.

Assessment within the group involved observation of the cognitive functioning of people living with mild to moderate dementia and also its impact on different aspects of their lives, particularly emotional, social and personal. The initiative was to establish a therapeutic intervention which would promote the maintenance of existing cognitive skills and functioning, to live well and productively with their diagnosis of dementia.

Swaab (1991) states that increased mental activity can lead to improvements in learning and increased cognitive functioning in dementia patients. It can also lead to new neuronal pathways being formed. As discussed by Spector, Cognitive Stimulation Therapy has been shown to be effective at improving concentration, mood and confidence (Spector et al.,

2011). By understanding the evidence behind the research, the initiative aimed to improve the quality of life and wellbeing of this client group within Tameside are Glossop.

The initiative provided the opportunity to develop a pathway from diagnosis at Memory Services, intervention at Whittaker Day Unit, and interface with the third sector. This would support individuals following diagnosis and engage them in a journey to support them to live as independently as possible within their communities.

Who was involved

The Cognitive Stimulation Therapy Group was developed by staff from the Whittaker Day Unit and Memory Services within Tameside Older People Mental Health Services. The Group was an initiative driven from members of a multidisciplinary team to ensure a relevant skill mix was utilised. This consisted of Mental Health Nurses, Psychology Assistant, Assistant Practitioner, Occupational Therapist, and Support Workers. People involved in the project have changed over time to provide opportunity to invest in staff professional development:

At strategic planning stages: Lynne Turton, Senior Occupational Therapist, Day Service Manager and Olwyn Fuller, Memory Services Manager.

Delivery stages: Whittaker Day Unit Team: Joanne Houghton, Mental Health Nurse; Sarah-Jayne Walker, Mental Health Nurse; Amanda Egerton, Assistant Practitioner; Eleanor Taylor, Psychology Assistant; Christine Clegg, Nursing Assistant; Michael Bromilow, Support Worker. Memory Services: Michelle McCusker, Mental Health Nurse; Susan Slater, Support Worker.

What we did and how we did it

Nominated staff from both services have been supported to attend formal training in Cognitive Stimulation Therapy, delivered by the Cognitive Stimulation Therapy Training and Consultancy organisation. This ensured the intervention would be facilitated by competent staff who have a wealth of experience working with people at all stages of dementia.

The initial pilot programme was devised based on the ‘Making a difference Cognitive Stimulation Manual for Group Leaders’.

The programme ran for the duration of 14 weeks, which was split into 7 weeks of Cognitive Stimulation (2 sessions a day) and 7 weeks of maintenance (1 session a day). Each session lasted for approximately 1 - 1 ½ hours. The sessions activated cognitive functions such as decision making, long, short and autobiographical memory, language and semantic processing, using auditory perception, making judgements, problem solving, visuo- perception and skills, facial recognition, reading and concentration.

Inclusion criteria was used to identify individuals clinical need and suitability and this included:

- Individuals with a diagnosis of dementia and in the mild to moderate stages.
- Individuals with relatively intact receptive and expressive language abilities, who were able to communicate and understand in a group environment to allow them to make the most of the material.

Exclusion Criteria identified that clients in an acute crisis phase of mental health or advanced stages of dementia would not be suitable.

All potential participants were invited to attend a screening assessment to confirm suitability, offer information about the group programme, and the opportunity to give choice and involvement in making decisions about if they felt this intervention would be beneficial as part of their treatment plan and on-going living with dementia.

The sessions were carefully planned by the team and key decisions were made in advance around delivery to ensure that they ran smoothly. This included preparation of how to manage potential group dynamics. Plans for delivery were also based on prior cognitive assessments, so that the strengths and areas of difficulties for each of the participants could be considered. Aims of the group were also based around encouraging the participants to have fun and share their humour to optimise engagement and positive experiences. During the session if the group facilitators were aware that the participants made a mistake, they did not prompt or attempt to correct them, this was centred on a 'no failure approach'.

Staff chose what sessions they considered would be most appropriate and interesting for clients, from the 24 suggestions in the manual. Some sessions were adapted to be appropriate for working with individuals with co-morbid mental health difficulties, such as the session on life history. Due to the practicalities of working within the Day Hospital, environment facilitators chose to run 2 sessions a day for 7 weeks and then 1 maintenance session a day for a following 7 weeks. The sessions were extended from 45 minutes to between 60 and 75 minutes, to ensure each client had appropriate time to contribute. The themes of each week were as follows:

Week	Session One	Session Two
Week 1	**Physical games** Involved playing a physical game of skittles. Clients were encouraged to also keep score/shout out the numbers on the skittles.	**Sounds** Involved playing a game of sound bingo; the sounds were common sounds such as a washing machine. The second activity involved playing famous songs (50's – 80's) and matching with pictures of the singers.
Week 2	**Childhood food and toys** Involved tasting retro sweets (lemon sherbets, liquorice) to promote discussion and reminiscence. The second activity involved comparing new and old childhood toys place on the table, promoting discussion.	**Food and budgeting** Real and Fake food items were priced up, clients had to choose items to make a meal and add up the amount if possible. The second activity involved tasting old foods to promote reminiscence (corned beef, piccalilli etc.)
Week 3	**Current affairs** Involved discussing famous news stories which were printed out as prompts and also discussing current affairs from recent paper.	**Local scenes and Categorising famous faces** Firstly pictures of local scenes were placed on the table to promote discussion and reminisce. The second activity involved categorising

		famous people. For example into singers, women, alive, comedians.
Week 4	**Life history and Names** Involved discussing where people went to school, where they have lived etc. The second activity involved discussing the meaning of peoples first and second names which had been pre-prepared for each individual.	**Being creative** The activity was to make Christmas cards.
Week 5	**Number games** The first activity was to guess the number of items in 3 jars filled with different objects. The second activity was to play dominoes.	**Quiz** Involved doing a general knowledge quiz and then '12 days of Christmas' Quiz.
Week 6	**Categorising objects** Involved categorising objects in different ways (e.g. Tomato, cucumber and apple). The second activity involved using word fluency to play a similar game to Scattegories.	**Word/Visual Game** Involved playing 'headbandz' game in which you have to guess various objects and animals from certain clues.
Week 7	**Household tips and treasures** Discussed household tips and treasures from the past and how these have changed.	**Orientation** Involved looking at a map of the UK and marking on places visited/places of importance, to promote discussion. Then looked at postcards from various UK holiday destinations to promote reminiscence.

The maintenance session followed some of the same themes but also included additional sessions. For example an 'Art discussion', 'Associated word matching' and a visually prompted discussion around old and new money and the cost of living 30 years ago compared to now.

All group sessions were facilitated by two members of staff; one to take a lead and one to prompt clients and ensure everyone was included. Without the second facilitator it is possible that quieter participants' comments could have been missed. Within the pilot group the psychology assistant was present to make observations of the content, delivery and client's performance and engagement.

How we monitored progress and the measures we used

Aims are outlined within the Manual and are to stimulate people's minds to be active and engaged, encourage new ideas, thoughts and associations, help to orientate people, focus on people's strengths, use reminiscence and stimulate language and executive functioning. Therefore the overall aims of this Cognitive Stimulation Group were to enhance cognitive and social functioning through implicit learning, ultimately aiming to improve quality of life.

Weekly evaluations for the group took place by group facilitators at the end of the each day. Doing this enabled staff to monitor the impact of intervention upon clients, monitor suitability, and review the content and delivery of material. Clients' progress was also monitored by live observations, assessment of clients' performance, and improvement within the group.

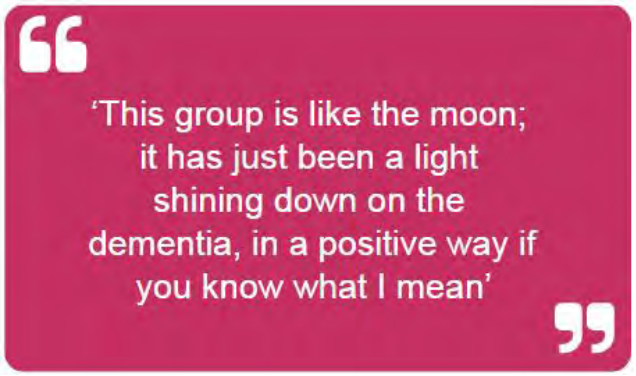
Measures used
Dementia Quality of Life, Version 4. (DEMQOL) Questionnaire.
Rating of Anxiety in Dementia Scale – RAIDS.
Cornell Depression in Dementia Scale.
Addenbrooke's Cognitive Examination – ACE III

How we evaluated the impact upon service, patients, staff and carers

Prior to the group starting, participant's suitability was assessed through the clinical observation and formal cognitive testing using the Addenbrookes Cognitive Examination ACE-III. Before the group started, individuals were asked to complete the DEMQOL version 4, Dementia Quality of Life questionnaires. Participants were re-assessed with the same questionnaire when the group came to an end. Result from both were collated and showed the essential quantitative data that were used for the evaluation of the intervention.

Weekly evaluations for the group took place by group facilitators at the end of each day. Doing this enabled staff to monitor the impact of intervention upon clients, monitor suitability, and review the content and delivery of material. Reflections from the weekly evaluations is taken forward to review the content and inform planning of future programmes, so that session themes or delivery methods can be changed or adapted where needed.

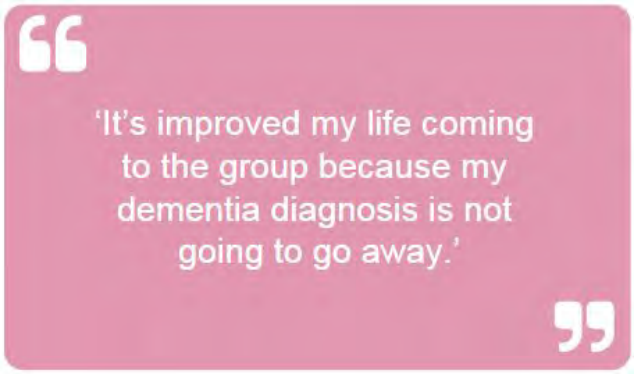
In addition, staff asked families for feedback to check how the participants were functioning within their own home and if they

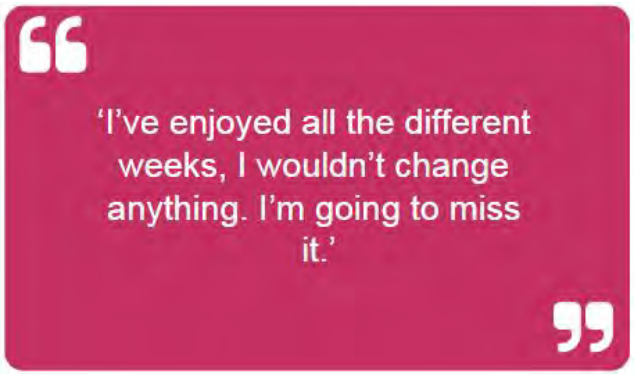


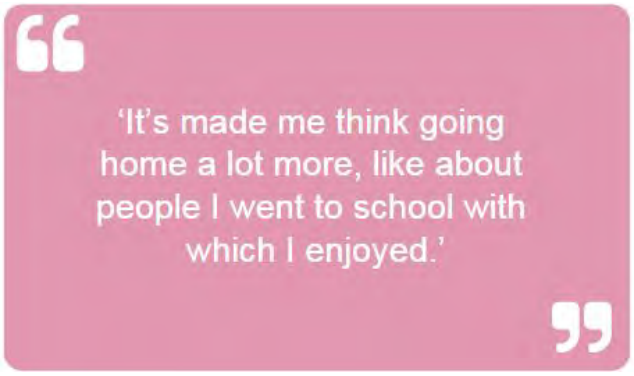
had made any improvements. Staff then used this information to feedback into team meetings which aided the evaluations of the groups. The staff felt rewarded by the group as they were able to observe the changes which took place. This included how they had progressed in their participation of task, and how people were able to form social bonds with one another. Throughout the groups, the participants also commented on their experience; this feedback was taken and used within the evaluations.

The final session was used as a 'celebratory afternoon tea' to mark the ending and to facilitate an informal discussion to collect qualitative feedback which would contribute to the programme evaluation and be included in the executive summary. In addition to giving individuals the opportunity to give feedback on the Cognitive Stimulating Therapy Group, they were also asked to complete a Friends and Family Test card to give comments on 'How likely you are to recommend our service to friends and family if they needed similar care or treatment?' This incorporated their experience within the group and also receiving a service at Whittaker Day Unit, and contributes to the client evaluations from the unit that are sent to the Patient Experience Team and contribute to the monthly Pennine Care NHS Foundation Trust patient experience evaluation.

The initiative was highly beneficial for the two services which were involved as skills were transferred between the teams. Although merging two services to facilitate one intervention has presented some challenges, both teams have met at key intervals. This facilitated planning and evaluation to identify potential practical







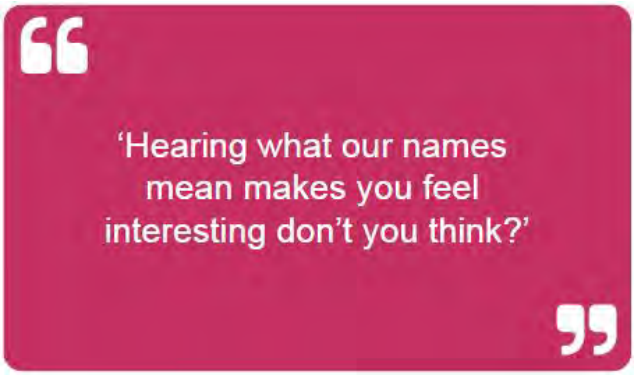
difficulties and best use of resources to deliver the intervention successfully. This was supported at a strategic level by the managers of each service, and provided opportunities for more experienced facilitators to share their evaluation.

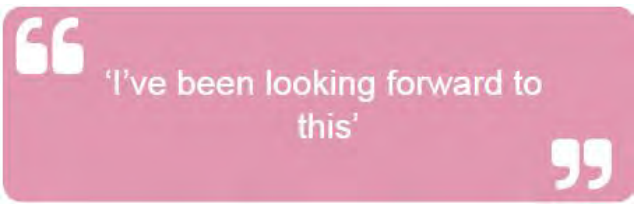
What the outcome was

Following the evaluation of the initial pilot programme and subsequent ones, it was evident from the outcome measures and the qualitative feedback that the Cognitive Stimulation Group was a success.

