Cambridgeshire and Peterborough NHS Foundation
Trust

Annual Report and Accounts 2015-16

A member of Cambridge University Health Partners
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Appendix 1: Quality Report
This report is based upon guidance issued by the Independent Regulator of NHS Foundation Trusts and was approved by the Board of Directors on 25 May 2016.

Signed ........................................ Date ......................
Aidan Thomas
Chief Executive

25/5/16
1. Chair’s statement

My first full year as Chair of Cambridgeshire and Peterborough NHS Foundation Trust has certainly been one of incredible change and challenge – both professional and personal.

There have been high points, and many of them. The results of the Care Quality Commission (CQC) inspection, when they were made public in October, validated what many of us had known for some time. The declaration that our services are officially ‘good’ was a tremendous boost for everyone, and could not have been achieved without the hard work and dedication of colleagues from across the Trust. Staff understood this was their chance to shine, to show what they do day in, day out, and they clearly demonstrated the pride they have in their work.

PRIDE also became the acronym for our new Trust values. Following a full consultation process with colleagues from across CPFT, a vote settled on PRIDE - standing for Professionalism, Respect, Innovation, Dignity and Empowerment. I think these values perfectly sum up what CPFT stands for and something all staff should aim to achieve on a daily basis.

Two initiatives have really caught my attention in the last 12 months – and the attention of others across the country. In September last year, the Psychological Wellbeing Service – formerly Improving Access to Psychological Therapies (IAPT) – relaunched. Previously, anyone who wanted treatment for the likes of depression, anxiety and stress had to go via their GP.

Following a £2 million investment from our commissioners, that barrier was removed and anyone registered with a GP in Cambridgeshire and Peterborough could self-refer to the service. There was an incredible amount of work done behind the scenes bringing in clinicians, and administration staff, and advertising the new service. But it was needed because, by the end of March, just seven months after the relaunch, nearly 12,000 people had entered treatment – well above the initial targets that had been set. I was delighted to make the Psychological Wellbeing Service the winner of the Chair’s Award For Outstanding Performance at this year’s CPFT Staff Awards. This just goes to show what our services can achieve with the right funding – something we continue to push for.

The Promise Project, which restates the Trust’s commitment to helping service-users towards recovery, and end the use of physical restraint, continues to go from strength to strength. Developed by our clinical director of acute adult services Dr Manaan Kar Ray and Patient Leader Sarah Rae, there was a signing of a special charter in October last year where organisations including Cambridgeshire County Council, Cambridgeshire and Peterborough Clinical Commissioning Group, Mind, Cambridgeshire Police, the University of Cambridge and Anglia Ruskin University pledged to support the project. It also has the backing of the prestigious Yale University in Connecticut, USA, along with others in Brisbane, Prague and Cape Town as well as the World Psychiatric Association.

The Promise Project won the Research Innovation of the Year Award at our Staff Awards. The Promise Project and the Psychological Wellbeing Service have also made it through the finals of the Health Service Journal’s Value In Healthcare Awards. The winners will be announced in May.

This time last year I wrote about the huge effort that had gone in to developing UnitingCare, our partnership with Cambridge University Hospitals NHS Foundation Trust, and the tendering for - and winning - of the older people’s and adults with long-term conditions contract from our local
Clinical Commissioning Group CCG. This was the biggest contract of its kind at the time and was put in place to enable us to transform the delivery of care to older people and adults with long-term conditions over the next five years. Despite all the work that had gone behind the scenes and on the frontline, in December it was decided the contract was no longer financially viable and it was transferred back to the CCG.

This was a significant blow for all those who had worked so hard to make the contract a success and will certainly mean that other contracts of this type will be scrutinised even more thoroughly than they are already.

There have been many positives however resulting from the contract, including the transfer of 1,400 community staff to CPFT. This has enabled better integration between physical and mental health care, which will make a big difference to our patients and their care.

The neighbourhood teams set up as part of the older people’s contract continue to make a vital difference to patients across Cambridgeshire and Peterborough, and the rate of admission to accident and emergency departments at our local acute hospitals has fallen.

There continues to be widespread support from Commissioners for continuing the development of the integrated model of care put in place subject to the availability of funding, and we are committed to working with our Commissioners to develop this further. I believe we are working more closely with partners than ever before. No more is this true than with the launch of the new Urgent Mental Healthcare Vanguard Programme, which aims to improve the out-of-hours support available to people in mental health crisis.

Commissioners, NHS organisations, police and representatives from the voluntary sector have put in place a range of new services which include a First Response Service - run by CPFT – which will provide out-of-hours assessments in the community and respond to urgent referrals from emergency services; the Sanctuary, a safe place in the community, hosted by mental health charity Mind, offering short-term practical and emotional support between 6pm and 1am; and mental health professionals in the police control room to provide advice and referral options to police.

Overall, this is part of a national programme, but locally the services began operating in Cambridge in April. The funding is non-recurrent but if the pilot is successful it could lead to the new services being commissioned longer term and across the country.

We are also now part of the Triangle of Care, working together with the Carers’ Trust, with the aim of strengthening the involvement of carers and families in care planning, treatment and support.

This is vital work because Census figures in 2011 revealed that more than 60,000 people in Cambridgeshire and more than 17,000 people in Peterborough reported they were providing some level of unpaid care.

Last summer, CPFT launched a two-year plan focussing on improving support for carers of mental health patients in the first year, and adult and older people’s community services in Peterborough and Cambridgeshire in the second.

In the last year I have visited 40 teams across the Trust, with plans to see many more in my diary. Among the raft of other notable moments for the Trust over the last 12 months have been:
• A huge - and successful – effort to reduce children’s waiting times.

• The successful launch of our Joint Emergency Team (JET) an urgent two-hour response service to support those over the age of 50 or those with long-term conditions in their home when they become very unwell and need urgent care, but do not need to go to hospital.

• Our Electro-Convulsive Therapy (ECT) clinics at the Cavell Centre and the Liaison Psychiatry team at Addenbrookes both being declared excellent by the Royal College of Psychiatrists.

• The opening of a new headquarters for our Eating Disorders Service in Norfolk.

• CPFT topping a new government league table for our research work.

• The launch of a new apprenticeship scheme to find our NHS stars of the future, and our ongoing programme to attract new recruits to the Trust.

• An event to mark the long service of more than 100 colleagues which took place at Burgess Hall in St Ives.

The role of the Chairman is to lead the Board of Directors, which is made up of the Trust’s Executive Directors and six Non-Executive Directors who bring experiences from other sectors and disciplines. During the year I welcomed two new Non-Executive Directors, Mike Hindmarch and Sarah Hamilton, while Stephen Legood was confirmed as Director of People and Business Development following a successful period as interim.

Alongside the Non-Executives’ induction and development programmes we have set up visits to all our services, with the objective of every team seeing at least one of us every year. I truly do want to ensure that the Board, where the direction of the Trust is decided, is connected to the front line service deliverers.

My other role is to chair the Council of Governors, some are appointed from other agencies while the larger and most active group are the elected governors who represent a range of constituencies – i.e. public, patients, carers, staff and geographic areas. The governors provide the public voice and are an important part of our public accountability. To be effective they need to be well versed in the work and thinking of the Trust so we now have a development programme to support them in both their advocacy and challenge of the Trust.

Finally, I completed my own challenge last June riding from Land’s End to John O’Groats, raising more than £18,000 for the charity Ormiston Families during the 13-day cycle. I must thank everyone who supported me.

Overall, we remain in challenging times. The effects of the cuts on the public sector are still being felt as keenly here as anywhere else. Cambridgeshire and Peterborough is the 10th lowest funded area in England in 2016/2017 at £1,058 per capita - 15 per cent below the average.

Increased demand versus reductions in income continues to provide an ongoing challenge.

Cambridgeshire and Peterborough remain in one the 11 “most challenged health economies” although we are committed to the Fit For The Future programme, a partnership which will see
local NHS organisations, councils and Healthwatch groups working together to tackle financial and demand pressures.

CPFT requires team work - but we know that we can’t act alone.

The local health and social care system requires all partners to integrate, to work together, to provide effective, safe, joined-up care for the people of Cambridgeshire and Peterborough.

We are only at the beginning of further transformation in our system to enable us to fit our citizens’ health requirements to the county’s over-stretched budget.

We’re not there yet, but I’m confident we’re moving in the right direction. We will never be able to do everything everyone wants but we will continue to do our best to deliver the most appropriate services to those who need our care.
This Chair's statement is signed by the Chair.

Signed ........................................

Julie Spence
Chairman

Date: 25 May 16
2. Performance report

The report and accounts have been prepared under a direction issued by Monitor (now known as NHS Improvement) under the National Health Service Act 2006.

2.1 Overview

2.1.1 Chief Executive Officer Statement on Performance

2015-2016 was very important for Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) for many reasons. Clinical staff and managers worked hard to ensure successful delivery of the Trust’s challenging financial targets but, perhaps more importantly, coped with significant increases in demand for our services which, once again, grew significantly more than the population. This was especially true in adult emergency health services, and children’s services.

Our staff also delivered major improvements, for example:

- The delivery of the children’s mental health waiting list.
- The establishment of new liaison services in Hinchingbrooke and Peterborough Hospitals.
- The successful achievements of national targets for the Psychological Wellbeing Service, in which we are among the best in England.
- Success in the bid for Prison Mental Health Services in Peterborough.

The year also saw the international launch of the Promise Project which harnessed the enthusiasm of staff teams and the Trust’s expertise in “recovery”, to deliver a massive reduction in the use of restraint through cultural change.

The most momentous change since achieving foundation trust status also took place in 2015 as CPFT with its partner, Cambridge University Hospitals NHS Foundation Trust, won the contract for the delivery of integrated care for older people. Despite the end of the contract after only eight months, the Trust successfully implemented a huge change programme across the county; introducing Joint Emergency Teams, integrated Neighbourhood and Locality teams, and increasing the size of CPFT by more than a third in the process.

The hard work and flexibility of staff have given the county one of the most modern, focussed community services in the country, and we look forward to working with commissioners and key partners to develop social capital for older people and those with long-term conditions, including mental health illness.

The quality of care provided by staff was recognised when CPFT became only the fourth of its type in the country to be awarded “good” overall in its inspection by the CQC. This is an endorsement of staff commitment, attitude and effort and a truly amazing year, for an organisation which can be rightly proud of its achievements.
2.1.2 History, purpose and vision

CPFT was formed on 1 June 2008 under the Health and Social Care (Community Health and Standards) Act 2003 succeeding the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust.

CPFT is a health and social care organisation, providing integrated community, mental health and learning disability services, across Cambridgeshire and Peterborough, and children’s community services in Peterborough.

CPFT supports about 100,000 people each year and employ more than 3,400 staff. Our largest bases are at the Cavell Centre in Peterborough, and Fulbourn Hospital in Cambridge, but our staff are based in more than 90 locations.

CPFT is a University of Cambridge Teaching Trust and a member of Cambridge University Health Partners, working together with the University of Cambridge Clinical School.

Our core purpose is to provide excellent community and mental health services to people of all ages across Cambridgeshire and Peterborough and beyond this geographical boundary. We also provide some specialist services on a regional and national basis.

CPFT is also responsible for the provision of integrated mental and physical health services for older people across Cambridgeshire and Peterborough, including district nursing, support for people with long-term conditions, case management, and Joint Emergency Teams. CPFT also provides minor injuries units, and X-radiography from community hospital sites, as well as inpatient rehabilitation and admission in community hospitals.

Our approach to the provision of services is governed by a philosophy of recovery and will be designed and delivered with the following principles in mind wherever possible:

- Focus on people rather than services.
- Build hope and aspiration with our service users.
- Emphasise strengths rather than emphasise limitations
- Educate people who provide services – ie, schools, employers, the media and members of the public to combat stigma.
- Foster collaboration between people who need support and people who support them.
- Promote autonomy through enabling and supporting self management, and as a result, decrease the need for people to rely on formal services and professional support.

**Our mission**

Our mission is to put people in control of their care. We will maximise life opportunities for individuals and their families by enabling them to look beyond their limitations to achieve their goals and aspiration. In other words:

‘To offer people the best help to do the best for themselves’
Our values
We manage our organisation through a small set of shared values that guide our decisions and actions:

- **Professionalism** - We will maintain the highest standards and develop ourselves and others by demonstrating compassion and showing care, honesty and flexibility
- **Respect** - We will create positive relationships by being kind, open and collaborative
- **Innovation** - We are forward thinking, research focused and effective by using evidence to shape the way we work
- **Dignity** - We will treat you as an individual by taking the time to hear, listen and understand
- **Empowerment** - We will support you by enabling you to make effective, informed decisions and to build your resilience and independence

Our vision
We want to give those people who need our services the best possible chance to live a full and happy life, despite their condition or circumstances.

- **Recovery** – we will adopt the principle in all our services, empowering patients to achieve independence and the best possible life changes, removing dependence and giving them and their families (in the case of children) control over their care.
- **Integration** – we will work closely with providers along pathways to deliver integrated person-centred care and support to local people close to their homes, principally in non-institutional settings. We will also integrate with key partners to improve efficiency and effectiveness and simplify access.
- **Specialist services** – we are one of England’s leading providers of key specialist mental health services, with particular expertise in eating disorders, children and young people’s mental health, autistic spectrum disorders and female personality disorders.

All of the above will be supported by our IT and estates strategies.

Business developments
The Trust continues to scan the market and provide the directorates and Executive Team with the necessary business development opportunities in line with our five-year strategic plan, with the Business and Performance Committee providing the necessary oversight.

We have continued to strengthen our Business Development Team and ensure the necessary systems are in place to support commercial development.

Growth
On 1 April 2015, 1,400 staff transferred from Cambridgeshire Community Services in order to support the delivery of integrated care for adults and older people in Cambridgeshire and Peterborough.
The transfer followed a successful joint bid with Cambridge University Hospitals NHS Foundation Trust. UnitingCare Partnership was set up to act as the integrator to commission the new model of service delivery.

In December 2015, the partnership terminated the contract as it was no longer financially sustainable. The contracts have transferred back to the Cambridgeshire and Peterborough Clinical Commissioning group.

The clinical services continue to be successfully delivered by CPFT, and we are working closely with the CCG and partners to ensure benefits of the UnitingCare model are not lost.

In September 2015, CPFT relaunched the Psychological Wellbeing Service, (formerly “IAPT”). The service allows patients with conditions including depression and anxiety to self-refer. In the first 20 weeks, the service treated more than 5,000 patients and it is well on target to meet the targets for its first year.

We, like many foundation trusts, are beginning to explore the possibility of expanding our services to overseas partners by offering expert advice and service design capability.

2.1.3 Service: Key issues and risks

Trends and factors likely to affect future developments, performance and position

The key trends that are likely to affect future developments include:

- Significantly less money; the Cambridgeshire and Peterborough health and social care system is financially challenged. The CCG has invested in mental health through the parity of esteem uplift. However, spend per head on adult mental health services across Cambridgeshire and Peterborough remains amongst the lowest nationally, with a deficit failing system of £250m over the next five years.

- Increased influence for GPs and local authorities in the context of a new system-wide planning approach will mean that CPFT must adopt a proactive external relationship management strategy.

- New care delivery options as suggested in the “NHS Five-Year Forward View”. The twin challenges of growing demand and financial constraint has led the health and social care system locally to move towards an integrated care model. A new sustainability and transformation programme has been set up to drive collaborative working; improve care for patients and save money.

- Rising demand for services. We have one of the fastest growing populations in the country. The Cambridgeshire population is forecast to increase by 4.4% and the Peterborough population by 5.7% by 2019. The demand for our services continues to increase particularly the number of people presenting with dementia.

CPFT recognises the value of a systematic approach to risk management and the risk framework enables the Board to comprehensively understand the risk profile of the organisation.

CPFT continues to demonstrate compliance with corporate governance principles. The Board of Directors maintains a sound system of internal control to safeguard public and
private investment, the NHS foundation trust’s assets, patient safety and subsequent risk management and escalation.

**Principal Risks and Uncertainties**
The nature of Trust activities means that a complex range of risks existed, but CPFT continues to demonstrate compliance with corporate governance principles that the Board of Directors maintains a sound system of internal control to safeguard public and private investment, the NHS foundation Trust’s assets and patient safety.

The Trust is committed to providing safe, effective and supportive services and therefore recognises the value and necessity of maintaining a true safety culture which is underpinned by a systematic risk management approach and subsequent escalation and scrutiny framework.

Over the last year, the risk management profile has undergone continuous review and development and August 2015 saw the launch of an electronic risk recording and escalation system. In support of cultural change, numerous training workshops have been held and well attended, which has enabled the success of all organisational risk to be managed, escalated and reported on centrally.

In April, the Board undertook its annual process of review and refresh against the organisational risk appetite and subsequent tolerance levels against delivery of each strategic objective. This in turn informs how risks are managed, scrutinised and escalated from ward through to board level.

The Board Assurance Framework (BAF) reflects with top strategic risks facing the Trust and is reviewed by the Trust Board at each Board meeting.

The Corporate Risk Register (BAF inclusive) is reviewed by the Executive on a monthly basis and the Audit and Assurance Committee at each meeting. Chaired by a Non-Executive Directorate, the Audit and Assurance Committee’s role is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across CPFT and ensure that the Trust is able to demonstrate compliance with accepted corporate governance principles. An annual internal audit is scheduled review our risk management processes.

The Business and Performance Committee (B&PC) and Quality, Safety and Governance Committee (QSGC) are sub-committees of the Board, chaired by a Non-Executive Director. Both committees meet bi-monthly and review the top 10 relevant risks to business objectives, alongside the quality, performance and financial governance and performance requirements within the Trust. The committees provide assurance to the Board on the overall performance of trust operations taking into account a holistic view of quality, performance and finances.

The Cambridgeshire and Peterborough health and social care system is financially challenged. The CCG has invested in mental health through the parity of esteem uplift. However, spend per head on adult mental health services across Cambridgeshire and Peterborough remains amongst the lowest nationally, with a deficit failing system of £250m over the next five years.
Increased influence for GPs and local authorities in the context of a new system-wide planning approach will mean that CPFT must adopt a proactive external relationship management strategy.

New care delivery options as suggested in the “NHS Five-Year Forward View”. The twin challenges of growing demand and financial constraint has led the health and social care system locally to move towards an integrated care model. A new sustainability and transformation programme has been set up to drive collaborative working; improve care for patients and save money.

With one of the fastest growing populations in the country, there is a rising demand for services. The Cambridgeshire population is forecast to increase by 4.4% and the Peterborough population by 5.7% by 2019. The demand for our services continues to increase particularly the number of people presenting with dementia.

2.1.4 Going concern

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

2.2 Performance analysis

Full details are described in the Quality Report (Appendix 1).

2.2.1 Key performance measures

Improving patient safety, service effectiveness and the patient experience
Information on improving patient safety is included in the Quality Accounts in Appendix 1.

National and local targets
Information on national and local targets is included in the Quality Accounts in Appendix 1.

Workforce performance
Workforce scorecard dashboards are presented to the directorate Performance and Risk Executive (PRE) meeting on a monthly basis, with actions implemented and reviewed. An overview of the Trust-wide workforce priorities is also discussed at the Workforce Executive Meeting, where performance against priorities is monitored.

Following the work undertaken the previous year, the targeted approach to improving recruitment timelines and reducing our vacancy rate has continued.

As seen in FY2015/16, vacancy rates continued to increase over FY16; the new service model and increased establishment for the Integrated Care Directorate in October 2015 increased Trust-wide vacancies from 4.56% in September 2015 to 10.63% in December 2015, this has continued to increase as some vacancies have been held and turnover has increased. The average length of time to fill a vacancy peaked in September 2015 to 12.96%; this was affected by the number of recruitment plans and the implementation of a new recruitment system, NHS Jobs 2. Now the system has been in use for a few months the recruitment timeline has reduced dramatically, taking 10.35 weeks on average in January 2016.
A number of recruitment initiatives have been put in place over the last year. These include:

- Nursing open days – these days have been set up to recruit to our nursing vacancies providing candidates the opportunity to meet the teams to ask questions.