Data summarised from the DEMQOL questionnaires used for outcome measures indicated that for many of the individuals their quality of life had improved, and a reduction in depression and anxiety symptoms were evident.

Observational assessment was valuable in seeing the change in individuals over the duration of the 14 weeks. They showed enhanced cognitive function, and demonstrated an increase in both their confidence and social skills. The programme enabled individuals with a similar diagnosis to come together, become more socially included and accepted for the 'Live well with dementia programme'. Qualitative feedback was essential to review the value and meaning of Cognitive Stimulation Therapy for the individuals, and to engage them in meaningful evaluation of services. The overall feedback from clients has been that they have enjoyed the group and found it interesting. A client stated they were 'more alert' which is in line with Spector et al., (2011) research suggesting that Cognitive Stimulation Therapy can lead to an improvement in concentration. Additionally, research has suggested that the therapy can improve mood and quality of life

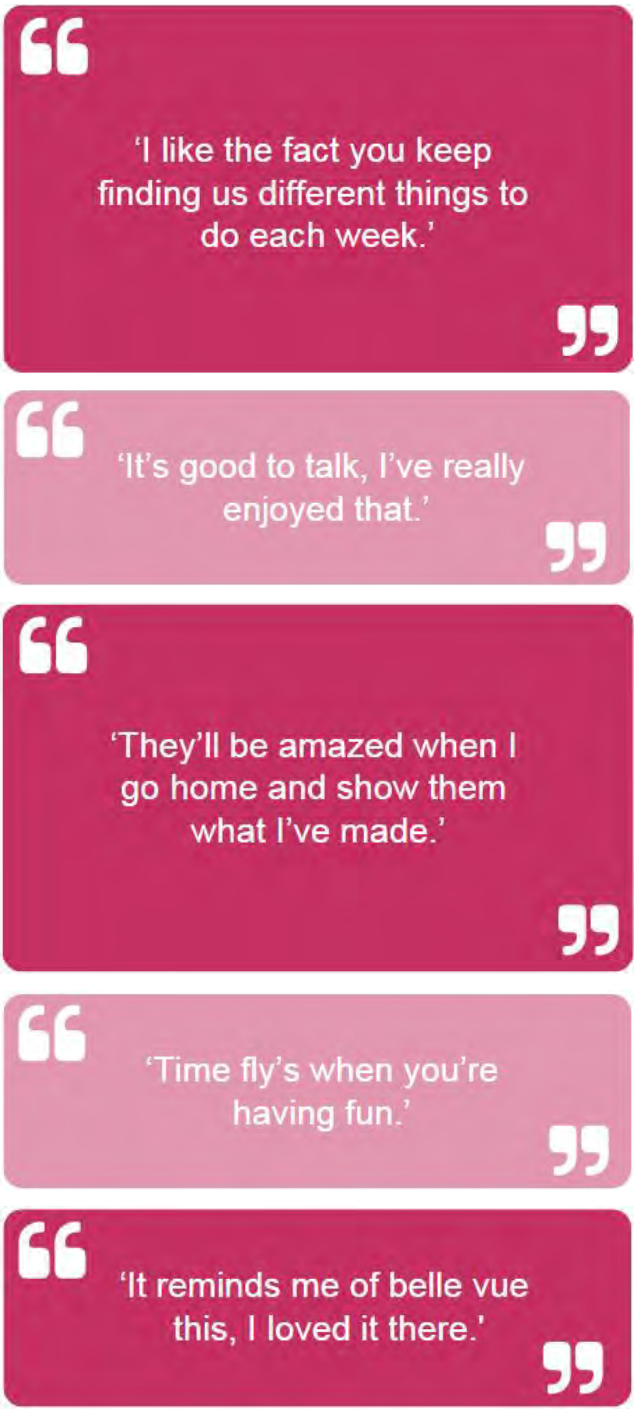




(Spector et al., 2011; Orrell et al., 2014) this was evidenced in this group as one client commented ‘this has really helped my depression’.

As the group came to the end, it was apparent that due to the bonds between people, they wanted to stay together as a group. A consistent theme from the programmes has been the value of developing a new social network. As a result, it was decided to support the transition to day services within the Tameside community. This has involved the Assistant Practitioner and Support Workers working with third sector services such as Age UK, The SHED, and the Canal Boat Society. Some people transferred as a group to continue their journey and social inclusion, others attended a service in pairs and others have explored voluntary work.

One pilot and three further programmes of Cognitive Stimulation Therapy have been delivered to date. This has supported collaborative working of staff from the Whittaker Day Unit and Memory Services. Investment in training has offered already experienced staff further professional development which supports the Trust’s values to deliver services by a competent and skilled workforce.



Strategic management from both services have demonstrated a commitment to shared accountability for delivering this intervention. This initiative has enabled Tameside Secondary Care Older People Mental Health Services to enhance the pathway for individuals who are given a diagnosis, particularly for those with Vascular Dementia who are discharged back to the care of their GP.

The two services are working collaboratively to deliver the psychosocial interventions and this will meet the standards for the 2019 accreditation with the Royal Collage of Psychiatry for the Memory Service National Accreditation Programme. The pathway offers access to a secondary care service providing a fluid course of assessment and treatment, involving diagnosis, Memory Information Group, Cognitive Stimulation Therapy and transition to third sector day services. By developing services in this way the individual experiences a fluent

journey which offers a focus of empowerment and confidence to live a good quality of life following a dementia diagnosis.

Mr Cole… I never thought I'd be where I am now

By: Lynne Turton, Whittaker Day Unit Manager

Patient Experience, Clinical Effectiveness, Patient Safety

Background

The aim of this case study is to provide an example of outstanding care delivered by Tameside Older People Mental Health Services. Mr Cole experienced a dramatic decline in his mental health which required assessment and treatment from secondary care mental health services. This included The Tameside Liaison Mental Health Service for Older People team within A&E, Hague acute psychiatric ward, the Psychology Therapy Service, Community Mental Health Team and the Whittaker assessment and treatment day unit. He received a seamless service facilitated by the interface of professionals from each service. This is evident in Mr Coles' own evaluation of his patient experience.

Why we did it

Tameside Older People Mental Health Services are all committed to the Trust vision 'To delivering the best care to patients, people and families in our local communities by working effectively with partners to help people to live well'.

Central to delivery of services to our clients and their families are the Trust values to engage them within the assessment process. This is essential to ensure the person and their family feel valued in formulating a treatment plan which is based on an individualised assessment, and delivers a meaningful treatment plan by skilled staff, which the person, their family and the multidisciplinary team will evaluate to be effective in responding to the mental health needs and promoting a positive recovery.

Mr Cole experienced a mental illness which was triggered by a traumatic experience where he required emergency surgery for a bowel resection in 2008. This followed several years of medical investigations. He reports challenging and distressing episodes prior to 2008, where he tried to seek medical assessment for abdominal pain; however, felt dismissed by medical professionals. Mr Cole believed this experience changed his life, his emotional and social functioning, and left him feeling unable to trust health care professionals. In addition, detailed assessments revealed a childhood characterised by severe adverse events.

Who was involved

The multi-disciplinary team involved in Mr Coles care included, Consultant Psychiatrists, Clinical Psychologists, Psychology Assistants, Community Psychiatric Nurse from the Older People Community Mental HealthTeam, Occupational Therapists, Nursing Staff, Support Workers, and Pharmacists at ward round meetings. Mr Cole has had named keyworkers/ Community Psychiatric Nurse within all service areas; Dr Nayer, Consultant Psychiatrist; Dr Emma Shlosberg, Consultant Clinical Psychologist; Melanie Greaves, Community Psychiatric Nurse Community Mental Health Team; Debra Williams, Team Manager of Community Mental Health Team; Brigid Woodcock, Hague Ward Manager, Natasha Murry, Keyworker on Hague; and all other staff on Hague Ward; Sarah-Jayne Walker, Staff Nurse, keyworker Whittaker Day Unit; Lynne Turton, Whittaker Day Unit Manager and Occupational Therapist; and all other Whittaker Day Unit Staff. Home Intervention Team; Tameside Liason Mental Health service for Older People; Ashleigh Adam, Involvement Co-ordinator; and the Trust's Patient Advice and Liaison Service.

What we did and how we did it

Mr Cole initially presented at his GP in November 2016 with suicidal ideation and plans. He was referred to Tameside A&E where he was assessed by the Mental Health Liaison Service. From A&E he was transferred to Hague Ward for an informal admission, due to severity of risk of harm to self. He was discharged in January 2017 with support from a named care co-ordinator from the Community Mental Health Team. In February, Mr Cole experienced a further relapse in mental state, with biological symptoms of depression, increased anxiety, paranoid ideation, and suicide plans and intent. In response to Mr Cole's mental health deterioration and escalating risks, with no protective factors, a second admission to Hague Ward was facilitated by his Community Psychiatric Nurse in consultation with the Consultant Psychiatrist.

During the admission Mr Cole worked with the nursing team to complete the initial assessment of his mental health needs. He engaged in one to one time with his named nurse to complete an individualised formulation based on the five P's model (Predisposing, Precipitating, Perpetuating factors, Problem definition, and Protective factors.) This provided Mr Cole with a sense of value in his contribution to his assessment, and gave the multi-disciplinary team a comprehensive understanding of his personal narrative leading to his current mental health circumstances. The Addenbrookes Cognitive Screening Examination (ACE III) was administered with Mr Cole to establish a baseline of his cognitive function.

Mr Cole was referred to the Older People's Psychological Therapy Service, and Whittaker Day Unit as part of his pathway of assessment and treatment as an inpatient. He attended

weekly multi-disciplinary ward round reviews with the Consultant Psychiatrist. At this time the Pharmacist was also present to facilitate a review of medication efficiency. The multi-disciplinary team worked collaboratively with Mr Cole to review his risk assessment and treatment plan each week. He consistently had a plan for medication, intervention and periods of leave. During the admission, the nursing team supported Mr Cole in maintaining his physical health investigations. The team involved Mr Cole in his assessment to formulate risk management plans as he progressed to have periods of graded home leave. During this time Mr Cole's Community Psychiatric Nurse remained involved in his care as a consistent mental health professional who he had previously formed a positive relationship with. She attended ward round reviews and co-ordinated communication with the wider team involved in his care.

Mr Cole attended Whittaker Day Unit as an inpatient. Initially he was reluctant to attend the therapy groups available; however, was given information and support to make informed decisions about what he felt would support his treatment during the admission. He was offered attendance at Whittaker Day Unit on days which offered activity for clients with a functional mental health presentation. He routinely attended from the ward two days per week, which formed part of his treatment package, and prepared for on-going assessment and treatment post discharge. Mr Cole was instrumental in making decisions about the interventions he valued to be beneficial for his mental health and psychosocial well-being. He initially chose to engage in the art group, cognitive challenges and Mindfulness.

Throughout Mr Coles' experience of the Older People Mental Health Services, he has been central to his assessment and treatment plans. This gave him a voice to express his psychological trauma and symptoms which he believed to be impacting on his ability to manage daily life. Engaging with Mr Cole with open communication ensured that he felt valued to engage, and his assessment lead to a meaningful and individualised treatment plan.

During the admission Mr Cole expressed on-going concerns about his diverticulitis and felt reluctant to progress with periods of home leave due to fears of how he would cope with any flare up. Medical staff on the ward responded to such concerns by liaising with the surgical registrar who was able to provide information from medical investigations. Mr Cole completed graded periods of home leave. During the leave, he received consistency in support from services including his Community Psychiatric Nurse home visit from the clinical psychologist, telephone communication with ward staff, contact from the Home Intervention Team, and supported transport with his son or the Whittaker Day Unit support worker. For each period of leave, Mr Cole engaged with the multi-disciplinary team during ward rounds to plan a collaborative documented Leave plan. This process supported the discharge planning. Mr Cole was discharged in April 2017. His immediate discharge plan included a seven day follow up meeting with his Community Psychiatric Nurse at his home, weekly Psychology appointments, attendance at Whittaker Day Unit two days per week, and information with telephone contacts for appropriate services.

Following an admission to Hague Ward all inpatients are provided with a Whittaker Day Unit information file giving details about the therapeutic group interventions available. From the initial visit to Whittaker, Mr Cole was allocated regular days of attendance, so that this could be incorporated into his weekly treatment plan on the ward. During each attendance,

Mr Cole was given the opportunity to discuss which groups he felt would be beneficial to attend as part of his treatment. Following discharge from Hague Ward, Mr Cole has worked with his keyworker to be involved in the assessment of his mental health and engage in formulating his individual care plan. He has been encouraged to engage with staff to make informed choices about which therapies would support his treatment and recovery process, giving a sense of collaborative working and ownership of his treatment. This was particularly valuable to Mr Cole, because of his previous experiences of health care services. During attendance at Whittaker Day Unit Mr Cole has completed the psychological therapy groups including the Acceptance And Commitment Therapy (ACT), Mindfulness and Relaxation to learn skills for future recovery. He has also attended the discussion and cognitive challenge, gardening and domestic activity groups.

From the Psychology assessment, Mr Coles' presentation was conceptualised within a trauma framework. Collaboratively it was agreed to offer a course of Eye Movement Desensitisation and Reprocessing (EMDR). Eye Movement Desensitisation and Reprocessing is a NICE guidance recommended structured psychological treatment effective for the treatment of current psychological disturbance that can be rooted to an earlier trauma.

Considering the context of Mr Coles' difficulties (mistrust of hospital clinicians) a considerable period of time was spent building a trusting therapeutic alliance. In addition, during the early stages of treatment Mr Cole was taught several affect management techniques, including Mindfulness, which gave him the necessary tools to manage distressing thoughts and feelings as they emerged.

The patient was seen for 1:1 therapy on Whittaker Day Unit. His attendance there along with his participation in the various therapeutic groups and social activities played a significant role in his recovery offering him the opportunity to consolidate skills learnt in therapy and access vital peer and social support.

The multi-disciplinary team working with Mr Cole have been supported by the Psychology service to gain a deeper understanding of his personal narrative. This has been facilitated by the completion of the 'Stick Man', a psychological formulation. This has offered peer supervision and opportunity to share experiences of working with Mr Cole to gain a richer and more comprehensive evaluation of his mental health needs.

During episodes of relapse signs, the service has been responsive to Mr Coles needs. Risk assessment and Risk Management is implemented on a collaborative approach with the multi-disciplinary team. Whittaker Day Unit has been responsive by adjusting the number of days attendance when increased support was needed. This in addition to structured support from the Community Mental Health Team and Home Intervention Team has facilitated timely risk management plans which have involved Mr Cole in the care planning process. Staff have supported him to recognise his personal progress and encouraged recovery to reduce his sense of need to be dependent on Mental Health Services to cope with challenges.