- Social media – recruitment Twitter and LinkedIn pages are regularly updated with vacancies and events, and a CPFT Facebook page is being used to promote jobs further. This is being managed through software called Hootsuite, which enables a targeted social media approach.

- Recruitment material developed – new banners, leaflets, posters and postcards have been produced for our recruitment events and to allow us to build mailing lists and so target particular audiences.

- Service user interview training – service users are now being trained to be on interview panels.

- Apprenticeship scheme – the Widening Participation Officer role has been successful in increasing awareness of CPFT as a place to work and launching the apprenticeship scheme. We now have 41 apprenticeships currently under way, which is expected to increase to 60 this year. There has also been an increase in work experience, including engaging in the Prince’s Trust scheme.

- Recruitment premia – this has continued to be used in our hotspot band 5 and band 6 nursing vacancies and a ‘refer-a-friend’ scheme has recently been launched.

- Targeted recruitment for student nurses, particularly within neighbouring universities which ordinarily there are no links to. This includes running workshops, career pathway and application/interview advice.

**Financial performance - overview of results for the year**

Following the award of the contract to provide Adult and Older Peoples Integrated Care Services which commenced on 1st April 2015, the Trusts turnover increased by £67m from £127m in FY2014-15 to £197m in FY2015-16. Expenditure rose at a similar level.

The Trust’s financial plan for the year, including the Adults and Older peoples Services, was to deliver a breakeven position and a Financial Sustainability Risk Rating (FSRR) of 3 against the Monitor Risk Rating metrics.

The financial performance of the Trust, reported in the Annual Accounts, was a deficit of £3.750m. The deficit included the financial impact of the UnitingCare contract settlement in the year, following the transfer of the Commissioning contract back to the Cambridgeshire and Peterborough Clinical Commissioning Group in December 2015.

The settlement costs, included in the accounts for the year, were £4.15m and were on a non-recurring nature.

Despite the deficit, the Trust delivered a Financial Risk Rating of 3 against the Monitor Risk Rating metrics.
The Trust continued to invest in infrastructure improvements, with Capital expenditure in FY2015-16 of £4.3m. Improvements in the year included investment in technology to improve IT resilience and performance, investment in Mobile Working to support clinical staff in the community, and improvement in facilities and estates to enhance the clinical environment. The capital programme was entirely funded by resources internally generated in the year.

2.2.2 Environmental matters

Strategy and action plan - CPFT understands its responsibilities to the environment and the wider community. It recognises that everything that it does impacts on the environment, which, in turn, can affect people’s health and wellbeing. The Trust, in its position as a public sector employer, consumer of resources and producer of waste, recognises its role in the promotion of sustainability and its contribution to the Government’s sustainability agenda. To this extent we understand the need to develop and maintain a sustainable development management system that will provide the framework to deliver against national and regional sustainable development initiatives and targets.

The Trust will operate a sustainable development management system based around the following processes:

- Sustainability assessment through the ongoing use of the Good Corporate Citizenship Self Assessment Model (GCCM).
- The development, implementation and ongoing monitoring of a Sustainable Development Management Plan (SDMP) which is informed by the outcomes of the GCCM assessment.
- Identification and assessment of environmental aspects and impacts of the Trust’s operations and the use of audit and review to ensure that all impacts are effectively managed.

CPFT is in the process of completing a sustainability assessment using the Good Corporate Citizen self-assessment model. The findings of the assessment will be used to inform the renewal of the Trust’s SDMP which will be aligned with the new NHS Sustainability Strategy – ‘Sustainable, Resilient, Health People and Places’.

CPFT has set up a steering group, The Sustainability Management Group, whose responsibility will be to champion sustainability and develop, implement and monitor the policies and action plans aimed at embedding sustainability across the organisation.

The group has developed a Sustainability Policy which has been ratified by the Trust Board and is working on the implementation of the policy.

It has also identified a number of initiatives aimed at reducing energy consumption which include:

- Improving the energy metering infrastructure to ensure that, wherever practicable, automated meters are used to record consumption allowing the Trust to get a comprehensive understanding of its energy usage.
- Replacement of inefficient lighting with LED lighting. Lighting surveys at Fulbourn Hospital are being carried out to identify costs and benefits and other sites in the Trust estate will be surveyed in due course.
Governance processes - we recognise that sustainable development is a corporate responsibility and needs to be fully embedded in our decision-making process. Furthermore, we understand that the principles of sustainable development must be embraced in order for us to realise the benefits of:

- Improved environmental performance.
- Better social co-operation and initiatives.
- Economic rewards from improved efficiency in resource use.

To this end the Trust Board will look to approve the SDMP which will provide the direction of travel over the next five years.

2.2.3 Social, community and human rights

The Trust has continued to work with its local authority partners on the implementation of the Care Act 2014. The full ramifications of this new legislation on the organisation of secondary mental health services has only started to emerge as the year has progressed and the task for the forthcoming year will be to develop an operating model that maximises the benefits of the Care Act for service users.

A great deal of thought was put in by many people in CPFT to develop a new approach to “recovery” in the light of the expansion of the Trust to include the new services for older people and adults with long-term conditions. The resultant strategy, signed off by the Board in January 2016, is called Building Recovery and Resilience, Promoting Wellbeing and Self Management. It is hoped that the new title reflects a wider approach across all ages and services within CPFT.

The Trust Board also approved its first Volunteering Strategy which has three aims:

(i) To promote volunteering within Trust services
(ii) promoting volunteering as a means of getting back into employment;
(iii) and as a way for individuals to contribute to their communities while at the same time increasing their own wellbeing through engagement in community activities.

A great example of volunteering are our Governors who give their time so freely to the Trust. Volunteers make a distinctive and valuable contribution to service users, their families and carers. They also provide a link with the local community and promote social inclusion. Furthermore, volunteering is a powerful tool in terms of recovery and resilience in that it provides an opportunity for service users to find positive meaning in their life and to help others.

2.2.4 Significant events since Statement of Financial Position

There have been no significant events since the date of the Statement of Financial Position.

2.2.5 Overseas developments

Proposals: CPFT is seeking out international opportunities, specifically in the Gulf Co-operation Council (GCC) area and southeast Asia. It is looking to develop and provide consultancy services, which include training, and to build on the quality brand of the Trust and the NHS. We aim to develop partnerships with countries or regions who want to
develop their mental health, behavioural medicine and Autism and ADHD (Attention Deficit Hyperactivity Disorder) service. We can offer the services of a specialist assessment team to carry out an initial standardised assessment of a country or area’s mental health services.

International events - CPFT participated in the Oman INFRA four-day event in October 2015 and the Arab Health three-day event in Dubai in January 2016. Valuable contacts and relationships were made during these events. CPFT was asked to host a ministerial visit from UAE, which took place in February 2016.

CPFT was also offered to explore opportunities in Hunan province (HP), China. As a result, clinical representatives from CPFT flew to Hunan province in October 2015 and visited a number of healthcare facilities. China has undergone a remarkable industrial and economic transformation over the last 20 years. The healthcare sector is developing rapidly and there is significant enthusiasm for co-operating with western nations.

International profile development and support - during the past year, CPFT has built close relationships with UKTI, Healthcare UK, UKEF and is a founder member of the newly formed UKIHMA, which was formed to support health organisations who wish to enter the international markets. The Trust has also participated in International Healthcare Strategy workshops and these have been excellent forums for networking with other NHS Trusts who are also looking to enter the international arena.
This Performance report is signed by the Chief Executive as Accounting Officer.

Signed ..................................  Date 25/3/16
Aidan Thomas
Chief Executive Officer
3. Accountability report

3.1 Directors report

3.1.1 Board of Directors

CPFTs board of directors are accountable for the performance and stewardship of the Trust. Their key responsibilities being to:

- Set overall strategic direction
- Ensure the Trust provides consistent high-quality, safe and effective services
- Promote effective dialogue between CPFT and the communities it serves
- Ensure all of the Trust activities are subject to high standards of governance
- Approve the annual report and accounts

NB Day-to-day responsibility for overseeing and directing delivery of services is held by a senior management team acting under delegated authority from the executive board.

The board comprises seven executive and seven non-executive directors (NEDs).

The Director of Service Integration attends board meetings without voting rights. The non-executive Chair maintains a casting vote. Seven formal board meetings were held during FY15/16.

Appointment of the Chair, non-executive and executive directors

The table below outlines responsibility for appointment of members of the board.

<table>
<thead>
<tr>
<th>POSITION</th>
<th>APPOINTMENT RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman</td>
<td>Council of Governors</td>
</tr>
<tr>
<td>Non-executive directors (NEDs)</td>
<td>Council of Governors</td>
</tr>
<tr>
<td>Chief Executive (CEO)</td>
<td>Chairman, NEDs collectively and Council of Governors</td>
</tr>
<tr>
<td>Executive directors</td>
<td>Chairman, CEO and NEDs collectively</td>
</tr>
</tbody>
</table>

Details of remuneration paid to the Chair, NEDs and executive directors are outlined in section 3.2.3.

NEDs are appointed for a term of three years and subject to an annual performance appraisal. NEDs may be reappointed for a second three-year term providing that they continue to be effective and demonstrate commitment to the role.

Removal of NEDs, including the Chair, requires the approval of three-quarters of the Council of Governors.
## Attendance at Board of Directors’ meetings

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Period served FYE 2016</th>
<th>Board meetings attended out of 7 (unless stated otherwise)</th>
<th>Date appointed to the board</th>
<th>Expiry, end of term of office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Spence, OBE</td>
<td>Chair (non-executive)</td>
<td>Full year</td>
<td>7</td>
<td>Jan 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>Deborah Cohen</td>
<td>Director of Service Integration</td>
<td>Full year</td>
<td>7</td>
<td>Sept 2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Melanie Coombes</td>
<td>Director of Nursing</td>
<td>Full year</td>
<td>6</td>
<td>Nov 2012</td>
<td>N/A</td>
</tr>
<tr>
<td>Chess Denman</td>
<td>Medical Director</td>
<td>Full year</td>
<td>5</td>
<td>Jan 2012</td>
<td>N/A</td>
</tr>
<tr>
<td>Scott Haldane</td>
<td>Director of Finance</td>
<td>Full year</td>
<td>6</td>
<td>Jan 2015</td>
<td>N/A</td>
</tr>
<tr>
<td>Stephen Legood</td>
<td>Director of People and Business Development (permanent post)</td>
<td>From Sept 2015 (1)</td>
<td>4 (1)</td>
<td>Sept 2015</td>
<td>N/A</td>
</tr>
<tr>
<td>Aidan Thomas</td>
<td>Chief Executive</td>
<td>Full year</td>
<td>7</td>
<td>Sept 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>Sarah Warner</td>
<td>Chief Operating Officer</td>
<td>Full year</td>
<td>6</td>
<td>Aug 2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Julian Baust</td>
<td>Deputy Chair (4)</td>
<td>Full Year</td>
<td>7</td>
<td>Reappointed April 2016</td>
<td>Mar 2019</td>
</tr>
<tr>
<td>Simon Burrows</td>
<td>Non-Executive Director</td>
<td>Full Year</td>
<td>6</td>
<td>Oct 2014</td>
<td>Sept 2017</td>
</tr>
<tr>
<td>Diana Forsyth</td>
<td>Non-Executive Director (2)</td>
<td>Until Jan 2016</td>
<td>3 (out of 5)</td>
<td>Oct 2014</td>
<td>Jan 2016</td>
</tr>
<tr>
<td>Sarah Hamilton</td>
<td>Non-Executive Director (2)</td>
<td>From Jan 2016</td>
<td>2 (out of 2)</td>
<td>Jan 2016</td>
<td>Jan 2019</td>
</tr>
<tr>
<td>Mike Hindmarch</td>
<td>Non-Executive Director (3)</td>
<td>From May 2015</td>
<td>5 (out of 5)</td>
<td>May 2015</td>
<td>May 2018</td>
</tr>
<tr>
<td>John Lappin</td>
<td>Non-Executive Director (3)</td>
<td>Until May 2015</td>
<td>1 (out of 1)</td>
<td>April 2013</td>
<td>May 2015</td>
</tr>
<tr>
<td>Jo Lucas</td>
<td>Non-Executive Director</td>
<td>Full Year</td>
<td>5</td>
<td>Oct 2014</td>
<td></td>
</tr>
<tr>
<td>Sir Patrick Sissons</td>
<td>Non-Executive Director (5)</td>
<td>Full Year</td>
<td>6</td>
<td>Reappointed in Jan 2016</td>
<td>Jan 2019</td>
</tr>
</tbody>
</table>

(1) Stephen Legood attended board meetings as Interim Director of People and Business Development prior to his appointment to the post permanently in September 2015.
(2) Diana Forsyth resigned effective January 2016. Sarah Hamilton was appointed effective January 2016 as direct replacement.
(3) John Lappin resigned effective May 2015. Mike Hindmarch was appointed effective May 2015 as a direct replacement.
(4) Julian Bausts term ended Mar 2016, he was reappointed in April 2016 for a further 3 years.
(5) Sir Patrick Sissons term ended December 2015, he was reappointed in January 2016 for a further 3 years.

### Meeting dates for FY15/16
Non-Executive Directors
Julie Spence OBE, Chairman

Chair of: Board of Directors
Council of Governors
Remuneration Committee

Julie has more than 30 years' distinguished public service with the police, having retired as Chief Constable of Cambridgeshire in late 2010. Appointed as Chair of CPFT in 2014, she is experienced operating with high levels of public scrutiny and accountability. Julie is currently Chair of the Police Mutual Assurance Society and a Trustee of Ormiston Families. She has previously lectured on leadership and organisational management at the University of Cambridge and Anglia Ruskin University.

Diana Forsyth, Non-Executive Director (until January 2016)

Diana has over 25 years' experience as a management consultant specialising in organisational development and change. She has worked at board level with a number of global organisations in the private and public sector. She previously served as a non-executive Director of Cambridge Community Service NHS Trust and the NHS Central Eastern Region Commissioning Support Unit.

Sarah Hamilton, Non-Executive Director (from January 2016)

Sarah is a solicitor with 20 years’ experience working in partnership with complex public sector organisations, including NHS Trusts. Sarah is a non-executive director of CILEx Law School and sits as Vice-Chair of the board of Trustees of a local women's refuge. Sarah previously served as a Governor of Hertfordshire Partnership NHS Foundation Trust for four years.

Simon Burrows, Non-Executive Director

Simon has more than 25 years’ commercial experience in the areas of research and customer insight, operational and process management, business development and financial management. He most recently served as Group Director at TNS (UK) the world’s biggest market, social and political research business. He previously served as a non-executive Director and Vice Chairman of the Market Research Society and IQCS for seven years.

Julian Baust, Non-Executive Director

Julian has more than 30 years’ commercial experience of organisational transformation, redesign and performance management gained within product and service industries. Prior to taking early retirement he was Chairman and Managing director of Kodak (UK) Ltd. Julian successfully led the business through transformations from analogue to digital. In addition to his role at CPFT, Julian serves as Vice-Chairman of Diabetes UK.
Patrick Sissons, Non-Executive Director

Patrick worked in University medical schools in clinical academic positions for more than 30 years - latterly as Regius Professor of Physic and Head of the School of Clinical Medicine at the University of Cambridge. He demonstrates a vast knowledge regarding how translational research and medical education can contribute to high-quality clinical services. Patrick is the Senior Independent Director and the non-executive lead for research.

Jo Lucas, Non-Executive Director

Jo has over 40 years' experience of working in mental health services in the UK and internationally. She has served as a board member of a number of organisations including as chair for a special needs housing association. She currently practices as a psychotherapist with a private practice in Cambridge and teaches for a counselling and psychotherapy training organisation. At CPFT she is the non-executive lead for recovery. Jo also serves as a Trustee of MIND (Cambridgeshire).

Mike Hindmarch, Non-Executive Director (from May 2015)

Mike is a chartered accountant with extensive management experience at board level in the private, public and third sector. Following a successful career with multi-national companies, Mike has more recently worked with a large national charity supporting people with multi-sensory impairment. He is also Vice-Chair of the Joint Audit Committee for the Police and Crime Commissioner and Chief Constable for Cambridgeshire and Peterborough and previously served as a non-executive director and Audit Chair at Cambridge Community Services NHS Trust.

John Lappin, Non-Executive Director (until May 2015)

John is a finance director with more than 30 years’ experience gained in the public and private sector. He most recently served as Director of Finance and Corporate Affairs at the Care Quality Commission. His previous roles included Director of Finance and Operations at distribution service group Rexel and Director of Finance at Royal Mail Letters/Parcelforce and the Genesis Housing Group.

Executive Directors
Aidan Thomas, Chief Executive

Areas of special interest and / or responsibility:
Responsible for meeting all the statutory and regulatory requirements of CPFT, in addition to being CPFT’s Accounting Officer to Parliament.

Aidan has more than 30 years’ experience working in the NHS and over 15 years’ experience as a Chief Executive, having previously held that role at Norfolk and Suffolk NHS Foundation Trust, West Essex Primary Care Trust and Epping Forest Primary Care Trust. He was a former director of human resources and director of older people’s services at Lambeth Community NHS Trust and director of operations at Essex and Herts Community NHS Trust. Aidan is passionate about developing ever better ways to deliver health and social care treatments to the communities CPFT serves.

Scott Haldane, Director of Finance
Areas of special interest and / or responsibility:
Finance and procurement including financial reporting, financial control, payroll, audit and procurement, capital planning, financial performance and management. Business information technology and estates management.

Scott has over 20 years’ experience in senior management roles and over 15 years’ as a Director of Finance. He graduated from the University of Stirling with a BA in Accountancy and Business Law in 1981 and qualified as a Chartered Accountant in 1984. He previously served as Director of Finance at Cambridge Community Services NHS Trust and NHS National Services Scotland respectively in addition to four years as Strategy & Business Development Director (Scotland) for ATOS IT Services (UK) Ltd. Scott previously served as Chairman of the Healthcare Financial Management Association and was recognised as public sector Finance Director of the year in 2006. He is currently a lay member of the court at the University of Stirling.

Melanie (Mel) Coombes, Director of Nursing and Quality

Areas of special interest and / or responsibility:
Nursing professional leadership and clinical management throughout CPFT.

Mel has more than 25 years’ experience working in the NHS. A registered nurse for all that time, she previously served as Deputy Director of Nursing and then acting Director of Nursing for five years at Coventry and Warwickshire NHS Partnership Trust. With a passion for improving quality, she led the development and implementation of ward-to-board reporting. She has also led on several developments at a national level including “better metrics” for learning disabilities services.

Dr Chess Denman, Medical Director

Areas of special interest and / or responsibility:
Responsible officer for medical revalidation; consultant appraisal; clinical research development and governance; clinical effectiveness and medicines management; Caldicott Guardian.

Chess has more than 20 years’ experience working in the NHS. She trained in medicine at Trinity College, Cambridge and London University before studying psychiatry at Guys and St Thomas' Hospitals and the Cassel Hospital in London. She then became a consultant psychiatrist in psychotherapy at Addenbrooke's NHS Trust (now Cambridge University Hospitals NHS Foundation Trust), before joining CPFT in 2003. Committed to improving services for mental health patients, she founded CPFT's Complex Cases Service for the treatment of personality disorders which won innovation site status and expansion funding from the Department of Health.

Sarah Warner, Chief Operating Officer

Areas of special interest and / or responsibility:
Operational performance and delivery of services.

Sarah has extensive experience working in the NHS, the last 10 years of which have been in senior operational roles. Prior to joining CPFT she served as Managing Director of the Hertfordshire Partnership University NHS Foundation Trust. The role saw her lead implementation of the Trust’s single point of access service and redevelopment of the
county-wide inpatient service. Prior to moving into mental health, Sarah was a general manager at the Royal Brompton and Harefield NHS Foundation Trust.

Deborah Cohen, Director of Service Integration

Areas of special interest and / or responsibility:
Service integration, partnership working, recovery

Deborah has more than 20 years’ experience working in health and social care roles. Prior to joining CPFT she served in various senior management roles including Service Head of Education, Health and Wellbeing at the London Borough of Tower Hamlets and Executive Director of Mental Health Service at Barnet, Enfield and Haringey NHS Mental Health Trust. Deborah is passionate about developing and promoting dementia services. Her joint commissioning team in Tower Hamlets won a national award for remodelling dementia services across health and social care and she previously led the London Association of Directors of Adult Social Services Mental Health Group.