Regular routine reviews with the Consultant Psychiatrist and multi-disciplinary team have offered Mr Cole consistency in evaluating his needs. During these reviews he has had the opportunity to voice his self-appraisal of his progress, express any concerns and

collaboratively plan for further recovery. Throughout attendance at Whittaker, Mr Cole was involved in discussions about possible transitions to day services which would promote his social inclusion needs and offered introductory visits supported by Whittaker Support staff.

How we monitored progress

In addition to formal measures, objective observations by clinical staff were recorded as evidence of Mr Cole's mental state, cognitive functioning, occupational functional skills, and social interactions. During individual time with his Community Psychiatric Nurse or Whittaker Keyworker and multi-disciplinary team reviews, Mr Cole has been invited to share his subjective evaluation of his experience and self-rate his affect. This has empowered him to feel valued in his care. These reviews with the Consultant Psychiatrist and multi-disciplinary team have offered Mr Cole consistency in evaluating his needs. During these reviews he has had the opportunity to voice his self-appraisal of his progress, express any concerns and collaboratively plan for further recovery.

Measures we used

Psychology: WHO 5 Wellbeing Scale was 24 at the start of therapy, by the end this was 80.

The WHO-5 Well-being Index is a short, self-administered questionnaire covering 5 positively worded items related to mood, vitality & general interest. It has shown to be a reliable measure of emotional functioning. Each of the 5 items is rated on a 6 point scale. Scores are summated with a raw score ranging from 0 -25. The scores are then transformed to 0-100 by multiplying by 4. Higher scores mean better well-being. A 10% difference can be regarded as a significant change.

How we evaluated the impact upon service/patients/staff/carers

Throughout Mr Cole's involvement with secondary care mental health services, he has been keen to share his experiences. He has completed the Trust's Friends and Family Test cards. He has taken part in Patient Advice and Liaison Service (PALS) engagement with service users to evaluate the service received at Whittaker Day Unit. This was completed through semi-structured interviews by a Patient Advice and Liaison Service Involvement Worker. Mr Cole has attended Pennine Care NHS Foundation Trust's consultation exercises and future strategy events. He has also contributed to focus groups on the subject of the Mixed Sex Accommodation project during the patient consultation process.

What the outcome was

Through a comprehensive assessment with Mr Cole, it was evident that he initially presented with complex psychological needs and a high risk of suicide. The formulation completed on Hague Ward and further formulations at Whittaker Day Unit, suggested precipitating and perpetuating factors to include his experience of disappointing appointments for his physical health where he felt let down by the information and response he received from staff. This resulted in losing trust in health care professionals. When reflecting on his personal experience of the Mental Health Services for Older People, it is evident that he required the assessment and intervention from the different teams and specialisms to ensure a comprehensive and holistic assessment was offered. This followed a collaborative approach by services, which is enhanced by the location of each being within the one building. For Mr Cole this provided a fluent journey on his pathway of

assessment and recovery. He worked with a consistent team of skilled professionals who were open in their communication with him. This enabled Mr Cole to feel valued as a partner within these processes and to have a voice about his care. He engaged with the clinical team to formulate a meaningful and individual plan of care as recognised by the Trust's values.

During the initial stages of Psychology intervention, Mr Cole rated his traumatic memories as highly distressing describing great difficulty attending hospital appointments to monitor his physical health. Following the desensitisation phase of treatment, Mr Cole no longer reported his memories as traumatic stating "*I'm 100% different now!"* explaining the traumatic memories had "*gone; it doesn't bother me anymore"*. Mr Cole's adverse childhood experiences were also addressed. By the end of therapy he explained "*I don't ponder on it now!"* recognising an emotional shift from anger to acceptance "*I've accepted it's part of my history; it's part of what happened to me"*.

Following the end of therapy Mr Cole fed back the following:

"To anyone who is about to use the service. Don't worry about it. Go to it with an open mind. Put your trust in the person you will be working with. I had my doubts like all people at first. I am not an easy person and was in a bad place but it worked. Give it a try. You can't lose anything! Simply the best. Thank you".

Qualitative feedback was consistent with quantitative feedback with results on depression measures at the end of therapy moving to the non-clinical range.

Mr Cole has developed a range of psychological coping skills, including application of mindfulness, relaxation, self-soothing, and valuating thoughts and behaviour in response to trigger situations. He has been able to use these skills to cope with challenging life events, including physical health concerns and medical investigations, his wife's health needs, social and family stressors and bereavements. During which time Mr Cole experienced a change in his emotions, however accepted this to be a normal reaction to such events and managed to maintain a stable mood and functioning. It was agreed at the multi-disciplinary team review in May 2018 that he would reduce his attendance at Whittaker Day Unit to one day. At the end of 2018, Mr Cole was discharged from the Community Mental Health Team and the Psychology Service. He was supported by his keyworker at Whittaker Day Unit to consider alternatives to attendance which would maintain a meaningful and productive routine, supportive of his social inclusion and recovery needs. Mr Cole engaged with the Volunteers service and has now taken a role as a befriender in the Stamford Unit Intermediate Care Service at Tameside Hospital. He has also taken up a befriender role with 'Being There', a Tameside charity providing home based support to people with a life limiting illness.

Mr Cole is now a motivated advocate for Tameside and Glossop Older People Mental Health Services. In addition to involvement in patient experience consultations, he has offered compliments in written form which have been shared with the Trust's Compliments Department and acknowledged by the Chief Executive.

When he reflects on his personal experience of Tameside Older People Mental Health Services, Mr Cole offered the following comments:

"It's brilliant, it really is. I'd stand up in front of a room full of people to say what help they would get from the service. Put your life in to it, it's worthwhile, 100%. I don't think people ever get cured. I don't expect to never get bad days, but I never thought I'd be where I am now.

It's also a lot to do with relationships with other patients. A mutual understanding. Getting to know each other leads to an acceptance. They notice the change. It's like a family, everyone understands.

The staff have given me the confidence to have the feelings in my heart to help people. That's why I'm volunteering. It's something I never thought I'd do. It's one of the best things I've done and it's through what I've learnt here. For once in my life, I've done something I can be proud of, getting well again and taking on a role to help other people."

Podiatry Direct

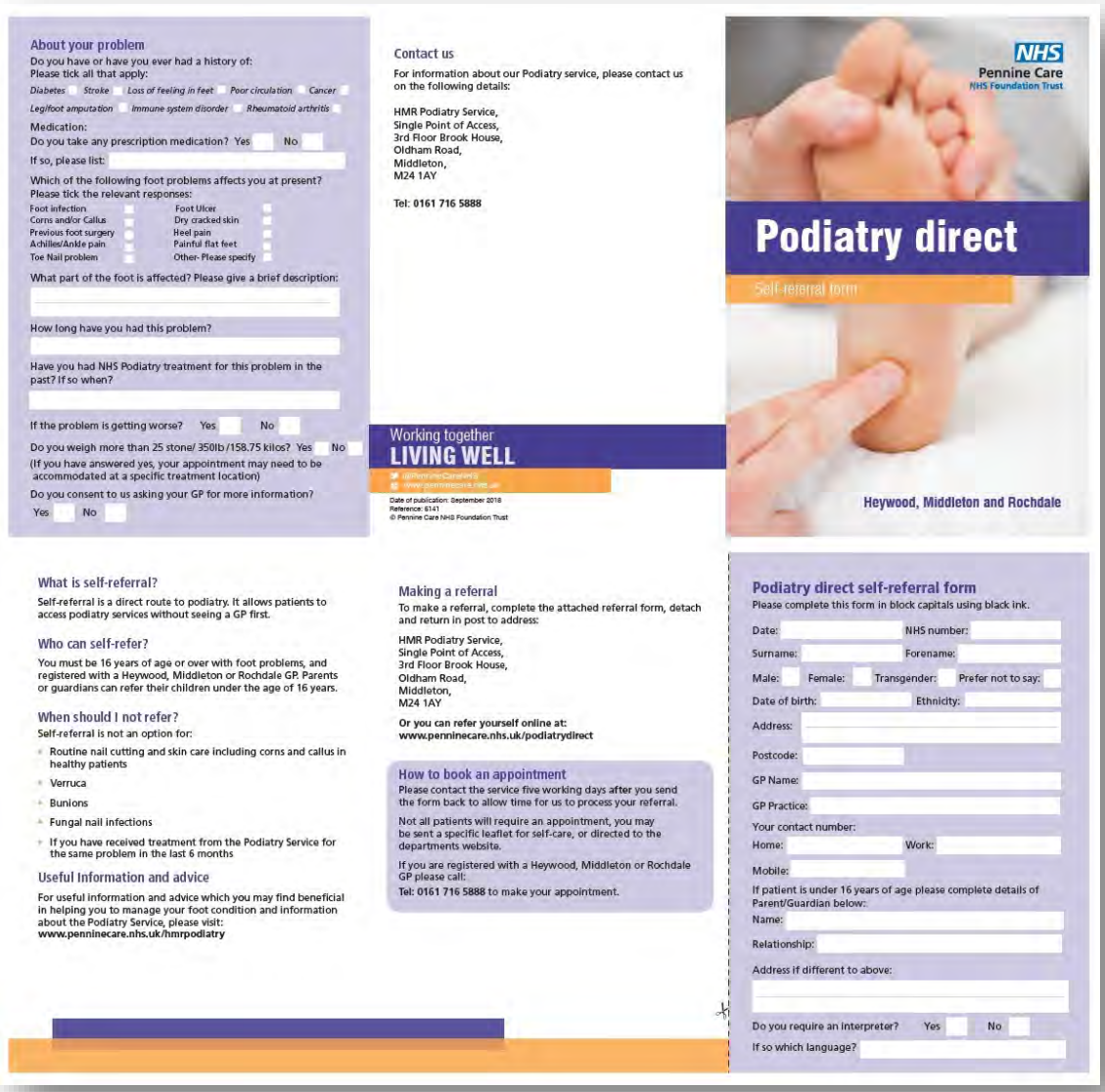
By: Karen Pritchard, Podiatry Team Leader, HMR; Sandra Barnett, Podiatry Strategic Lead, HMR, Bury and Oldham

Patient Experience, Clinical Effectiveness

Aim of initiative

Patient self-referral to NHS services is becoming increasingly prevalent resulting in significant NHS and patient-related cost benefits. Benefits to the NHS include reduced investigations, reduced prescribing and release of valuable medical consultation time and costs. Benefits to patients include quicker access direct to the service, negating the need to see a GP, less reliance on medication, appropriate referral for diagnostics, development of self-management strategies and increased autonomy in making decisions about their care. Specifically to Podiatry, there has also been an increasing emergence nationally of self-referral schemes employing new technologies to increase methods of access.

Whilst the HMR Podiatry service already offered self-referral through a paper based form which could be obtained in GP surgeries, the service was not widely promoted and the paper based form was the only method of access. Building on the opportunity afforded to the service to redesign the service delivery model in the 2016 procurement exercise and the success, knowledge and experience of other Pennine Care NHS Foundation Trust self-referral services, namely Military Veterans and Physio Direct, a CQUIN was proposed to re-launch self-referral as 'Podiatry Direct' utilising multiple methods of access including the development of an innovative on- line self-referral platform. The initiative was financed through a local CQUIN scheme.



Why we did it

The launch of Podiatry Direct aimed to give patients more autonomy and support the self-management agenda. The service was already using a paper patient referral and the opportunity came with the local CQUIN to expand it to an on-line platform.

Patients can now use their computer, phone or tablet to refer straight in to podiatry service and prevent GP appointments. The launch has increased patient referrals and decreased GP referrals.

Who was involved

A variety of teams have been involved in the initiative, including the Trust's Creative Design Team, Communications Department; Agency 97, who designed the website; the Trust's Patient Experience Team; the Single Point of Access team, who processed the referrals; Paula Jones, Adult Services Lead, as project lead; Sandra Barnett, Podiatry Strategic Lead, HMR, Bury and Oldham; Karen Pritchard, Podiatry Team Leader, HMR; and the Podiatry triage team.

What we did and how we did it

Development and implementation of paper based 'Podiatry Direct' (postal form)

This phase significantly involved the Trust's Creative Design Team who developed the paper based (postal) referral leaflet, form and posters which would be made available in all GP practices and Pharmacies, together with other key stakeholders such as Petrus, Sanctuary and Diabetes support groups. All promotional materials and form were co-designed with patients. Patients attending the Podiatry drop-in service were asked to comment on the design of the form, the quality of the information provided, the clarity of the instructions to make an appointment and the ease of filling in the form. Full roll out of the paper-based version was slightly delayed due to the time taken to develop promotional materials. A downloadable version of the form was made available on the Podiatry homepage of the Trust website.

Roll out and promotion of the paper based referral and ensuring governance approval for on-line platform

This phase saw the continued roll out and promotion of Podiatry Direct (postal). Promotional materials were distributed initially to GP practices in July 2018, and then to Pharmacies and other stakeholders. Surgeries were offered the opportunity for a practice visit to discuss the scheme should they wish.

In this phase, the design brief was established with the web design company, Agency 97; however, further development of the platform was delayed due to the complexities and time taken in completing and gaining approval against the Privacy Impact Assessment (PIA) through the Trust's internal Information Governance Processes. Approval was received late October 2017 allowing the development to progress.

Implementation of 'Podiatry Direct' Online May 2108

This phase involved the implementation of the on-line self-referral platform and training of both clinical and administration staff in managing the associated administration platform for triage and booking of appointments.

How we monitored progress and the measures we used

To evaluate the effectiveness and impact of Podiatry Direct, referral patterns have been analysed pre-implementation, post paper-based (postal) implementation and post online implementation. Patient Experience questionnaires have also been distributed and analysed, both the paper based (postal) and the on-line self-referral method. GP's shared an electronic questionnaire to collect experiences.