Stephen Legood, Director of People and Business Development

Areas of special interest and / or responsibility:
Strategy development, business planning, business development, commissioning, marketing and client management, service transformation. Human resources, learning and development, leadership and management development; workforce equality and diversity; workforce productivity, temporary staffing, medical services.

Stephen has over 20 years’ experience working in the NHS which has taken him from ward to board, having started as a nurse. Prior to his current role Stephen served as CPFTs interim Chief Operating Officer having previously served with the organisation in a number of associate director roles, leading on commissioning, contracting, system redesign and delivering large-scale service developments. Stephen is a Governor of Cambridgeshire University Hospitals NHS Trust.

3.1.2 Register of Interests

CPFTs Directors Register of Interests lists details of any (potential) conflicts of interest of serving members of the board.

The register is maintained by the Trust Secretary and is available for inspection by members of the public upon request at the following address: Trust Secretary, Cambridgeshire and Peterborough NHS Foundation Trust, Elizabeth House, Fulbourn Hospital, Cambridge, CB21 5EF.

The Trust has not made any contributions to any political parties.

3.1.3 Board of Directors’ Sub-Committees

The Board has discharged some of its functions throughout the year through its sub-committees as outlined below. The work of the sub-committees and their terms of reference are reviewed annually to ensure these remain up to date, effective and fit for purpose.
Audit and Assurance Committee
The committee is responsible for ensuring an effective system of integrated governance, risk management and internal control is in place to support the achievement of CPFTs strategic objectives.

The committee is tasked with reviewing all internal and external audit reports and accounts to ensure CPFT is compliant with NHS and Monitor governance and audit standards.

Membership of the committee consists of three non-executive directors (excluding CPFTs Chair), one of whom is appointed to the role of Chair. At least one member of the committee shall be deemed to have relevant financial expertise.

Meeting dates

Business and Performance Committee
The committee is responsible for monitoring, reviewing and providing onward assurance to the board on in-year financial performance and delivery of services against set targets and budget.

The committee is tasked with providing assurance to the board on delivery of the long-term business and financial strategy and support the service development strategy.

Membership of the committee consists of four non-executive directors, one of whom is appointed to the role of Chair, and four executive directors.

Meeting dates

Quality, Safety and Governance Committee
The committee is responsible for monitoring CPFTs performance in developing and coordinating clinical governance and quality policy and practice.

The committee is tasked with providing assurance to the board that high standards of care, appropriate governance structures and efficient processes and controls are in place across CPFT.

Membership of the committee consists of four non-executive directors, one of whom is appointed to the role of Chair, and four executive directors.

Meeting dates

The table overleaf details committee membership and meeting attendance during FY16/15.
Executive directors are invited to attend other committee meetings (- they are not members of-) where agenda items involve areas of risk or operation within their individual remit. For example, the Director of Finance is a required attendee at each Audit and Assurance committee meeting.

A nominated member(s) of the Council of Governors attends each sub-committee meeting.

<table>
<thead>
<tr>
<th>NAME</th>
<th>MEMBERSHIP</th>
<th>MEETING ATTENDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AAC B&amp;P QS&amp;G</td>
<td>AAC – out of 5 B&amp;P – out of 8 QS&amp;G – out of 8</td>
</tr>
<tr>
<td>Deborah Cohen</td>
<td>● ● -</td>
<td>5 6</td>
</tr>
<tr>
<td>Melanie Coombes</td>
<td>● - -</td>
<td>6</td>
</tr>
<tr>
<td>Chess Denman</td>
<td>● - -</td>
<td>4</td>
</tr>
<tr>
<td>Scott Haldane</td>
<td>● - 7</td>
<td>-</td>
</tr>
<tr>
<td>Stephen Legood</td>
<td>● ● -</td>
<td>6 4</td>
</tr>
<tr>
<td>Sarah Warner</td>
<td>● ● -</td>
<td>5 5</td>
</tr>
<tr>
<td>Julian Baust</td>
<td>● Chair ●</td>
<td>5 6 6</td>
</tr>
<tr>
<td>Simon Burrows</td>
<td>● ● -</td>
<td>4 7 -</td>
</tr>
<tr>
<td>Diana Forsyth</td>
<td>● ● -</td>
<td>6 (out of 7) 5 (out of 7)</td>
</tr>
<tr>
<td>Sarah Hamilton</td>
<td>● ● -</td>
<td>1 (out of 1) 1 (out of 1)</td>
</tr>
<tr>
<td>Mike Hindmarch</td>
<td>● Chair ●</td>
<td>5 6 -</td>
</tr>
<tr>
<td>John Lappin</td>
<td>● ● 1 (out of 1)</td>
<td>- -</td>
</tr>
<tr>
<td>Jo Lucas</td>
<td>● Interim Chair - - 5</td>
<td></td>
</tr>
<tr>
<td>Sir Patrick Sissons</td>
<td>● - -</td>
<td>5</td>
</tr>
</tbody>
</table>
Board and sub-committee effectiveness
CPFTs *Scheme of Delegation* policy outlines the level of decision making that can be delegated and those responsibilities reserved for the board of directors.

The work of the board and various sub-committees and their terms of reference are reviewed annually to ensure they remain up to date, effective and fit for purpose.

In line with Monitor’s *Well-Led Framework* the board completed an annual self-assessment, the results of which formed the basis of their development plan for the year. External facilitation to support evaluation of the board is planned for the year ahead.

3.1.4 Better payment practice codes

CPFT is committed to making payments to suppliers within the timescales required by the Code. In 2015/16, the Trust paid 77% of invoices within 30 days of invoice date (2014/15: 72%).

CPFT had no payments of interest under the Late Payment of Commercial Debts (Interest) Act 1998.

3.1.5 Enhanced quality governance reporting

Information on the quality governance reporting is detailed in the Quality Accounts (Appendix 1) and the annual governance statement.

**Information on complaints handling**

The complaints team registered 185 formal complaints between 1 April 2015 and 31 March 2016, compared to 161 in 2014-15.

There has been a slight increase in formal complaints from the previous year, and this can be attributed to the integration of the adult and older people’s community services from April 2015. However, this increase has been counterbalanced by the increasing number of teams attempting to locally resolve concerns prior to them being escalated as a formal complaint.

The Patient Advice and Liaison Service recorded 582 enquiries for 2015-16 compared to 449 in 2014-15.

3.1.6 Cost statement

CPFT has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

3.1.7 Income disclosures

Monitor, the independent regulator of NHS Foundation Trusts - in exercise of powers conferred on it by paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 - directs that the keeping of accounts and the annual report of each NHS foundation trust shall be in the form as laid down in Monitors *Annual Reporting Guidance for NHS foundation trusts* within the NHS Foundation Trust Annual Reporting Manual, known as the FTARM, that is in force for the financial year.
As an organisation we are required by the NHS Act 2006 (as amended by the Health and Social Care Act 2012) to state whether our income from the provision of goods and services for the purposes of the health service in England is greater than our income from the provision of goods and services for any other purpose. We can confirm that this was the case, as evidenced by our accounts.

We are also required by the same act to provide information on the impact that other income has had on our provision of healthcare. We can confirm that our other operating income has had no adverse impact on our provision of goods and services for the purposes of the health service in England.

### 3.1.8 Auditors’ disclosures

To the best of their ability the board of directors are not aware of any relevant audit information of which the auditors are unaware.

Each member of the board is considered to have taken relevant steps to content themselves that the auditors are fully aware of any relevant audit information.

### 3.2 Remuneration Report

#### 3.2.1 Annual Statement on Remuneration

**Remuneration Committee (not subject to audit)**

The committee is responsible for identifying and appointing candidates to fill all Executive Director positions on the Board and for determining their remuneration and other conditions of service, along with the size, structure and composition of the Board of Directors. The committee also oversees the performance of the Executive Team through the annual objective setting and review process.

The remuneration and main terms of service of the Chief Executive, Executive Directors of the Trust and any other staff groups not subject to national terms and conditions of service. This includes:

- All aspects of salary (including any performance-related element/bonuses and cost of living increases);
- Provision of other benefits including pensions and cars; and
- Any arrangements for termination of employment and other contractual terms.

<table>
<thead>
<tr>
<th>NAME</th>
<th>ROLE</th>
<th>MEETING ATTENDANCE – out of 2 (15 May 2015 and 17 December 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Spence OBE</td>
<td>Committee Chair</td>
<td>2</td>
</tr>
<tr>
<td>Julian Baust</td>
<td>Member</td>
<td>2</td>
</tr>
<tr>
<td>Diana Forsyth</td>
<td>Member (until January 2016)</td>
<td>2</td>
</tr>
<tr>
<td>Sarah Hamilton</td>
<td>Member (from January 2016)</td>
<td>0 (out of 0)*</td>
</tr>
<tr>
<td>Prof. Sir Patrick Sissons</td>
<td>Member</td>
<td>2</td>
</tr>
</tbody>
</table>

*The committee met twice during the financial year (May and December 2015). No meetings were held between January-March 2016.*
The committee also approves the objectives of the members of the Executive Team and monitors and evaluates the performance of individual directors on at least an annual basis, against their agreed objectives. New objectives are set on an annual basis and these are used for performance measurement in the next financial year.

Other attendees may be co-opted from time to time in accordance with the agenda items. During the course of 2015-16 the committee was supported in its work by:

Aidan Thomas, Chief Executive
Keith Spencer, CEO of UnitingCare Partnership (until September 2015)
Stephen Legood, Director of People and Business Development (From September 2015)

3.2.2 Senior Managers’ Remuneration Policy

During the course of the year, the committee has considered and taken decisions on senior managers’ remuneration. There have been no substantial changes relating to remuneration made during the course of the last year. In terms of the senior managers’ remuneration policy, the committee and Trust is satisfied that the current policy of no performance bonuses is in line with the Trust’s strategic objectives.