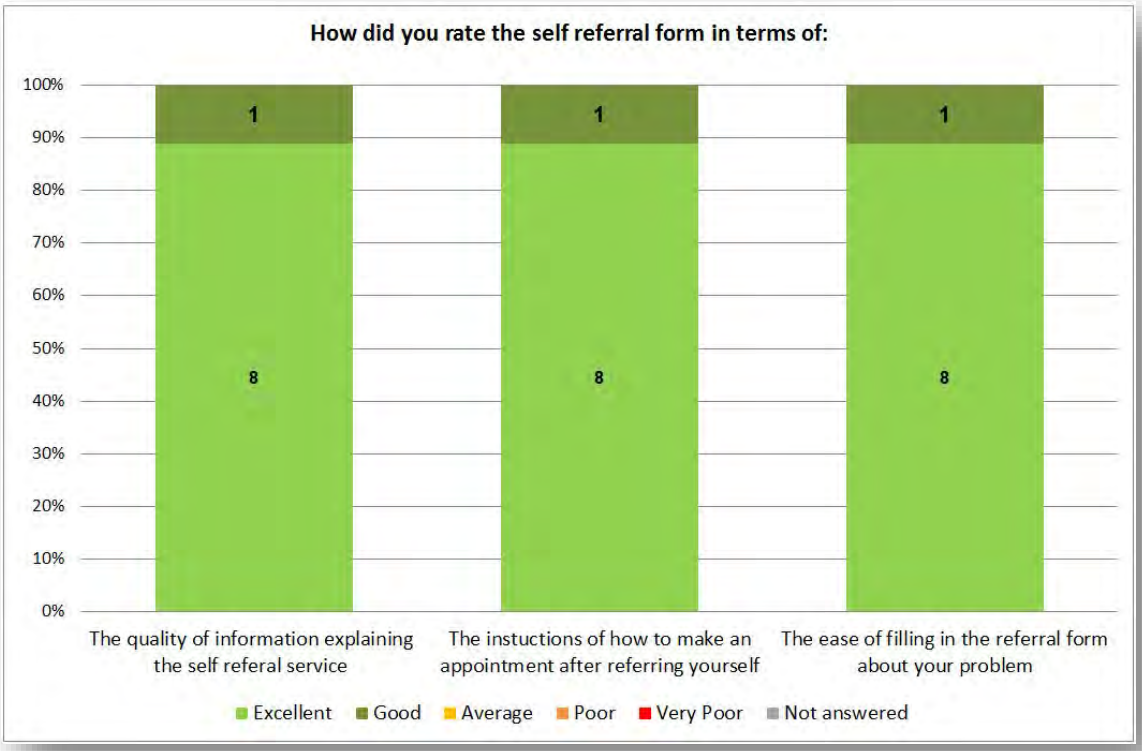
Referral Analysis There has been no obvious increase in referral numbers since the introduction of the scheme over the last 18 months, with an average of 454 referrals per month. This reassuringly suggests that to date there is no unmet need, although it is still early in the implementation process for the on-line route.

Pre – Implementation From 1 April 2017 to 21 July 2017, 1987 referrals were received. Of these 85% were made by GP practice, 10% were self-referral.

Post paper-based (postal) implementation From 1 August 2017 to 31 May 2018, 4575 referrals were received. Of these 72% were made by GP practice, 24% were self-referral.

Post online implementation From 1 June 2018 to 21 September 2018, 1606 referrals were received. Of these 64.5% were made by GP practice, 33% were self-referral.

Patient Experience Questionnaire Outcomes 35 patients who had used the paper based form were sent a patient experience questionnaire either in the post or through a text message link during quarter 3. Of these, there were 9 respondents; 100% of patients said they would use the service again.



How we evaluated the impact upon the service, patients, staff and carers

Patient comments were collated.

Attempts have been made to contact GP's to evaluate the impact of the scheme on GP practice time and to explore the level of awareness of the scheme in primary care; however, to date no responses have been received.

> Good easy access and fast appointment
> Very helpful and a speedy appointment and problem was addressed.
>
> I found this to be a very efficient service. The referral service was very easy to understand and use. I received an appointment quickly and was offered a choice of clinic location. The podiatrist was extremely professional and explained my treatment and future management. A fantastic service - many thanks.
>
> It's a cracking service so much easier than seeing GP first

What the outcome was

A very effective product has been produced and well received and it is anticipated that other services will be able to learn and adapt the product in the future.

Fracture Liaison Service

By: Gareth Hughs, Physiotherapist and Team Leader; Helen Ashton, Urgent Care Service Lead, MSK Physiotherapy, Falls Prevention team, Community Stroke Team and Community Neuro Rehabilitation Team

Patient Experience, Clinical Effectiveness, Patient Safety

Introduction

Pennine Care NHS Foundation Trust's Oldham Falls and Fracture Prevention Team, Pennine Musculo-Skeletal Partnership, Oldham Clinical Commissioning Group, Pennine Acute Hospital and the National Osteoporosis Society came together to re-design and improve the effectiveness of the Fracture Liaison Service that was being offered by Pennine Musculo-Skeletal Partnership at the time.

A steering group was established up to improve the service with the input from the three organisations and led to the implementation of a re-designed service led by Pennine Musculo-Skeletal Partnership in June 2018.

Aim of the initiative

To identify, investigate, initiate treatment and integrate care for all eligible patients over the age of 50 within Oldham who have suffered a fragility fracture; with the aim of reducing their risk of subsequent (or secondary) fractures.

To assist patients in ageing well and see a reduction in disability; increasing the number of people being able to live at home for as long as possible, with the aim of having fewer people suffering serious falls.

To respond to the first fracture to prevent a second.

To work in partnership with patients, their carers, health and social care professionals to ensure patients achieve their potential ability and to promote independence.

To assist in the prevention of un-necessary hospital admissions.

Why we did it

The National Osteoporosis Society provided details for the population of Oldham that suggested that a Fracture Liaison Service would deliver financial benefits through the prevention of future fractures leading to a reduction in non-elective admissions and bed days.

Modelling, using estimates of benefits provided by the National Osteoporosis Society, indicates that implementing a fully resourced Fracture Liaison Service will prevent approximately 171 fractures over five years.

The current average acute length of stay following a hip fracture at the Royal Oldham Hospital is 14.4 days. It has been estimated that over five years, a Fracture Liaison Service in Oldham could prevent 73 hip fractures, which equates to 1,051 acute bed days saved.

As well as being costly for the Trust, each of these fractures can have a serious impact on an individual's quality of life, including their ability to care for themselves and their risk of further morbidity. Hip fractures lead to a significant loss of healthy life years. In one study, as many as 27 disability adjusted life-years per 1,000 people (over the age of 50) were lost due to hip fractures.

Who was involved

The new Fracture Liaison Service is a joint venture with the Pennine Acute NHS Trust, Pennine Musculo-Skeletal Partnership, Pennine Care NHS Foundation Trust and Oldham Clinical Commissioning Group.

Pennine Musculo-Skeletal Partnership provides the administration to review the fractures from the database and uses specialist rheumatology nurses and nurse practitioners to deliver advice, medication and treatment where necessary.

The Pennine Care NHS Foundation Trust's Falls Prevention Team as part of the Integrated Therapy Hub provide the immediate short term rehabilitation to improve post-surgery and treatment outcomes to patients that have suffered a fracture. The teams also provide the long term rehabilitation to ensure patients remain fit and healthy with good strength and balance to further reduce the risk of falls and subsequent fractures in the future.

Pennine Acute Trust provide the post-operative fracture care such as assessment and diagnostics and refer on to the Fracture Liaison Service and Falls Service that are based in the community once the patient leaves hospital.

What we did and how we did it

The steering group reviewed the existing pathway and developed a cost effective model that captured more patients that had suffered a fragility fracture from the radiology database. This model contacted patients in a timely manner after the fracture and offered an assessment for osteoporosis, where appropriate they are provided with bone health medication and a referral on to the Falls Team if required to prevent further falls.

Case finding is carried out via the radiology database of all fragility fractures. It became apparent during the design of the Fracture Liaison Service that there would be an increase in referrals to the falls service.

It was agreed that the potential onward referral data would be monitored for a 6 month period to assess the impact. This data has been analysed and it has shown 50% of Fracture Liaison Service patients would be referred to the falls service; this is not including patients that are already known to the falls service. Currently discussions are taking place within the steering group to ensure the team can manage the increase in referrals and the team are looking at what additional resources are needed.

How we monitored progress and the measures used

The National Fracture Liaison Service database captures the number of patients identified through Fracture Liaison Service; the number of patients that are assessed by Fracture Liaison Service and the number of patients who are treated with appropriate medication. Pennine Care Musculo-Skeletal Partnership submit data to the National Fracture Liaison Service database.

Expected Outcomes

Prevent people from dying prematurely

Enhancing quality of life for people with long term conditions

Helping people to recover from episodes of illness or injury

Providing a positive experience of care

Increase cost-effectiveness by reducing variation and delivering best practice through locally agreed standardised pathways for bone health interventions for secondary fracture prevention

Reduce costs to the local health economy through effective secondary fracture prevention

Reduce the long term incidence of hip fractures in people aged 65+ and 80+

Reduce the incidence of fragility fractures

Increase in the number of referrals to the Falls Prevention Team

Reduction in the number of acute bed days

Increase in the percentage of people aged between 50-74 with osteoporosis who are being treated with a bone sparing agent

Increase equity of service, with equal access to services for the whole population

Improve the quality of the experience for the individual and their family by developing high-quality education around the opportunities for intervention

Learning Lessons From Suicides and Homicides

By: Matt Walsh, Patient Safety Lead; Richard Cliff, Trust Solicitor

Patient Safety

Aim of initiative

To deliver, firstly to adult mental health front-line managers and then front-line staff, two sessions arising from suicides and homicides that had occurred for patients of Pennine Care NHS Foundation Trust. The sessions were aimed at delivering three key messages:

1. Current national data
2. Current learning from internal incidents
3. Current research and learning to support better informed risk assessment, formulation and management.

Why we did it

The NHS Serious Incident Framework informs and drives the Trusts approaches to undertaking investigations into serious incidents and the lessons learned, usually taking the form of an ‘action plan’. The experience of the effectiveness of action plans reaching front-line staff is patchy and the evidence of a transactional approach to learning being effective is also poor. This piece of work brought front-line colleagues together as a team to discuss the data, lessons and best practice in a forum designed to encourage reflective thinking about cases open to them and to inform and drive critical thinking about current cases and risk management.

Who was involved

Matt Walsh, Patient Safety Lead, delivered the sessions to front-line staff. Richard Cliff, Trust Solicitor, constructed the slide decks and gave in-put to lessons arising from coroner’s inquests. National Confidential Inquiry into Suicide and Homicide (NCISH) produced the original slide decks illustrating national data.

What we did and how we did it

Information and training slide decks were designed for presentation and use at each session. Individual Boroughs were visited and a session delivered to the adult management team to bring together a ‘pathway’ approach from a service-line perspective.

The Patient Safety Lead delivered the sessions face to face using relevant materials and holding case-based discussions relating to the incidents that had occurred. Colleagues discussed individual cases based on lessons learned and critical reflection on risk assessment, formulation and management.

How we monitored progress and the measures used

Feedback from individuals and managers of participating teams have reported positive feedback and an increase in confidence has been reported from front-line staff.

Team managers may use informal monitoring via their management supervision sessions to better inform case-based discussions arising in the supervision sessions.

When the final sessions have been delivered the Patient Safety Lead will be evaluating the sessions via a survey to participating team managers.

How we evaluated the impact upon service/patients/staff/carers

Progress and impact can be measured across different factors, some of which are not easy to quantify.

Quantitatively The greater the numbers of clinicians that are reached during the learning lessons from suicides & homicides training will mean that there is greater impact than if the learning lessons from suicides & homicides was delivered to single team etc. Therefore having delivered the learning lessons from suicides & homicides training across all adult acute and adult community mental health sites the impact is increased. There are further plans to increase the impact by delivering learning lessons from suicides & homicides across other service lines; e.g. older people, in the future and using different forums; e.g. clinical skills programme.

Qualitatively The feedback received from clinicians provides a descriptive format of impact; to this end I have had positive feedback around the following themes; improved confidence in assessments; improved confidence when things go wrong; improved understanding of suicide data and demographics associated with increased risk; improved understanding of the static and dynamic risk factors associated with harm to others and rates of homicide committed by those with mental disorder. Clinicians have also commented on having improved awareness on theories associated with ideation-to-action models of suicide behaviour; clinical risk formulation and safety planning with patients.

Operationally It is envisaged that the impact will be demonstrated by clinicians delivering an improved and informed clinical assessment, formulation and management of the risk of harm to self and others through their clinical decision-making and records. Progress of the impact of the learning lessons from suicides & homicides will be monitored by individual team managers who will be responsible for adjusting and revisiting the learning lessons from suicides & homicides training with their clinicians dependant on clinician-turnover and or skill-set degradation (unlikely due to repetitive nature of skill use).

Corporately The impact will be assessed through the critical review of incident reports and supporting clinical documentation which may demonstrate transferring the lessons to be learned into clinical practice; e.g. improved clinical risk formulations, safety planning and contemporaneous clinical records.

Progress There has been significant coverage of adult areas; community mental health teams, in-patient managers, home treatment teams, access teams, RAID teams; but there are still some areas within adults to reach; i.e. individual community mental health teams. The next phase of progression is to other service lines; e.g. older peoples, if requested or required by line managers.

What the outcome was

Management support The learning lessons from suicides & homicides has been welcomed by all managers who have engaged in the process, through this engagement and readiness to open their team to learning lessons it increases the chances of the sustainability by reminders of the learning and refreshing clinicians' understanding of the lessons both through managerial and clinical supervision as case discussion, through zoning and risk management of the patients and at clinical care decision-making points for patients; e.g. direct clinical risk assessment, formulation and management of the clinical risk of suicide or harm to others. This management support should also gain the endorsement of collaborative senior managers in the locality with responsibility for working across service lines or pathways. It will be for managers to assess the impact of the learning in terms of sustainability in the face of staff turn-over and changing patient profiles; this may necessitate revisiting the training.

Integration across the Trust The sustainability of the learning lessons from suicides & homicides sessions will also be improved due to the integrated nature of the delivery of learning lessons from suicides & homicides across the Trust. I have ensured that learning lessons from suicides & homicides has not been delivered in clinical isolation; e.g. a single team, or geographical isolation; e.g. a single borough, and that it has been integrated within existing systems of learning (STORM v.2 and Higher Clinical Risk Formulation training) and

with leads for that training. Sustainability has also been considerably improved by the sharing of the learning method and platform to others across the Trust who can deliver this after my role has finished with the project and is integrated into the Trust's Quality Strategy: Learning from Deaths.

Change theory Traditionally learning for clinicians has been class-room based and it was decided after consultation with senior managers that delivering the learning lessons from suicides & homicides directly to front-line teams would deliver a richer experience by enabling clinicians to use their own clinical case examples in the safety of a peer or team setting and learning environment. To this end, in brief, our theory of change started by identifying a clear ultimate goal to deliver a team based approach and working backwards established the preconditions for reaching that goal (direct delivery of learning lessons from suicides & homicides to clinicians). At each step any assumptions were examined and addressed with managers and the clinicians. The next step is to identify indicators.