**Remuneration and performance conditions**

To determine Board level salary the Remuneration Committee may use one or more of the following:

- Benchmarking data surveyed amongst the Trust’s peer group including NHS providers;
- National and regional analysis of NHS chief executives and executive directors remuneration; and
- Reviews of advertised executive director roles across the NHS.

Other than for the Medical Director, amendments to annual salary are decided by the Remuneration Committee on the basis of the size and complexity of job portfolio. Annual salary is inclusive – other payments such as bonus, overtime, long hours, on-call, standby, etc - do not feature in Executive Directors’ remuneration. The Medical Director’s salary is in accordance with the national terms and conditions of the service consultant contract 2003.

Cost-of-living increases for directors are linked to the Agenda for Change terms of employment which apply to all Trust staff.

**Service contracts**

Executive Directors are appointed to permanent contracts, subject to six months’ notice of termination by either party.

Date of the contract, the unexpired term, and details of the notice period are as follows:

<table>
<thead>
<tr>
<th>Executive Director</th>
<th>Date in Post</th>
<th>Unexpired Term</th>
<th>Notice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aidan Thomas – Chief Executive</td>
<td>September 2013</td>
<td>Permanent</td>
<td>Six months</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Start Date</td>
<td>Tenure</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Scott Haldane</td>
<td>Director of Finance</td>
<td>January 2015</td>
<td>Permanent</td>
</tr>
<tr>
<td>Deborah Cohen</td>
<td>Director of Service Integration</td>
<td>September 2014</td>
<td>Permanent</td>
</tr>
<tr>
<td>Melanie Coombes</td>
<td>Director of Nursing and Quality</td>
<td>November 2012</td>
<td>Permanent</td>
</tr>
<tr>
<td>Dr Chess Denman</td>
<td>Medical Director</td>
<td>January 2012</td>
<td>Permanent</td>
</tr>
<tr>
<td>Sarah Warner</td>
<td>Chief Operating Officer</td>
<td>August 2014</td>
<td>Permanent</td>
</tr>
<tr>
<td>Stephen Legood</td>
<td>Director of People and Business Development</td>
<td>May 2014</td>
<td>Permanent</td>
</tr>
</tbody>
</table>

There are no special contractual compensation provisions for the early termination of Executive Directors’ contracts.

Early termination by reason of redundancy is subject to either:

- the provisions of the *Agenda for Change: NHS Terms and Conditions of Service Handbook* (Section 16); or
- for those above the minimum retirement age, early termination by reason of redundancy or ‘in the interests of the efficiency of the service’ is in accordance with the NHS Pension Scheme.

Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.
## 3.2.3 Annual Remuneration Report

### A) Remuneration - Subject to Audit

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Year ending 31 March 2016</th>
<th>Year ending 31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary and Fees (bands of £5000) £000</td>
<td>Taxable Benefits * (total to the nearest £100) £000</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Non-Executive Directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Julie Spence OBE (Non - Executive Chairman)</td>
<td>Note 1</td>
<td>45 - 50</td>
</tr>
<tr>
<td>David Edwards (Non - Executive Chairman)</td>
<td>Note 2</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Jo Carson (Non - Executive Director)</td>
<td>Note 3</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Sarah Fossey (Non - Executive Director)</td>
<td>Note 4</td>
<td>15 - 20</td>
</tr>
<tr>
<td>Robert Dixon (Non - Executive Director)</td>
<td>Note 5</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Simon Burrows (Non - Executive Director)</td>
<td>Note 6</td>
<td>10 - 15</td>
</tr>
<tr>
<td>John Lagon (Non Executive Director)</td>
<td>Note 7</td>
<td>15 - 20</td>
</tr>
<tr>
<td>Julian Baut (Non Executive Director)</td>
<td>Note 8</td>
<td>125 - 130</td>
</tr>
<tr>
<td>Ailin Renton (Chief Operating Officer)</td>
<td>Note 9</td>
<td>135 - 140</td>
</tr>
<tr>
<td>Lisa Hunt (Chief Operating Officer)</td>
<td>Note 10</td>
<td>130 - 135</td>
</tr>
<tr>
<td>Keith Spencer (Deputy Chief Executive)</td>
<td>Note 11</td>
<td>110 - 115</td>
</tr>
<tr>
<td>Melanie Coombes (Director of Nursing)</td>
<td>Note 12</td>
<td>110 - 115</td>
</tr>
<tr>
<td>Phillip Cave (Director of Finance)</td>
<td>Note 13</td>
<td>125 - 130</td>
</tr>
<tr>
<td>Deborah Cohen (Director of Service Integration)</td>
<td>Note 14</td>
<td>115 - 120</td>
</tr>
<tr>
<td>Anne Marwick (Interim Director of Service Integration)</td>
<td>Note 15</td>
<td>105 - 105</td>
</tr>
</tbody>
</table>

**Note 1:** Appointed as Chair in June 2014 previously a Non-Executive since January 2013  
**Note 2:** Resigned June 2014  
**Note 3:** Resigned October 2014  
**Note 4:** Appointed January 2016  
**Note 5:** Resigned December 2015  
**Note 6:** Resigned October 2014  
**Note 7:** Resigned December 2015  
**Note 8:** End of term of office September 2014  
**Note 9:** Interim Appointment under Service Contract July 2014 - September 2014  
**Note 10:** Appointed September 2013 under a Service Contract, resigned May 2014  
**Note 11:** Seconded as Chief Executive of UnitingCare LLP until February 2016  
**Note 12:** Appointed May 2014  
**Note 13:** Appointed June 2013 Resigned January 2015  
**Note 14:** Appointed February 2015  
**Note 15:** Appointed July 2014  
**Note 16:** Interim Appointment under Service Contract July 2014 - September 2014  

* Taxable Benefits relate to the provision of lease cars.  
** Pension related benefits - Negative pension related benefits have occurred as salary increase did not match the inflation assumption directed for the calculation.
### B) Pension Benefits 2015/16 - Subject to Audit

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60</th>
<th>Real increase in lump sum at age 60</th>
<th>Real increase in CETV at age 60</th>
<th>Total accrued pension at age 60 at 31 March 2016</th>
<th>Lump sum at aged 60 related to accrued pension at 31 March 2016</th>
<th>Cash Equivalent Transfer Value at 31 March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aidan Thomas (Chief Executive)</td>
<td>0 - 2.5 (bands of £2500) £000</td>
<td>2.5 - 5 (bands of £2,500) £000</td>
<td>25 (bands of £5000) £000</td>
<td>60 - 65 (bands of £10,000) £000</td>
<td>180 - 185 (bands of £35,000) £000</td>
<td>1,262 (bands of £25,000) £000</td>
</tr>
<tr>
<td>Dr Chess Denman (Medical Director)</td>
<td>2.5 - 5.0 (bands of £500) £000</td>
<td>7.5 - 10 (bands of £10,000) £000</td>
<td>69 (bands of £17,500) £000</td>
<td>55 - 60 (bands of £12,500) £000</td>
<td>170 - 175 (bands of £42,500) £000</td>
<td>1,213 (bands of £25,000) £000</td>
</tr>
<tr>
<td>Sarah Warner (Chief Operating Officer) Note 1</td>
<td>2.5 - 5.0 (bands of £2500) £000</td>
<td>5 - 7.5 (bands of £500) £000</td>
<td>56 (bands of £11,000) £000</td>
<td>30 - 35 (bands of £7,000) £000</td>
<td>80 - 85 (bands of £20,000) £000</td>
<td>453 (bands of £90,000) £000</td>
</tr>
<tr>
<td>Keith Spencer (Director of People and Business Development) Note 2</td>
<td>5.0 - 7.5 (bands of £7500) £000</td>
<td>17.5 - 20 (bands of £35,000) £000</td>
<td>125 (bands of £25,000) £000</td>
<td>50 - 55 (bands of £12,500) £000</td>
<td>160 - 165 (bands of £42,500) £000</td>
<td>1,040 (bands of £25,000) £000</td>
</tr>
<tr>
<td>Stephen Legood (Interim Director of People and Business Development) Note 3</td>
<td>2.5 - 5.0 (bands of £2500) £000</td>
<td>2.5 - 5 (bands of £1250) £000</td>
<td>33 (bands of £6500) £000</td>
<td>10 - 15 (bands of £3000) £000</td>
<td>30 - 35 (bands of £7000) £000</td>
<td>206 (bands of £4500) £000</td>
</tr>
<tr>
<td>Melanie Coombes (Director of Nursing)</td>
<td>2.5 - 5.0 (bands of £2500) £000</td>
<td>2.5 - 5 (bands of £1250) £000</td>
<td>47 (bands of £9500) £000</td>
<td>35 - 40 (bands of £7000) £000</td>
<td>95 - 100 (bands of £20,000) £000</td>
<td>590 (bands of £12,000) £000</td>
</tr>
<tr>
<td>Scott Haldane (Director of Finance) Note 4</td>
<td>0 - 2.5 (bands of £500) £000</td>
<td>0 (bands of £0) £000</td>
<td>28 (bands of £5600) £000</td>
<td>0 - 5 (bands of £1000) £000</td>
<td>0 (bands of £0) £000</td>
<td>96 (bands of £0) £000</td>
</tr>
<tr>
<td>Deborah Cohen (Director of Service Integration) Note 5</td>
<td>0 - 2.5 (bands of £500) £000</td>
<td>0 (bands of £0) £000</td>
<td>30 (bands of £6000) £000</td>
<td>0 - 5 (bands of £1000) £000</td>
<td>0 (bands of £0) £000</td>
<td>45 (bands of £9000) £000</td>
</tr>
</tbody>
</table>

**Notes**

- Note 1 - Appointed September 2014
- Note 2 - Seconded as Chief Executive of UnitingCare LLP until February 2016
- Note 3 - Appointed May 2014
- Note 4 - Appointed January 2015
- Note 5 - Appointed October 2014

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pensions Scheme.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.
### B) Pension Benefits (Cont’d) 2014/15