Our theory of change specified how we created a range of conditions that helped learning lessons from suicides & homicides deliver on the desired outcomes – improving awareness of the lessons to be learned from suicides and homicides. This included setting out the right kinds of partnership between clinicians and self, types of setting for the training, particular kinds of technical assistance, and tools and processes that helped the clinicians to operate more collaboratively and be more aware for their day to day practice. The purpose of doing so is to help clinical staff to check that the learning was appropriate, debate with them and enrich them to strengthen clinical practice and implementation. For this reason, theory of change as a process emphasizes the importance of dialogue with the clinicians, acknowledging multiple viewpoints and recognition of power relations, as well as cultural realities of working in the NHS; it also supported the beginnings of a conversation about Just Culture as I bound learning lessons from suicides & homicides in the context of understanding system rather than individual error.

Modifications During the course of delivering learning lessons from suicides & homicides, the session underwent revisions and modifications in accordance to changes to clinical incidents, investigations and new lessons to be learned in conjunction with critical and constructive feedback from clinical colleagues and managers. Research demonstrates that the sustainable impact of learning lessons from suicides & homicides will be improved if it is flexible to modification and change throughout the course of the project life.

Improvements
Improved understanding of the national and local data for suicides and homicides
Improved understanding of the high risk demographic data for suicide and homicide
Improved understanding and knowledge of the lessons learned from Pennine Care NHS Foundation Trust's serious incidents concerning suicide and homicide
Improved understanding of the lessons arising from inquests in relation to clinical care responsibilities (communication, record keeping and risk assessment)
Improved knowledge and understanding of the theoretical underpinning for the assessment of the risk of suicide and homicide

Improved knowledge and understanding of the need for clinical risk assessment and the recording of the details of that risk assessment
Improved confidence in relation to the formulation and management of the risk of suicide and homicide
Improved confidence to escalate internally cases of clinical complexity and risk for frontline clinicians

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	2016/17	2017/18	2018/19				
					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	99.97%	99.87%	99.98%	99.57%	99.97%	99.95%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	>95%	99.88%	99.99%	100%	100%	100%	100%	100%
Maximum 6-week wait for diagnostic procedures	<1%	N/A	0.98%	1.48%	0.82%	3.55%	1.52%	0.39%
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%	72%	33.51%	76.94%	63.77%*	82.79%	86.02%	80.00%*
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:								
a) Inpatient wards		55.60%	***	***				
b) Early intervention in psychosis services		54%	N/A	NCAP **				
c) Community mental health services (people on care programme approach)		89%	***	***				
Improving access to psychological therapies (IAPT):								
a) proportion of people completing treatment who move to recovery (from IAPT dataset)	>50%	N/A	51.4%	53.31%	55.24%	53.58%	51.18%	53.38%
b) waiting time to begin treatment (from IAPT minimum dataset)	>75%	77.6%	86.69%	77.08%	84.76%*	77.66%*	70.82%	75.59%
i. within 6 weeks of referral								
ii. within 18 weeks of referral	>95%	96.6%	99.51%	98.76%	99.22%	98.87%	98.29%	98.66%
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	720.0	217.9	207.3	165.3	352.7	146.3

*Data reflects the correct performance but may not fully agree with nationally published data
**Data included in NCA Psychosis programme, report expected June 2019
*** Data to be confirmed by RCPSYCH

Annex One: Statements

Statement from Joint Health Overview and Scrutiny Committee

The membership of the Joint Health Overview and Scrutiny Committee has been a consultee regarding the Pennine Care NHS Foundation Trust's Quality Account for 2018/19.

The primary aim of the Quality Account is to support the NHS in improving the quality of healthcare services, while at the same time enhancing public accountability. Members of the Joint Committee have, throughout the year, scrutinised the priorities and data provided by the Trust and have supported the declared levels of compliance.

In past submissions Members of the Joint Committee have commended the Trust on its willingness to engage with the scrutiny committee. In 2017/18 it was noted that engagement with the Trust has been problematic due in part to changes with the Executive team as well as external pressures. In many ways this proved to be the case in 2018/19 too. Members of the Committee were concerned at the apparent lack of continuity with different senior staff from the Trust attending the Committee's formal meetings, seemingly unaware of conversations and commitments made at earlier meetings.

However on the occasions when the Trust has attended meetings of the JHOSC, their representatives continue to be open and transparent. Trust Executives have attended every meeting of the Joint Committee during this municipal year and the desire to provide high quality service for mental health patients, as well as those it serves in the community continues to be the Trust's primary focus. Members look forward to working with the Trust via the establishment of a task and finish group, which will hopefully include meaningful engagement with the Trust's Council of governors, following a successful introductory meeting that was held in March 2019.

It should be noted that throughout 2018/19 the Committee held a series of informal meetings with senior Trust executives which were meant to inform the agenda for formal Committee meetings. However these meetings were useful as senior Trust Executives were able to talk candidly about the services the Trust provides. These conversations included the Trusts current and projected budgetary position, the Improvement Plan arising from October 2018's CQC 'well led' inspection (which of course, found that the Trust 'requires improvement') and proposals for mixed and single sex accommodation on the Trust's hospital wards.

Throughout 2018/19 Members of the Committee felt that the lack of continuity in relation to the Trust's senior staff contributed to the Committee's inability to adequately scrutinise the Trust's performance. However, in this vein, it is noted that the imminent appointment by the

Trust, of a Deputy Chief Executive, should help the Committee as there will be a direct point of contact at the Trust, so the Committee can pursue its agenda more thoroughly.

The Committee is aware that 2019/20 is potentially a year of big changes for the Trust and the Committee sees an opportunity to play the role of 'critical friend' to help the Trust to successfully manage those changes.

The Committee are mindful of the ongoing financial challenges faced by the Trust, and want to ensure that the Trust's commitment to high quality service provision would continue to underpin all areas of service development.

The Committee maintains its support for the National Health Service and for the work provided by the Pennine Care NHS Foundation Trust. The Committee recognises and acknowledges the work undertaken by the Trust's staff. The Committee is looking at every opportunity to build a strong working relationship with the Trust and also with the Trust's Council of Governors.

In conclusion the Committee expresses its support for the ongoing work carried out by all aspects of Pennine Care NHS Foundation Trust and will help in any way that is practicably possible.

Councillor Colin McLaren

Oldham MBC

Chair - Joint Health Overview and Scrutiny Committee (for Pennine Care)

10th May 2019

Statement from Council of Governors

Statement prepared on behalf of the Council of Governors focusing on the Governors involvement and engagement in the Quality Account

The Council of Governors for Pennine Care NHS Foundation Trust welcomes the opportunity to provide a statement on the Quality Account for 2018/19.

During 2018/19, the Council of Governors has undertaken a programme of work to refocus its activities on its core statutory roles of holding the Non-Executive Directors (NEDs) to account and representing the views of membership. As a result, a revised Council of Governors Committee structure was agreed that included the establishment of a Chair, NED and Governor Committee. The Committee enabled more detailed discussions to take place between NEDs and Governors across the domains of quality, safety, performance, workforce, and finance thereby allowing Governors to seek assurance from the Trust that it is meeting its responsibilities to the local population. Material within the Quality Account resonates with information provided to and discussed with Governors during the year.

Governors were invited to attend a development session regarding the Quality Account on 6 March 2019. During the session, Governors were provided with an overview of the aims of the Quality Account, its content, and were informed of the process for selecting the local indicator for audit by Grant Thornton, the Trust's external auditors. Governors voted on the area to be selected, the chosen indicator was 'improving access to psychological therapies: waiting time to begin treatment within 6 weeks of referral'.

During production of the Quality Account 2017/18, Grant Thornton reported an 'adverse conclusion' based on the results of the quality testing for the two mandatory 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 audit highlighted a number of discrepancies linked to data quality; noting that there was no indications that this matter impacted on the quality of care to patients. Governors were provided with an explanation of the findings around data quality via a development session held on 12 June 2018. The report was further presented by Grant Thornton at the Council of Governors on 8 August 2018. The Governors note and welcome an update within the 2018/19 Quality Account regarding the Trust's actions to improve data quality.

The Quality Account 2018/19 sets out a range of quality improvement projects, and Governors were pleased to be included in the stakeholder panel to select initiatives for showcasing in the document.

During the year, Governors were involved in the extensive engagement and involvement programme regarding mixed-sex accommodation, which included helping to facilitate group sessions with patients and staff on the wards. In addition, the Council has received regular updates from the Chief Executive at full Council of Governors meetings about this matter; plus the Chair, NED and Governor Committee has provided the Governors with assurance that this issue is being addressed and the Council looks forward to receiving the findings of this work.

The Council received the key findings from the 2018 CQC inspection from the Executive Director of Nursing, Healthcare Professionals and Quality Governance on 13 February 2019. Whilst the Trust's overall rating remained 'requires improvement', Governors noted the significant improvement in many areas since the 2016 inspection and recorded support for the Trust's improvement journey towards 'good'.

The Council acknowledge the introduction of new Quality Priorities and look forward to receiving further information on the Just Culture initiative and progress against delivery of the Quality Strategy. Governors received a presentation on the learning from deaths initiative on 7 May 2019.

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 noted the launch of the 'Safe Haven' - a new out of hours service to support those above 18 years of age and their carers who are experiencing a mental health crisis and or emotional distress.

The Trust has continued to value, engage with, support and involve Governors throughout 2018/19 and has provided a variety of development sessions to enhance and maintain Governors' knowledge. The Council looks forward to supporting the development of the Trust's future strategy with the focus on improving and enhancing mental health, learning disabilities and wellbeing services.

Evelyn Asante-Mensah OBE
Chair (on behalf of the Council of Governors)
30 April 2019

Statement from Clinical Commissioning Groups

Statement prepared on behalf of Bury CCG, Heywood, Middleton and Rochdale CCG, Oldham CCG, Tameside and Glossop CCG, and Stockport CCG

HEALTHIER PEOPLE, BETTER FUTURE

NHS
Heywood, Middleton and Rochdale
Clinical Commissioning Group

HMR CCG

Quality Account Response

Author – Alison Kelly

Head of Quality and Safeguarding &

Deputy Executive Nurse

Quality Accounts enhance public accountability and engage the leaders of an organisation and Commissioning Organisations in the quality improvement agenda. They allow formative challenge and celebration of good practice.

The Quality Account from Pennine Care Foundation Trust looks at achievements within the last 12 months, gaps in provision and sets out the Quality Plan for the next 12 months.

Commissioners welcome the opportunity to respond to this year's submission as Quality continues to be at the heart of commissioning processes. PCFT have consulted widely with the Commissioners who make up the Pennine Care Footprint and this response is on their behalf.

The Commissioners are:

- NHS Bury CCG
- NHS Oldham CCG
- NHS Heywood, Middleton and Rochdale CCG
- NHS Tameside and Glossop CCG
- NHS Stockport CCG
- NHS Trafford CCG

The report provided is comprehensive, outcome focussed and transparent. Quality is firmly embedded in the new Trust Strategy as the Trust moves towards providing Mental Health and Learning Disability Services only. CCGs recognise the challenge that such transition can afford, affecting the whole system. It is heartening that Quality continues to be a major focus for the Trusts service delivery. This Quality Account provides a great depth of information set in a context of Just Culture. Areas for celebration and those for development are clearly articulated across all services and domains. The CCGs feel this is a positive account despite ongoing challenges across the health economy such as finance, recruitment and improvement journeys.

Success can be seen against the Priorities for Quality Improvement originally identified in 2016/17. Care Planning was prioritised after the CQC inspection and the second inspection in 2018 recognised improvement. It is assuring to note that reasonable adjustment consideration in relation to Learning Disabilities is included in ongoing development of care planning.

Record keeping is a further priority area. It is good to see that the Child Protection Information System is live in out of hours services in Bury which ensures greater safety for children accessing these services. Going forward the Trust have outlined realistic goals for the improvement of record keeping per se. These include electronic systems across all in-patient areas, electronic referral for GPs and links to pan Greater Manchester initiatives. All in all, this should lead to smoother information transfer which can only lead to better patient outcomes.

The establishment of the Safe Haven Initiative is seen as a positive move by CCGs in terms of previously identified Inconsistencies within the Crisis Services. CCGs look forward to ongoing impact and evaluation reports detailing improvement for patients.

It can be seen the Trust has worked hard to look at bed occupancy and ways to improve patient flow through its systems. This has included the patient flow hub and improvements in delayed transfer of care.

A huge amount of work is acknowledged in relation to mixed sex accommodation. The CCGs applaud the positive and inclusive approach to consultation and await the ongoing implementation plan. Current mixed sex breaches are reported monthly to Commissioners.

The learning from deaths initiative is in line with National Government imperatives. Commissioners are impressed that PCFT joined the pilot and that a culture of learning from death has been adopted within a framework of candour. Links to the LeDeR program would be welcomed in relation to this work.

The two new Quality Priorities identified by the Trust assure the CCGs that there is a real shift across the Organisation to promote cultural change. The Just Culture work and the one-day event to launch this is to be commended. It is hoped that the shift to this way of working will enhance incident reporting and SI processes and that staff will feel processes feel fairer and more transparent.

The Trust Learning Library is part of the 2018/23 Quality Strategy also. It will provide a vehicle for learning and sharing best practice. It will include a variety of methods for shared learning. CCGs will be interested to see the ongoing impact of this initiative both on staff and ultimately patients.

CCGs commend the Trust on its work in relation to both National and local audits. It is good to see that the audit topics span both physical and mental health issues. This shows the Trusts commitment to learning and innovation. CCGs however, would like to see audit of a smaller scale specifically driven by SI outcomes and action plans from Child Practice Reviews and Safeguarding Adult Reviews.

In relation to Serious Incidents CCGs acknowledge the improvement in Incident Report writing and action planning. It is felt that the 8a Clinical Leads have enhanced SI work and the panel members look forward to working closely with them going forward. CCGs would welcome audit to evidence application of action plans and learning taking place.

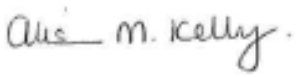
CCGs note and confirm the Trust’s work towards the Commissioning for Quality and Innovation Schemes (CQUINs) for 2018/19.

The CCGs acknowledge the work the Trust has done over the last year in relation to CQC Registration, Reviews and Investigations. The Trust acknowledges the progress it has made so far and the areas for development to move to Good. CCGs recognise the impact of striving for improvement and can see a movement within the Trust culturally in relation to the improvement journey. This is positive, and CCGs welcome the transparency such a culture affords. CCGs wish to work collaboratively with the Trust going forward in the journey to Good.

PCFT have taken great strides in providing assurance around their commitment to Quality. CCGs look forward to continued collaboration and transparency to meet the quality agenda and improve outcomes for patients.

CCGs will continue to address Quality in the following way:

- Quality compliance will be measured using the new Quality Schedule on a quarterly basis
- CQUINS will be monitored in Contract Quality and Performance Meetings across the footprint
- The SI process will be developed in conjunction with the Trust to ensure a Just Culture/Human Factors approach which is outcome focussed
- Safeguarding compliance will be measured in line with statute
- We request dip sample audits to evidence implementation of learning and action plans from a variety of sources including SIs
- We would welcome the new Safeguarding business case
- Equality and Diversity needs to be visible in all work streams



Alison Kelly

Head of Quality and Safeguarding & Deputy Executive Nurse
Heywood, Middleton and Rochdale Clinical Commissioning Group
7 May 2019

Statement from Trafford Council & Clinical Commissioning Group

NHS
Trafford
Clinical Commissioning Group

Trafford CCG are committed to ensuring that the population of Trafford receive the best quality health care as possible, and to support this we continually monitor and improve our services and how we commission them. The CCG welcomes the opportunity to comment on the Quality Account 2018/19 for Pennine Care NHS Foundation Trust (PCFT) Community Services. PCFT are at this time, in the due diligence phase of the transition of community services in Trafford to Manchester Foundation Trust (MFT) and the CCG are very much looking forward to working closely with them going forward.

Over the course of 2018/19, the CCG has engaged regularly with the Trust to provide ongoing review and monitoring of the organisations progress against key quality improvement initiatives. The Quality Account for 2018/19 accurately reflects the national

and local priorities of PCFT and the Trust has included and commented on all the requirements set out in national guidance.

We are supportive of the new quality priorities for 2019/20 outlined in the report, and we are encouraged by the “Just Culture” initiative which is promoted by NHS improvement. The CCG is keen to ensure staff are given as much opportunity as possible to report patient safety incidents and they should feel confident to speak up and support in embedding the learning within the organisation. It is also recognised that the Learning Library will be of great benefit to PCFT staff to enable them to utilise a wide range of learning tools and resources to be able to offer ongoing improvements in care.

The CCG recognise the work that has been undertaken to support in improving services across Trafford and have noted good practice during 18/19 in areas such as:

- Staff training – PCFT have progressed well with continued improvement in staff training levels in key areas such as Safeguarding Adult Protection Level 2 which is now performing within target (data Feb 2019). The continued maintenance of consistent performance above the target level of 90% for mandatory training is also noted.
- Improving the waiting times in key services remains one of the key focuses for the CCG and PCFT, there have been improvements made in Community Neuro Rehabilitation Team waiting times due to the waiting list initiative project undertaken in collaboration with the CCG.

The CCG were pleased to hear that Ascot House in Trafford was rated as Good overall by CQC in their last inspection which was undertaken in January 2019. It was encouraging to see the improvements made since their last inspection and that the residents reported a high quality service. The CCG also undertook a Quality Walk Round at Ascot House in January 2019, the outcome of this was also positive with only minimal improvements required, the CCG will continue to work with the facility to offer ongoing high quality care.

The monthly Performance and Quality Improvement meetings have demonstrated PCFT’s commitment to quality and performance improvements across the range of services provided. We remain committed to engaging with the future community provider in an inclusive and innovative manner to promote continued improvements in the quality of service provision across Trafford.

Sara Radcliffe
Corporate Director of Commissioning
2 May 2019

Statement from Healthwatch

Statement prepared on behalf of Healthwatch Bury, Healthwatch Rochdale, Healthwatch Oldham, Healthwatch Tameside, Healthwatch Stockport and Healthwatch Trafford to the Trust's Quality Account 2018/19

We welcome the renewed emphasis on mental health services as the Trust's core business.

We also recognise the Trust's openness surrounding its CQC rating and what it perceives to be areas that need development. We look forward to these being rectified in 2019/20 and beyond. The Trust has many challenges specifically around workforce finance and performance which will shape its quality agenda, but we are confident that with its new leadership in place that significant improvements will be made.

We also welcome the focus on evidence of effectiveness, family and carer experience and the use of data and information. The emphasis on developing locality plans is important, given the direction of the NHS.

The importance of looking at the estate – an area often neglected – is encouraging as it will improve facilities for service users and carers as well as staff. I should also release resources for reinvestment in service user care.

We support the stated priorities, even though some of these are basic requirements. Having said that, we know that this is an issue across other areas of the NHS and not limited to this Trust.

The cooperation with a neighbouring mental health trust is to be commended and hopefully will continue. Trusts can learn from each other where they invest in the same information systems (such as PARIS) as this will enable benchmarking in all areas of performance to take place and ultimately improve quality.

The initiative to improve crisis services is fundamental. People in crisis have no regard to the clock and need responses 24/7. Easy and uncomplicated access to such services need to be clear and transparent to the service user and their families. Stockport's plans would meet such need and, once implemented and evaluated, could serve as a model for other CCGs in the Pennine footprint and beyond. There are regrettably no dates in the QA to further this proposal so it is unclear how long such an initiative will take to bring to fruition.

We recognise some of the skill mix issues in CRHTS and would also wish the Trust to look at issues of capacity.

We note the bed management initiative and the need for this to link to community team capacity. We remain concerned at the level of out-of-area placements but recognise that reductions have been made in 2018/19 and we note the Trust's initiative in relation to short-stay admissions but, again, draw attention to issues of capacity, particularly in community teams.

In regard to mortality the introduction of the structured judgement review is vital as is the plan to recruit additional staff to support this and the involvement of families. We would suggest that this initiative is supported by benchmarking.

We believe that initiatives like ‘Just Culture’ and Freedom to Speak’ are fundamental to learning lessons and should be applauded.

We commend the number of audits and research which the Trust has undertaken,

Given the significant proportion of people in in the Pennine footprint we would have expected diversity to have featured more prominently in this QA. We would also wish to have seen more in relation to physical health and dementia, although we recognise that many of the initiatives are generic.

We continue to expect that NICE quality standards are complied with and where they are not, would wish this to be made explicit to commissioners where resources are the issue, so that in the event of adverse occurrences, risks are shared.

We commend Pennine’s leadership team for this QA.

Peter Denton

Healthwatch Manager, Healthwatch Tameside

On behalf of the following Healthwatch organisations:

- Trafford
- Rochdale
- Oldham
- Tameside
- Stockport
- Bury

14 May 2019

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 2018/19* and supporting guidance, *Detailed requirements for quality reports 2018/19*
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2018 to the 24 May 2019
    - papers relating to quality reported to the Board over the period April 2018 to 24 May 2019
    - feedback from commissioners (Joint) dated 7 May 2019
    - feedback from commissioners (Trafford) dated 2 May 2019
    - feedback from governors dated 30 April 2019
    - feedback from local Healthwatch organisations dated 14 May 2019
    - feedback from joint health overview and scrutiny committee dated 10 May 2019
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 approved 7 May 2019
    - the 2018 national patient survey dated 22 November 2018
    - the 2018 national staff survey dated 8 October 2018
    - the Head of Internal Audit's annual opinion over the trust's control environment dated March 2018
    - CQC inspection report dated 28 January 2019

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

24/5/19 Date ..... Chairman

24/5/19 Date Claire Molloy Chief Executive

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 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

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

- Early Intervention in Psychosis: people experiencing a first episode of psychosis treated with a 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 2018/19' 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 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' 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 2018 to 24 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 24 May 2019;
- feedback from commissioners dated 2 and 7 May 2019;
- feedback from governors dated 30 April 2019;feedback from local Healthwatch organisations dated 14 May 2019;
- feedback from the Overview and Scrutiny Committee dated 10 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, approved 7 May 2019;
- the national patient survey dated 22 November 2018;
- the national staff survey dated 8 October 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated March 2019;
- the Care Quality Commission's inspection report dated 28 January 2019; and
- any other information obtained during our limited assurance engagement.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the 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 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 2018/19' 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 and is subject to separate terms and conditions. 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 qualified conclusion

The indicator reporting the proportion of people experiencing first episode psychosis or 'at-risk mental state' who wait two weeks or less to start NICE-recommended package of care did not meet the six dimensions of data quality in the following respects:

- Relevance – Our testing identified errors in 12 out of the 25 cases tested of which 5 resulted in data being incorrectly included in the performance indicator according to the definitions set out in the applicable guidance.
- Accuracy - Our testing identified errors in 5 of the 25 cases tested, 4 errors in the clock start date and 1 error in the end date. The errors resulted in clock start or end times being incorrectly recorded in line with the applicable guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the 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 2018/19' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
Leeds
24 May 2019

Further Information

For further information regarding Pennine Care NHS Trust's Quality Account please contact:

Linda Chadburn BSc(Hons) PGCBA MBA
Clinical Effectiveness & Quality Improvement Lead
Quality Governance

Pennine Care NHS Foundation Trust
225 Old Street, EBlock, 2nd Floor
Ashton-under-Lyne
OL6 7SR

Telephone: 0161 716 3040

Email: l.chadburn@nhs.net

Pennine Care NHS Foundation Trust

Annual Accounts for the year ended 31 March 2019

Foreword to the Accounts

Pennine Care NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by Pennine Care NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Claire Molloy
Chief Executive
24 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	271,701	260,426
Other operating income	4	14,136	7,043
Operating expenses	6, 8	(282,919)	(266,150)
Operating surplus/(deficit) from continuing operations		**2,918**	**1,319**
Finance income	11	126	38
Finance expenses	12	(1,062)	(1,195)
PDC dividends payable		(2,270)	(2,371)
Net finance costs		**(3,206)**	**(3,528)**
Other gains / (losses)	13	348	-
Surplus / (deficit) for the year from continuing operations		**60**	**(2,209)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	**-**	**-**
Surplus / (deficit) for the year		**60**	**(2,209)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,223)	(1,961)
Revaluations	18	8	4,574
Total comprehensive income / (expense) for the period		**(1,155)**	**404**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	15	4,230	2,084
Property, plant and equipment	16	107,102	105,607
Receivables	24	1,645	1,453
Total non-current assets		**112,977**	**109,144**
Current assets			
Inventories	23	-	88
Receivables	24	21,809	13,086
Non-current assets held for sale / assets in disposal groups	26	208	660
Cash and cash equivalents	27	8,632	17,417
Total current assets		**30,649**	**31,251**
Current liabilities			
Trade and other payables	28	(32,015)	(25,866)
Borrowings	31	(445)	(1,500)
Provisions	33	(3,368)	(1,565)
Other liabilities	30	(1,658)	(5,867)
Total current liabilities		**(37,486)**	**(34,798)**
Total assets less current liabilities		**106,140**	**105,597**
Non-current liabilities			
Borrowings	31	(14,719)	(15,296)
Provisions	33	(26)	(27)
Total non-current liabilities		**(14,745)**	**(15,323)**
Total assets employed		**91,395**	**90,274**
Financed by			
Public dividend capital		78,467	76,412
Revaluation reserve		10,196	11,553
Income and expenditure reserve		2,732	2,309
Total taxpayers' equity		**91,395**	**90,274**

The notes on pages 255 to 297 form part of these accounts.

Claire Molloy
Chief Executive
24 May 2019

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**76,412**	**11,553**	**2,309**	**90,274**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	-	-	221	**221**
Surplus/(deficit) for the year	-	-	60	**60**
Other transfers between reserves	-	(67)	67	**-**
Impairments	-	(1,223)	-	**(1,223)**
Revaluations	-	8	-	**8**
Transfer to retained earnings on disposal of assets	-	(75)	75	**-**
Public dividend capital received	2,055	-	-	**2,055**
Taxpayers' equity at 31 March 2019	**78,467**	**10,196**	**2,732**	**91,395**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**74,250**	**8,940**	**4,518**	**87,708**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2017 - restated	**74,250**	**8,940**	**4,518**	**87,708**
Surplus/(deficit) for the year	-	-	(2,209)	**(2,209)**
Impairments	-	(1,961)	-	**(1,961)**
Revaluations	-	4,574	-	**4,574**
Public dividend capital received	2,162	-	-	**2,162**
Taxpayers' equity at 31 March 2018	**76,412**	**11,553**	**2,309**	**90,274**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		2,918	1,319
Non-cash income and expense:			
Depreciation and amortisation	6.1	3,943	2,956
Net impairments	7	1,442	(1,976)
Income recognised in respect of capital donations	4	(30)	-
(Increase) / decrease in receivables and other assets		(8,621)	4,170
(Increase) / decrease in inventories		88	-
Increase / (decrease) in payables and other liabilities		730	6,444
Increase / (decrease) in provisions		1,802	309
Net cash generated from / (used in) operating activities		**2,272**	**13,222**
Cash flows from investing activities			
Interest received		126	38
Purchase of intangible assets		(3,065)	(1,315)
Purchase of property, plant, equipment and investment property		(6,300)	(5,137)
Sales of property, plant, equipment and investment property		1,140	-
Receipt of cash donations to purchase capital assets		30	-
Prepayment of PFI capital contributions		(192)	(186)
Net cash generated from / (used in) investing activities		**(8,261)**	**(6,600)**
Cash flows from financing activities			
Public dividend capital received		2,055	2,162
Movement on loans from the Department of Health and Social Care		(1,250)	(1,250)
Capital element of PFI, LIFT and other service concession payments		(382)	(233)
Interest on loans		(23)	(56)
Interest paid on PFI, LIFT and other service concession obligations		(1,045)	(1,146)
PDC dividend (paid) / refunded		(2,151)	(2,500)
Net cash generated from / (used in) financing activities		**(2,796)**	**(3,023)**
Increase / (decrease) in cash and cash equivalents		**(8,785)**	**3,599**
Cash and cash equivalents at 1 April - brought forward		**17,417**	**13,818**
Cash and cash equivalents at 31 March	27.1	**8,632**	**17,417**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

Note 1.1.1 Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. This is as directed by the 2018/19 Department of Health and Social Care Group Accounting Manual 2018/19, 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 2019/20 submitted to NHSI on the 4th April is achieving a breakeven control total. The Trust has signed up to a deficit position for 2019/20 of £12.0m with NHSI and will receive £12.0m of non-recurring Finance Recovery Fund and Provider Sustainability Funds.