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60</th>
<th>Real increase in lump sum at age 60</th>
<th>Real increase in CETV at age 60</th>
<th>Total accrued pension at age 60 at 31 March 2015</th>
<th>Lump sum at aged 60 related to accrued pension at 31 March 2015</th>
<th>Cash Equivalent Transfer Value at 31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(bands of £2500) £000</td>
<td>(bands of £5000) £000</td>
<td>£000</td>
<td>(bands of £5000) £000</td>
<td>(bands of £5000) £000</td>
<td>£000</td>
</tr>
<tr>
<td>Aidan Thomas (Chief Executive)</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>75</td>
<td>60 - 65</td>
<td>175 - 180</td>
<td>1,262</td>
</tr>
<tr>
<td>Dr Chess Denman (Medical Director)</td>
<td>2.5 - 5.0</td>
<td>5 - 7.5</td>
<td>73</td>
<td>55 - 60</td>
<td>170 - 175</td>
<td>1,213</td>
</tr>
<tr>
<td>Lisa Hunt (Interim Chief Operating Officer) Note 1</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Sarah Wamer (Chief Operating Officer) Note 2</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>30 - 35</td>
<td>80 - 85</td>
<td>453</td>
</tr>
<tr>
<td>Keith Spencer (Director of People and Business Development)</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>50 - 55</td>
<td>160 - 165</td>
<td>1,040</td>
</tr>
<tr>
<td>Stephen Legood (Interim Director of People and Business Development) Note 3</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>10 - 15</td>
<td>30 - 35</td>
<td>206</td>
</tr>
<tr>
<td>Melanie Coombes (Director of Nursing)</td>
<td>2.5 - 5.0</td>
<td>2.5 - 5</td>
<td>89</td>
<td>30 - 35</td>
<td>95 - 100</td>
<td>590</td>
</tr>
<tr>
<td>Scott Haldane (Director of Finance) Note 4</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2.5 - 5.0</td>
<td>0 - 2.5</td>
<td>66</td>
</tr>
<tr>
<td>Philip Cave (Director of Finance) Note 5</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Deborah Cohen (Director of Service Integration) Note 6</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0 - 2.5</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Anne Markwick (Interim Director of Service Integration) Note 7</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Lorna Payne (Director of Service Integration) Note 8</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Notes**

Note 1 - Appointed September 2013 Resigned May 2014 under a contract for services with Lisa Hunt Associated Limited

Note 2 - Appointed September 2014

Note 3 - Appointed May 2014

Note 4 - Appointed January 2015

Note 5 - Left January 2015

Note 6 - Appointed October 2014

Note 7 - Interim Appointment under Service Contract July 2014 - September 2014

Note 8 - Appointed June 2013, Resigned July 2014

N/A - The NHS Pension Scheme only provides actuarial valuations of pensions at the year end. It is therefore possible to calculate figures for directors who are appointed or resign mid-year.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable by the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

**Real Increase in CETV** - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

**Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pensions Scheme.**
3.3 Staff report (*)

3.3.1 Analysis of average staff numbers

<table>
<thead>
<tr>
<th>DEPARTMENT/ROLE</th>
<th>NO. OF STAFF BY CONTRACT TYPE</th>
<th>TOTAL STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fixed-term temp</td>
<td>Permanent</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>-</td>
<td>141</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Administrative and estates</td>
<td>-</td>
<td>246</td>
</tr>
<tr>
<td>Healthcare assistants and other support</td>
<td>-</td>
<td>929</td>
</tr>
<tr>
<td>staff</td>
<td></td>
<td>929</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting</td>
<td>-</td>
<td>937</td>
</tr>
<tr>
<td>staff</td>
<td></td>
<td>937</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>learners</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical</td>
<td>-</td>
<td>705</td>
</tr>
<tr>
<td>staff</td>
<td></td>
<td>705</td>
</tr>
<tr>
<td>Healthcare science staff</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Social care staff</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Agency and contract staff</td>
<td>195</td>
<td>-</td>
</tr>
<tr>
<td>Bank staff</td>
<td>-</td>
<td>128</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>OVERALL TOTAL</td>
<td>3089</td>
<td>601</td>
</tr>
</tbody>
</table>

Of which:
Number of employees (WTE) engaged on capital projects 6 - 6

3.3.2 Workforce gender breakdown

<table>
<thead>
<tr>
<th>ROLE/CATEGORY</th>
<th>STAFF NUMBERS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Directors/senior managers</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Other employees</td>
<td>3081</td>
<td>594</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3089</td>
<td>601</td>
</tr>
</tbody>
</table>

Directors:
Male - Aidan Thomas, Scott Haldane, Stephen Legood, Julian Baust, Patrick Sissons, Simon Burrows and Mike Hindmarch.

Female - Mel Coombes, Chess Denman, Deborah Cohen, Sarah Warner, Julie Spence, Jo Lucas and Sarah Hamilton.

(*) Excludes social work staff on local authority contracts of employment who are seconded into the Trust under section 75 agreements).

Developing a skilled and engaged workforce
CPFT has been proactive in responding to the requirements of an expanded and diverse workforce. Key highlights during the year include:

**Virtual learning:** supported through enhanced technology capabilities; this includes the development of a new website, investment in a new learning management system and licences to deliver programmes via the virtual college network and clinical skills resource.

**In person learning:** provision of a range of classroom courses enabling staff to gain skills in areas such as IV therapies, tissue viability, dementia, and a range of physical health care skills.

**Care Certificate:** introduced as a mandatory requirement for all newly employed band 2-4 staff in September 2015.

**Nursing pathway:** 24 foundation degrees were commissioned.

**Empowered to Care:** we continue to deliver the programme where relevant work has commenced on a tailored programme for the integrated care workers employed in the Integrated Care Directorate.

**Overall training:** CPFT supports a mandatory framework. Effective delivery mechanisms ensure managers are fully supported in meeting the organisations targets and maintaining a safe, effective and competent workforce.

CPFT have reached a 95% compliance rate in three core modules; good governance, working safely and adult safeguarding. Overall CPFT compliance rate is 89.5%. CPFT is presently taking an active part in the Health Education East of England (HEEoE) regional mandatory training streamlining project.

### 3.3.3 Information on NHS sickness data

Average percentage sickness rate for the Trust is over our Trust target of 4.35%. A targeted approach is underway in each directorate to reduce sickness absence supported through a new harmonised sickness policy and overall Health and Wellbeing Strategy and accompanying action plan.

#### Sickness Analysis

<table>
<thead>
<tr>
<th>Name</th>
<th>Sickness % (average of 12 Months)</th>
<th>Average FTE 2016</th>
<th>FTE-Days available</th>
<th>FTE days lost to sickness absence</th>
<th>Average sick days per FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridgeshire and Peterborough NHS Foundation Trust</td>
<td>4.86%</td>
<td>3202</td>
<td>1172064.42</td>
<td>57012.7776</td>
<td>17.8</td>
</tr>
</tbody>
</table>

*Source: ESR, Year ending 31st March 2016 & Workforce Review Data 2015-16*
3.3.4 Staff policies

Staff policies and actions applied during FY15/16 included the following:

- Procedure for Handling Concerns around Medical and Dental employees
- Clinical Excellence Award Scheme for NHS consultants
- Medical Rota Management Policy
- Maintaining Professional Registration Policy
- Career Break Policy
- Protection of Pay and Conditions of Service
- Organisational Change Policy (including redundancy)
- Redeployment Procedure
- Sickness Absence and Employee Wellbeing Policy
- Grievance Policy
- Disciplinary Policy and Procedure

All CPFT policies have an Equality Impact Assessment to ensure they do not put any potential or current employees at a detriment regarding any of the nine protected characteristics.

The Trust supports the “Two Ticks” initiative and guarantees an interview for those applicants who have a disability and ensures that, if applicants require support during the recruitment process, this is provided.

CPFTs redeployment process supports employees that need to be redeployed as a result of long-term medical condition and are unable to undertake their current role. The policy supports additional training and taking advice from occupational health as part of the redeployment process. Information and guidance for employees is available through the Staff Matters pages on the CPFT intranet.

CPFTs Wearing Two Hats Forum provides peer support for staff experiencing mental health challenges with a long-term aim of establishing a staff access pathway to CPFT services (and links to other Trusts). This group is part of the Health and Wellbeing Strategy.

CPFT encourages all employees to learn and develop with equal opportunities for all. The Trust ensure that all employees have the appropriate training and ensure that employees with disabilities are able to access all of training required. The Trust’s Recovery College East and Peer Support Worker programme support employees, as well as service users, within the Trust.

There are various methods of ensuring that employees receive information. All employees receive a weekly newsletter “Staff News”; information is posted on the Trust’s intranet; the Trust’s Joint Consultation and Negotiating Partnership (JCNP) consults with Trade Union members and employees on various aspects of the Trust’s business and is a direct link between the Trust’s senior management and employees.

The JCNP receives workforce information, negotiates with the Trust on matters affecting terms and conditions of employment, is responsible for the monitoring and development of policies and procedures and discussions on any matters affecting employees.
As part of our engagement with employees, we ran a series of workshops to formulate CPFT’s new values. As a result of the workshops, a number of options were put to the entire Trust where teams and individuals voted. Our new values were launched in January 2016 and over the next six months we will be using these values as part of our appraisal and recruitment processes.

CPFT has a nominated Local Counter-Fraud Specialist (LCFS) who works on behalf of the Board to ensure staff are trained and are aware of the seriousness and importance of this issue.

All concerns are reported to the LCFS and the Director of Finance for consideration and, where necessary, onward investigation.

The Audit and Assurance Committee are notified of any significant issues as they arise and receive a formal report from the LCFS at two intervals during the course of the year.

**Equal opportunities**

Promoting equality, embracing diversity and ensuring full inclusion for people who use our services is central to CPFT’s vision and values. CPFT maintains a number of equality policies, which include: *Equality and Diversity and Human Rights Policy; Dignity at Work policy; Flexible Working Policy; Maternity, Paternity, Adoption Policy, Positive and Proactive care: the recognition, prevention and therapeutic management of violence and aggression.*

CPFT adopted the national NHS Equality Delivery System (now EDS2) in 2011, three years in advance of it becoming mandatory for NHS suppliers. Full details of EDS2 can be found at [www.england.nhs.uk/about/gov/equality-hub/eds/](http://www.england.nhs.uk/about/gov/equality-hub/eds/)


The following staff networks and other groups support promotion of equality and diversity across CPFT:

**Equality and Diversity**

CPFT is committed to providing an environment where all staff, service users and carers enjoy equality of opportunities. CPFT understands the importance of being compliant with the various pieces of equality legislation and acknowledges the benefits and contribution that managing equality and diversity makes to the achievement of its business objectives in the areas of employment, service planning and service delivery.