In preparing the plan for the Trust, key areas of potential risk have been reviewed and mitigated:

- Income - contracts for 2019/20 with all commissioners have been signed
- Cost Improvement Programmes - the Trust has a track record of delivering challenging efficiency programmes, with £6.7m delivered in 2018/19

- The Trust has actively engaged in local strategic transformation planning with GM Health and Social Care Partnership 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

Operationally, there will be significant changes to the Trust's service offering during 2019/20 as a result of the transfer of community services provision. However, as these services will continue to be provided by another public sector entity there is no impact on the Trust's assessment of its ability to continue as a going concern.

Despite planning to achieve the control total i.e. break even position, a review of the Trust's cash position still highlights the requirement for a revenue loan in 2019/20; this is driven by timing and receipt of Finance Recovery Fund / Provider Sustainability Funds and anticipated settlement of old year invoices. Options to continue to mitigate to defer the loan draw down will continue to be pursued.

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. On this basis, the Trust has adopted the going concern basis for preparing the financial statements.

Note 1.3.1 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

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

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

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

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual.

Note 1.3.2 Revenue grants and other contributions to expenditure

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

Note 1.3.3 Other income

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

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Pension costs
NHS Pension Scheme

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

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

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

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust

- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.6.2 Measurement

Valuation

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

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

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

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

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have

short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

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

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

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

Note 1.6.3 De-recognition

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

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

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

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

Note 1.6.4 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.6.5 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	4	50
Plant & machinery	5	25
Transport equipment	7	7
Information technology	3	10

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

Note 1.7 Intangible assets

Note 1.7.1 Recognition

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

Software

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

Note 1.7.2 Measurement

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

Subsequently intangible assets are measured at 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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Development expenditure	5	5
Software licences	3	7

Note 1.8 Inventories

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

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust’s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Note 1.10.1 Recognition

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

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

Note 1.10.2 Classification and measurement

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit losses are determined by applying 5% to relevant non-NHS receivables and a weighted loss for external staff debt applied to 30% of the outstanding amount.

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

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

Note 1.10.3 Derecognition

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

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

Note 1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Finance leases

The Trust does not have any finance leases

Operating leases

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

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 33.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Public dividend capital

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

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

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

(i.) donated assets (including lottery funded assets),
(ii.) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii.) any PDC dividend balance receivable or payable.

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

Note 1.15 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.16 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.

Note 1.17 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

Exchange gains or losses on monetary items are recognised in income or expense in the period in which they arise.

Note 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled on an accrual basis with the exception of provisions for future losses.

Note 1.20 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

• As required by IFRS15 contracts have been grouped and each group reviewed to determine the correct accounting treatment. This has resulted in material contracts being classified as contract receivables with the timing of the release of the income matching the fulfilment of the performance obligation.

Note 1.20.1 Sources of estimation uncertainty

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

- In making assumptions regarding redundancy costs (see note 33.1), the Trust has utilised actual estimates provided by payroll where applicable; where this is not possible the Trust has taken a prudent approach to estimating the likely costs of delivering the planned service redesign and potential redundancies.
- The Trust has an estimation of the valuation of land and building assets and their lives, based on the information provided by Cushman & Wakefield as at 31st March 2019. During 2018/19 a desktop valuation has been completed and the asset values have been adjusted in line with the revised valuation.

Note 1.21 Early adoption of standards, amendments and interpretations

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

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases, application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by FReM. Expected to be applied for the year ending 31st March 2021.

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 2019/20.

IFRIC 23 Uncertainty over Income Tax Treatments, application required for accounting periods beginning on or after 1 January 2019.

IFRS 17 Insurance Contracts, application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by FReM.

Note 2 Operating Segments

All activity at the Trust is health care related and a large majority of the 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 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 Trust and in turn incur the expenses are one provision, which it is deemed appropriate to identify as a single segment, namely 'healthcare'.

The Trust identifies the Trust's Board (which includes all Executive and Non-Executive Directors) as the Chief Operating Decision Maker as defined by IFRS 8. Monthly operating results are reported to the Trust's Board. The financial position of the Trust in month and for the year to date are reported, along with projections for the future performance and

position, as a position for the whole Trust, rather than as component parts making up a whole. The Trust's Board does not have separate directors for particular service areas or divisions. The Trust's external reporting to NHSI (the regulator) is on a whole Trust basis, which also implies the Trust is a single segment.

All decisions affecting the Trust's future direction and viability are made based on the overall total segment, presented to the Board. The Trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.1

Note 3.1 Income from patient care activities (by nature)

	2018/19 £000	2017/18 £000
Mental health services		
Cost and volume contract income	12,247	8,253
Block contract income	139,936	133,897
Other clinical income from mandatory services	6,973	2,112
Community services		
Community services income from CCGs and NHS England	91,207	88,961
Income from other sources	17,654	27,203
All services		
Agenda for Change pay award central funding	3,684	-
Total income from activities	**271,701**	**260,426**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	19,904	20,424
Clinical commissioning groups	220,504	212,964
Department of Health and Social Care	3,685	-
Other NHS providers	2,695	2,191
NHS other	16	-
Local authorities	22,503	23,386
Injury cost recovery scheme	23	25
Non NHS: other	2,371	1,436
Total income from activities	**271,701**	**260,426**
Of which:		
Related to continuing operations	271,701	260,426
Related to discontinued operations	-	-

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

The Trust does not receive any income relating to overseas visitors

Note 4 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	522	809
Education and training (excluding notional apprenticeship levy income)	4,216	4,008
Non-patient care services to other bodies	846	1,238
Provider sustainability / sustainability and transformation fund income (PSF / STF)	6,986	520
Income in respect of employee benefits accounted on a gross basis	923	1,038
Other contract income	418	(601)
Other non-contract operating income		
Receipt of capital grants and donations	30	-
Charitable and other contributions to expenditure	164	-
Rental revenue from operating leases	31	31
Total other operating income	**14,136**	**7,043**
Of which:		
Related to continuing operations	14,136	7,043
Related to discontinued operations	-	-

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,106

Note 5.2 Transaction price allocated to remaining performance obligations

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

Note 5.3 Income from activities arising from commissioner requested services

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

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	250,363	233,223
Income from services not designated as commissioner requested services	30,443	34,246
Total	**280,806**	**267,469**

Note 5.4 Profits and losses on disposal of property, plant and equipment

The following land and building assets were used in the provision of commissioner requested services and have been disposed of during the year.

Broomfield Lane Clinic:

- Net book value £281k
- Proceeds less overage charge £700k

Lees Street:

- Net book value £285k
- Proceeds £290k

Astley Street:

- Net book value £94k
- Proceeds £191k

These properties were released for sale following a review of other properties and service moves.

Note 5.5 Fees and charges

No income has been received from fees or charges raised under legislation

Note 6.1 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	5,973	5,893
Purchase of healthcare from non-NHS and non-DHSC bodies	4,680	2,569
Staff and executive directors costs	218,020	207,187
Remuneration of non-executive directors	172	166
Supplies and services - clinical (excluding drugs costs)	5,523	5,599
Supplies and services - general	2,146	2,073
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,735	2,763
Consultancy costs	286	370
Establishment	3,513	3,736
Premises**	13,168	12,871
Transport (including patient travel)	2,852	2,821
Depreciation on property, plant and equipment	3,146	2,705
Amortisation on intangible assets	797	251
Net impairments	1,442	(1,976)
Movement in credit loss allowance: contract receivables / contract assets	(531)	
Movement in credit loss allowance: all other receivables and investments	-	560
Audit fees payable to the external auditor*		
audit services- statutory audit	47	46
other auditor remuneration (external auditor only)	7	7
Internal audit costs	96	88
Clinical negligence	923	1,248
Legal fees	866	252
Insurance	292	333
Research and development	585	484
Education and training	1,638	1,184
Rentals under operating leases**	11,005	12,281
Early retirements	1	(53)
Redundancy	1,772	964
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	915	883
Hospitality	3	4
Losses, ex gratia & special payments	-	50
Other services, eg external payroll	35	79
Other	812	712
Total	**282,919**	**266,150**
Of which:		
Related to continuing operations	282,919	266,150
Related to discontinued operations	-	-

* Audit fees are disclosed above including VAT where this cannot be recovered

** The 2017/18 Rentals under operating lease figure has been restated to include £764k of expenditure previously shown within the Premises expenditure line.

Note 6.2 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	7	7
Total	**7**	**7**

Note 6.3 Limitation on auditor's liability

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

Note 7 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	1,442	(1,976)
Total net impairments charged to operating surplus / deficit	**1,442**	**(1,976)**
Impairments charged to the revaluation reserve	1,223	1,961
Total net impairments	**2,665**	**(15)**

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	173,973	165,039
Social security costs	14,442	13,826
Apprenticeship levy	856	808
Employer's contributions to NHS pensions	21,144	20,388
Pension cost - other	38	-
Temporary staff (including agency)	10,898	9,089
Total gross staff costs	**221,351**	**209,150**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**221,351**	**209,150**
Of which		
Costs capitalised as part of assets	2,101	1,106

Note 8.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the trust agreed on the grounds of ill-health (8 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £170k (£564k in 2017/18).

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

Note 8.2 Directors' remuneration

	2018/19 Total £000	2017/18 Total £000
Director's remuneration	1,019	976
Employer contributions to the pension scheme	121	124
	1,140	**1,100**

Total number of directors to whom benefits are accruing under:	2018/19 Number	2017/18 Number
Defined benefit schemes	9	8

No advances, credits or guarantees have been granted to any directors of the Trust.

Full disclosure of Directors' remuneration is given in the remuneration report section of the Annual Report.

Note 9 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

Past and present employees are covered by the provisions of the two NHS pension schemes or the National Employment Savings Trust (NEST). Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at:

www.nhsbsa.nhs.uk/pensions
www.nestpensions.org.uk

Note 10 Operating leases

Note 10.1 Pennine Care NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Pennine Care NHS Foundation Trust is the lessor.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	31	31
Total	**31**	**31**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	31	31
- later than one year and not later than five years;	124	124
- later than five years.	125	156
Total	**280**	**311**

The 2017/18 figures have been restated to exclude arrangements at a number of properties that don't meet the requirements of an operating lease. These excluded amounts are now shown in Note 4 as other contract income.

Note 10.2 Pennine Care NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Pennine Care NHS Foundation Trust is the lessee.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	11,005	12,281
Total	**11,005**	**12,281**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	10,950	10,683
- later than one year and not later than five years;	23,209	28,597
- later than five years.	29,109	34,576
Total	**63,268**	**73,856**
Future minimum sublease payments to be received	-	-

The 2017/18 Rentals under operating lease figure has been restated to include £764k of expenditure previously shown within the Premises expenditure line.

The future minimum lease payments due as at 31st March 2018 have also been restated.

Note 11 Finance income

Finance income represents interest received on assets in the period.

	2018/19 £000	2017/18 £000
Interest on bank accounts	126	38
Total finance income	**126**	**38**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	17	49
Main finance costs on PFI and LIFT schemes obligations	1,045	1,146
Total interest expense	**1,062**	**1,195**
Total finance costs	**1,062**	**1,195**

Note 12.2 Better Payment Practice Code

Compliance with the Better Payment Practice Code in respect of invoices received from both NHS and non-NHS trade creditors is included in the Annual Report.

Note 12.3 The Late Payment of Commercial Debts (Interest) Act 1998 / Public Contract Regulations 2015

	2018/19 £000	2017/18 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	480	-
Losses on disposal of assets	(132)	-
Total gains / (losses) on disposal of assets	**348**	**-**
Total other gains / (losses)	**348**	**-**

Note 14 Discontinued operations

	2018/19	2017/18
	£000	£000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	**-**	**-**

Note 15.1 Intangible assets - 2018/19

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**789**	**79**	**1,721**	**2,589**
Additions	2,837	-	106	**2,943**
Reclassifications	1,721	-	(1,721)	**-**
Disposals / derecognition	(246)	-	-	**(246)**
Valuation / gross cost at 31 March 2019	**5,101**	**79**	**106**	**5,286**
Amortisation at 1 April 2018 - brought forward	**457**	**48**	**-**	**505**
Provided during the year	782	15	-	**797**
Disposals / derecognition	(246)	-	-	**(246)**
Amortisation at 31 March 2019	**993**	**63**	**-**	**1,056**
Net book value at 31 March 2019	**4,108**	**16**	**106**	**4,230**
Net book value at 1 April 2018	**332**	**31**	**1,721**	**2,084**

Note 15.2 Intangible assets - 2017/18

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**1,708**	**79**	**305**	**2,092**
Transfers by absorption	-	-	-	**-**
Additions	39	-	1,416	**1,455**
Disposals / derecognition	(958)	-	-	**(958)**
Valuation / gross cost at 31 March 2018	**789**	**79**	**1,721**	**2,589**
Amortisation at 1 April 2017 - as previously stated	**1,180**	**32**	**-**	**1,212**
Provided during the year	235	16	-	**251**
Disposals / derecognition	(958)	-	-	**(958)**
Amortisation at 31 March 2018	**457**	**48**	**-**	**505**
Net book value at 31 March 2018	**332**	**31**	**1,721**	**2,084**
Net book value at 1 April 2017	**528**	**47**	**305**	**880**

Note 16.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**14,746**	**86,779**	**410**	**2,254**	**106**	**4,732**	**109,027**
Additions	-	2,893	1,413	312	-	3,020	**7,638**
Impairments	-	(4,349)	-	-	-	-	**(4,349)**
Reversals of impairments	-	1	-	-	-	-	**1**
Revaluations	-	(16)	-	-	-	-	**(16)**
Reclassifications	-	1,514	(1,517)	-	-	3	**-**
Transfers to / from assets held for sale	(95)	(117)	-	-	-	-	**(212)**
Disposals / derecognition	-	(268)	-	(593)	-	(848)	**(1,709)**
Valuation/gross cost at 31 March 2019	**14,651**	**86,437**	**306**	**1,973**	**106**	**6,907**	**110,380**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**326**	**-**	**969**	**53**	**2,072**	**3,420**
Provided during the year	-	2,097	-	168	15	866	**3,146**
Impairments	-	(1,624)	-	-	-	-	**(1,624)**
Reversals of impairments	-	(59)	-	-	-	-	**(59)**
Revaluations	-	(24)	-	-	-	-	**(24)**
Transfers to / from assets held for sale	-	(4)	-	-	-	-	**(4)**
Disposals / derecognition	-	(180)	-	(549)	-	(848)	**(1,577)**
Accumulated depreciation at 31 March 2019	**-**	**532**	**-**	**588**	**68**	**2,090**	**3,278**
Net book value at 31 March 2019	**14,651**	**85,905**	**306**	**1,385**	**38**	**4,817**	**107,102**
Net book value at 1 April 2018	**14,746**	**86,453**	**410**	**1,285**	**53**	**2,660**	**105,607**

Note 16.2 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
Valuation / gross cost at 1 April 2017 - as previously stated	**14,608**	**82,293**	**1,512**	**3,297**	**384**	**6,669**	**108,763**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	2	2,424	1,919	259	-	1,087	**5,691**
Impairments	(2)	(3,646)	-	-	-	-	**(3,648)**
Reversals of impairments	-	1,988	-	-	-	-	**1,988**
Revaluations	431	2,896	-	-	-	-	**3,327**
Reclassifications	-	3,021	(3,021)	-	-	-	**-**
Transfers to / from assets held for sale	(293)	(379)	-	-	-	-	**(672)**
Disposals / derecognition	-	(1,818)	-	(1,302)	(278)	(3,024)	**(6,422)**
Valuation/gross cost at 31 March 2018	**14,746**	**86,779**	**410**	**2,254**	**106**	**4,732**	**109,027**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**3,041**	**-**	**2,036**	**314**	**4,680**	**10,071**
Transfers by absorption	-	-	-	-	-	-	**-**
Provided during the year	-	1,703	-	235	17	750	**2,705**
Impairments	-	(557)	-	-	-	-	**(557)**
Reversals of impairments	-	(1,118)	-	-	-	-	**(1,118)**
Revaluations	-	(1,247)	-	-	-	-	**(1,247)**
Reclassifications	-	334	-	-	-	(334)	**-**
Transfers to / from assets held for sale	-	(12)	-	-	-	-	**(12)**
Disposals / derecognition	-	(1,818)	-	(1,302)	(278)	(3,024)	**(6,422)**
Accumulated depreciation at 31 March 2018	**-**	**326**	**-**	**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**
Net book value at 1 April 2017	**14,608**	**79,252**	**1,512**	**1,261**	**70**	**1,989**	**98,692**

Note 16.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019							
Owned - purchased	14,651	77,360	306	1,385	38	4,817	**98,557**
On-SoFP PFI contracts and other service concession arrangements	-	8,545	-	-	-	-	**8,545**
NBV total at 31 March 2019	**14,651**	**85,905**	**306**	**1,385**	**38**	**4,817**	**107,102**

Note 16.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018							
Owned - purchased	14,746	77,767	410	1,285	53	2,660	**96,921**
On-SoFP PFI contracts and other service concession arrangements	-	8,686	-	-	-	-	**8,686**
NBV total at 31 March 2018	**14,746**	**86,453**	**410**	**1,285**	**53**	**2,660**	**105,607**

Note 17 Donations of property, plant and equipment

Cash of £30k for garden improvements at two mental health sites was received in 2018/19 from Pennine Care Charitable Foundation and spent in year.

Note 18 Revaluations of property, plant and equipment

The most recent valuation has an effective date of 31st March 2019. This was undertaken by the Trust's current valuers Cushman & Wakefield. The valuation complies with RICS guidance.

Note 19.1 Investment Property

The Trust does not hold any investment property.

Note 20 Investments in associates and joint ventures

The Trust does not have any investments in associates and joint ventures.

Note 21 Other investments / financial assets (non-current)

The Trust does not have any other investments / financial assets (non-current).

Note 22 Disclosure of interests in other entities

The Trust does not have any interests in other entities.

Note 23 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	-	87
Other	-	1
Total inventories	**-**	**88**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £2,813k (2017/18: £2,763k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 24.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	19,965	
Contract assets*	-	
Trade receivables*		9,805
Accrued income*		2,189
Allowance for impaired contract receivables / assets*	(167)	
Allowance for other impaired receivables	-	(1,012)
Prepayments (non-PFI)	1,313	1,486
PDC dividend receivable	60	179
VAT receivable	638	420
Other receivables	-	19
Total current trade and other receivables	**21,809**	**13,086**
Non-current		
Contract receivables*	-	
Contract assets*	-	
Trade receivables*		-
Accrued income*		-
Allowance for impaired contract receivables / assets*	-	
PFI prepayments - capital contributions	1,645	1,453
Total non-current trade and other receivables	**1,645**	**1,453**
Of which receivables from NHS and DHSC group bodies:		
Current	16,193	9,592
Non-current	-	-

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

Note 24.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2018 - brought forward		**1,012**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	791	(1,012)
Changes in existing allowances	(523)	-
Reversals of allowances	(8)	-
Utilisation of allowances (write offs)	(93)	-
Allowances as at 31 Mar 2019	**167**	**-**

Note 24.3 Allowances for credit losses - 2017/18

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

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**452**
Increase in provision	1,012
Unused amounts reversed	(452)
Allowances as at 31 Mar 2018	**1,012**

Note 24.4 Exposure to credit risk

The Trust is not exposed to significant credit risk.

Note 25 Other assets

The Trust does not have any other assets.

Note 26 Non-current assets held for sale and assets in disposal groups

	2018/19	2017/18
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**660**	**-**
Prior period adjustment		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**660**	**-**
Transfers by absorption	-	-
Assets classified as available for sale in the year	208	660
Assets sold in year	(660)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**208**	**660**

The Trust holds 314/316 Oldham Road, a non-current land and buildings asset, with a net book value of £208k. This asset is no longer being held for its service potential and a sale has been agreed and progressing to completion during 2019/20. It has therefore been valued in accordance with IFRS 5 at the lower of its carrying amount and fair value less costs to sell.

Note 26.1 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 27.1 Cash and cash equivalents movements

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

	2018/19	2017/18
	£000	£000
At 1 April	**17,417**	**13,818**
Net change in year	(8,785)	3,599
At 31 March	**8,632**	**17,417**
Broken down into:		
Cash at commercial banks and in hand	73	90
Cash with the Government Banking Service	8,559	17,327
Total cash and cash equivalents as in SoFP	**8,632**	**17,417**
Total cash and cash equivalents as in SoCF	**8,632**	**17,417**

Note 27.2 Third party assets held by the Trust

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

	31 March 2019	31 March 2018
	£000	£000
Bank balances	296	289
Monies on deposit	-	-
Total third party assets	**296**	**289**

Note 28.1 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
Trade payables	4,995	5,181
Capital payables	2,283	1,067
Accruals	17,386	13,005
Social security costs	2,607	2,389
Other taxes payable	1,594	1,321
Accrued interest on loans*		6
Other payables	3,150	2,897
Total current trade and other payables	**32,015**	**25,866**

Of which payables from NHS and DHSC group bodies:		
Current	9,311	6,923
Non-current	-	-

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

Note 28.2 Early retirements in NHS payables above

The Trust does not have any early retirements in the NHS payables.

Note 29 Other financial liabilities

The Trust does not have any other financial liabilities.

Note 30 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	1,658	5,867
Total other current liabilities	**1,658**	**5,867**

Note 31 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	-	1,250
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	445	250
Total current borrowings	**445**	**1,500**
Non-current		
Obligations under PFI, LIFT or other service concession contracts	14,719	15,296
Total non-current borrowings	**14,719**	**15,296**

Note 31.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2018	**1,250**	**15,546**	**16,796**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,250)	(382)	**(1,632)**
Financing cash flows - payments of interest	(23)	(1,045)	**(1,068)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	6	-	**6**
Application of effective interest rate	17	1,045	**1,062**
Carrying value at 31 March 2019	**-**	**15,164**	**15,164**

Note 32 Finance leases

The Trust does not have any finance leases either as lessor or lessee.

Note 33.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits*	Legal claims	Redundancy	Total
	£000	£000	£000	£000
At 1 April 2018	**29**	**150**	**1,413**	**1,592**
Arising during the year	1	647	2,677	**3,325**
Utilised during the year	(2)	(23)	(474)	**(499)**
Reversed unused	-	(85)	(939)	**(1,024)**
At 31 March 2019	**28**	**689**	**2,677**	**3,394**
Expected timing of cash flows:				
- not later than one year;	2	689	2,677	**3,368**
- later than one year and not later than five years;	9	-	-	**9**
- later than five years.	17	-	-	**17**
Total	**28**	**689**	**2,677**	**3,394**

Pensions: injury benefits

These are commitments made to one former member of staff who receives Injury Benefits through NHS Resolution. Payments are handled by NHS Resolution 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 NHS Resolution where the cases have been notified to the Trust as outstanding at 31 March 2019. This includes in addition one employment tribunal. It is expected that these balances will be settled within one year.

Redundancy

The redundancy provision includes estimated costs for service areas restructuring as a result of the transfer of community services.

Note 33.2 Clinical negligence liabilities

At 31 March 2019, £773k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Pennine Care NHS Foundation Trust (31 March 2018: £3,105k).

Note 34 Contingent assets and liabilities

The Trust does not have any contingent assets and liabilities.

Note 35 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	244	3,201
Intangible assets	-	2,246
Total	**244**	**5,447**

Note 36 Other financial commitments

The Trust does not have any other financial commitments.

Note 37 On-SoFP PFI, LIFT or other service concession arrangements

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.

As at 31 March 2019 the current net liability of the scheme is £15,164k and current unitary payments are £2,535k 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 Trust's section of the PFI transaction.

Note 37.1 Imputed finance lease obligations

Pennine Care NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**34,385**	**33,957**
Of which liabilities are due		
- not later than one year;	1,464	1,379
- later than one year and not later than five years;	6,114	5,514
- later than five years.	26,807	27,064
Finance charges allocated to future periods	(19,221)	(18,411)
Net PFI, LIFT or other service concession arrangement obligation	**15,164**	**15,546**
- not later than one year;	445	250
- later than one year and not later than five years;	1,502	1,195
- later than five years.	13,217	14,101

Note 37.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**60,885**	**59,914**
Of which liabilities are due:		
- not later than one year;	2,592	2,441
- later than one year and not later than five years;	10,826	9,764
- later than five years.	47,467	47,709

Note 37.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**2,535**	**2,448**
Consisting of:		
- Interest charge	1,045	1,146
- Repayment of finance lease liability	383	233
- Service element and other charges to operating expenditure	915	883
- Addition to lifecycle prepayment	192	186
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**2,535**	**2,448**

Note 38 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no PFI schemes deemed to be off-Statement of Financial Position.

Note 39 Financial instruments

Note 39.1 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 Trust has with Commissioners and the way those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The 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 Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies, agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors, Mersey Internal Audit Agency.

Currency risk

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

Interest rate risk

The 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 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 Trust's objective is to minimise credit risk, which it achieves by a programme of proactive credit control and internal controls.

Liquidity risk

The Trust's operating costs are incurred under contracts with Commissioners, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

Note 39.2 Carrying values of financial assets

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

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	19,798	**19,798**
Cash and cash equivalents at bank and in hand	8,632	**8,632**
Total at 31 March 2019	**28,430**	**28,430**

	Loans and receivables	Total book value

Carrying values of financial assets as at 31 March 2018 under IAS 39	£000	£000
Trade and other receivables excluding non financial assets	11,001	**11,001**
Cash and cash equivalents at bank and in hand	17,417	**17,417**
Total at 31 March 2018	**28,418**	**28,418**

Note 39.3 Carrying value of financial liabilities

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

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Obligations under PFI, LIFT and other service concession contracts	15,164	**15,164**
Trade and other payables excluding non financial liabilities	27,814	**27,814**
Provisions under contract	3,366	**3,366**
Total at 31 March 2019	**46,344**	**46,344**

	Other financial liabilities	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	1,250	**1,250**
Obligations under PFI, LIFT and other service concession contracts	15,546	**15,546**
Trade and other payables excluding non financial liabilities	19,367	**19,367**
Provisions under contract	1,563	**1,563**
Total at 31 March 2018	**37,726**	**37,726**

Note 39.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 39.5 Maturity of financial liabilities

	31 March 2019	31 March 2018

	£000	£000
In one year or less	31,625	22,430
In more than one year but not more than two years	306	268
In more than two years but not more than five years	1,196	927
In more than five years	13,217	14,101
Total	**46,344**	**37,726**

Note 40 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	165	92	-	-
Total losses	**165**	**92**	**-**	**-**
Special payments				
Ex-gratia payments	8	23	45	50
Total special payments	**8**	**23**	**45**	**50**
Total losses and special payments	**173**	**115**	**45**	**50**
Compensation payments received		-		-

Note 41 Gifts

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Gifts made	-	-	-	-

Note 42.1 Initial application of IFRS 9

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

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

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £6k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £221k decrease in the carrying value of receivables.

Note 42.2 Initial application of IFRS 15

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

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

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

The standard has had a trivial impact for the Trust with previously trade receivables are primarily now contract receivables and accrued income is now within the contract receivables.

Note 43 Related parties

Pennine Care NHS Foundation Trust is a public interest body authorised by NHS Improvement, 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.

One Non-Executive Director is Chair of Council at the University of Salford. A further Non-Executive Director is an Associate Community Governor at St Mary's Church of England Primary School. A member of staff working in the Trust's procurement department has a son who is a Director of Fraggell Productions.

There have been non-material transaction during 2018/19 with these organisations. All of these transactions are considered to be at arms length.

The Department of Health and Social Care is regarded as a related party and the parent organisation of the Trust. During the year Pennine care NHS Foundation Trust has had a significant number of material transactions with the Department itself, and with other NHS bodies for which the Department is also regarded as the parent Department. These entities include:

- NHS England
- Clinical Commissioning Groups including:
    - NHS Bury CCG
    - NHS Heywood Middleton and Rochdale CCG
    - NHS Manchester CCG
    - NHS Oldham CCG
    - NHS Stockport CCG
    - NHS Tameside and Glossop CCG
    - NHS Trafford CCG
- Health Education England
- NHS Property Services
- Community Health Partnerships
- Pennine Acute Hospitals NHS Trust
- Local Authorities:
    - Bury MBC
    - Rochdale BC
    - Stockport MBC
    - Trafford MBC
- HMRC
- NHS Pensions Scheme

Note 44 Transfers by absorption

There have not been any transfers by absorption in the year where the Trust has been either the receiving or divesting party.

Note 45 Prior period adjustments

There have not been any prior period adjustments

Note 46 Events after the reporting date

The Trust is expecting to transfer services relating to Community Services to other NHS bodies in the following financial year - 2019/20.