CPFT is committed to:

- Developing policies, processes, procedures, practices and behaviours which challenges all forms of discrimination and promotes equality of opportunity at all levels.
- Creating an organisation that harnesses the different perspectives and skills of all staff and provides a working environment free from discrimination, harassment or victimisation.
The Equality and Diversity Steering Group is Chaired by the Director of People and Business Development, the group oversees development, implementation and monitoring of Equality and Diversity within CPFT.

**Ethnic Minority Network (EMN)**
The EMN supports and helps celebrate diversity within the CPFT and on E&D-related issues. Activities involving the network included:
- Cultural awareness training sessions
- Celebrated Black History Month in October 2015 with series of talks at Recovery College East.

**LGBT Staff Network (Lesbian, Gay, Bisexual and Transgender)**
Activities involving the network included:
- Supporting vulnerable LGBT people and trans-awareness day.
- LGBT awareness training

CPFT is a member of Stonewalls Healthcare Equality Index, a tool for health organisations to benchmark and track equality progress for their lesbian, gay and bisexual patients and communities.

**Staff Disability Network**
Activities involving the network included:
- Developing working relationship with the Peterborough Disability Forum in support of disability-related issues.

**Consultation with and involvement of employees**
Any service changes within the last year have been carried out in consultation with the staff involved.

CPFT’s Staff Consultative forum meets every two months to engage and consult with trade union colleagues. There, they discuss and negotiate employment-related changes, organisational changes and changes to terms and conditions. CPFT also meets with trade unions on a regular basis to work in partnership to review and develop of employment policies.

Communication with staff continues with the Executive Team involved in back-to-the-floor sessions, Non-Executive Director service visits, “Aidan’s Answers” e-mail system, intranet updates on weekly staff bulletins and monthly team briefs.

**Education and training activities**
CPFT continued to provide educational opportunities and continuing professional development (CPD) for medical staff at all levels throughout the year.

CPFT continued to provide:
- Short-term placements for medical students from the University Clinical School
- Intake of foundation year trainees
- Hosting the regional course for membership of the Royal College of Psychiatry
- In collaboration with the University of Cambridge Department of Psychiatry organised a lecture series
Continuing Professional Development funding has been allocated to meet both operational and professional requirements.

Health Education East of England (HEEoE) funding of £377,000 for CPD was invested in maintenance programs including: Mentorship and Practice Teaching, Non-Medical Prescribing, Wound Management, Advanced Clinical Assessment skills and Psychological Interventions.

The Quality Improvement Performance assessment undertaken by HEEoE was positive. Our Library and Information Service achieved a score of 97% in the Library Quality Assurance assessment.

CPFTs clinical placements team is actively engaging with HEEoE to develop and support the Flexible Nursing Pathways ensuring strong links with Anglia Ruskin University. CPFT has supported seven nurses to complete their district nurse pathway and two school nurses undertaking the SPHN pathway.

CPFT also has a number of staff undertaking degree level programmes in mental health, community pathways, and minor injuries.

**Health, safety and occupational health**  
CPFTs Health at Work policy details how staff are supported in relation to their health and working environments.

A number of key support channels provided include:

- **Occupational health service**: provided by Optima via Serco.
- **Counselling services**: provided by Insight Healthcare.
- **Stress-awareness training**: stress assessment tools are available to all managers in support of their teams.
- **General information**: relevant information is posted and regularly updated on CPFTs Staff Matters intranet page.

### 3.3.5 Staff Survey

**Summary of performance – results from the National NHS Staff Survey**

The Chief Executive and executive Board continue to provide drop-in sessions and back-to-the-floor days. This forms part of the Organisational Development Strategy and supports actions from the Staff Survey in 2015.

Each quarter the Pulse survey is run, which forms the Trust’s cultural barometer and includes questions required for the staff Friends and Family Test (FFT).

**National Staff Survey**

1582 staff completed the National Staff Survey, which accounts for a response rate of 46% - this is an increase from 2014 (43%) and is in line with the national average for combined community and mental health/learning disability trusts in England.

These details highlight the five key findings for which CPFT compares most favourably with other combined community and mental health/learning disability trusts in England.
The NHS staff survey, based on the 2014 survey results, has seen improvements or stability in all but one comparable key findings. This is a great achievement, particularly when considering the unprecedented change and pressures the Trust has had over the last year. Following the 2014 survey, an action plan focused on five themes were:

- Staff safety
- Work pressure
- Management support (ensuring managers have the skills to support staff)
- Culture and values (care is fundamental, supportive and positive culture)
- General (communications around the staff survey and action plans – how to engage staff to get involved and keep them updated on improvements/changes due to feedback).

Work on the action plan is still underway including the delivery of the Organisational Development Strategy and the Health and Wellbeing strategy, however marked improvements in scores around the key priorities have been seen, including improving communication for all staff, reduction in the number of staff suffering with work related stress and an increase in the staff confidence and security around reporting unsafe clinical practice from 3.48 (2014) to 3.74 (2015) out of 5.

The staff survey results are currently being analysed so that a 2015 Staff Survey Action Plan can be put in place to support improvements across the Trust. This will include

<table>
<thead>
<tr>
<th>TOP 5 MEASURES (in no particular order)</th>
<th>NATIONAL AVERAGE</th>
<th>CPFT 2015</th>
<th>CPFT 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff feeling pressure in the last 3 months to attend work when unwell</td>
<td>60%</td>
<td>54%</td>
<td>56%</td>
</tr>
<tr>
<td>Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>28%</td>
<td>25%</td>
<td>27%</td>
</tr>
<tr>
<td>Staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>92%</td>
<td>93%</td>
<td>92%</td>
</tr>
<tr>
<td>Staff confidence and security in reporting unsafe clinical practice <em>(ranked out of 5, 1 being worst 5 being best)</em></td>
<td>3.70</td>
<td>3.74</td>
<td>3.48</td>
</tr>
<tr>
<td>Staff reporting good communication between senior management and staff</td>
<td>33%</td>
<td>36%</td>
<td>28%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BOTTOM 5 MEASURES (in no particular order)</th>
<th>NATIONAL AVERAGE</th>
<th>CPFT 2015</th>
<th>CPFT 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff agreeing their role makes a difference to patients</td>
<td>89%</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>Staff receiving support from immediate managers <em>(ranked out of 5, 1 being worst 5 being best)</em></td>
<td>3.86</td>
<td>3.80</td>
<td>3.72</td>
</tr>
<tr>
<td>Staff suffering work-related stress in the last 12 months</td>
<td>38%</td>
<td>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Staff satisfaction with resourcing and support <em>(ranked out of 5, 1 being worst 5 being best)</em></td>
<td>3.33</td>
<td>3.24</td>
<td>--</td>
</tr>
<tr>
<td>Staff reporting good communication between senior management and staff</td>
<td>33%</td>
<td>36%</td>
<td>28%</td>
</tr>
<tr>
<td>Staff satisfaction with level of responsibility and involvement <em>(ranked out of 5, 1 being worst 5 being best)</em></td>
<td>3.90</td>
<td>3.83</td>
<td>3.72</td>
</tr>
</tbody>
</table>
specific actions for directorates and localities and they will be monitored by the Workforce Executive.

The overall staff engagement in the Trust has improved from 3.51 in 2014 to 3.77, as can be seen on the below chart. This is now close to the national average.

<table>
<thead>
<tr>
<th>Overall Staff Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>National 2015 average for combined MH/LD and Community Trusts</td>
</tr>
<tr>
<td>Trust Score 2014</td>
</tr>
<tr>
<td>Trust Score 2015</td>
</tr>
</tbody>
</table>

Looking at specific key findings that make up this area, all had improved from 2014. CPFT scored an average for recommending the Trust as a place to work or receive treatment and staff motivation to work. However, an area for improvement would be staff ability to contribute towards improvements at work. This should be addressed by the ongoing culture change and the Organisational Development Strategy, particularly around leadership / management development.

The draft action plan will be taken to the Workforce Executive in March 2016 and the Wider Leadership Team in April 2016 for comments, before being taken to the Quality, Safety and Governance Subcommittee of the Board of Directors for final sign off.

**Research and Development activities**

CPFT is committed to the principle that research and development (R&D) is crucial for the better understanding and treatment of mental health disorders.

CPFTs R&D department is:

- currently providing governance and oversight for 150 studies
- the most research-active mental health trust in the Eastern region, having recruited 1,999 patients into National Institute for Health Research (NIHR) portfolio studies between 2014-2016
- recognised as one of top 6 (out of 20) regional NHS Trusts for value-for-money, a measure of the number of patients recruited in proportion to the amount of R&D funding received.

CPFT R&D benefits from NIHR funding through the Cambridge Biomedical Research Centre (BRC), where Mental Health has been a research theme since 2012.

Examples of some of the research currently ongoing within CPFT include:

*Understanding how brain development is linked to adolescent risk of depression.*
Led by Professor Ian Goodyer the study was funded by a strategy award from the Wellcome Trust.

**New treatments for Alzheimer’s disease and dementia.**
Led by Professor John O’Brien and Consultant Psychiatrists Ben Underwood and Pranathi Ramachandra, CPFT have financed major investments in research clinics and a specialised dementia research facility on the Fulbourn Hospital site. Fourteen studies commenced during FYE2016, which compares with a total of six studies only having commenced over the previous three years in total.

**Investigating how the immune system is involved in mental health disorders.**
Professor Peter Jones is leading an MRC-funded clinical treatment of immunological treatment for patients with a first episode of psychosis and who have high levels of antibodies against key signalling proteins (glutamate receptors) in the brain; Professor Ed Bullmore is leading a Wellcome Trust-funded consortium to investigate the links between treatment-resistant depression and high levels of inflammatory biomarkers.

**Habits and the cognitive neuroscience of addiction:**
Working with colleagues in the University Department of Psychology, CPFT continues to support research into drug and alcohol dependence.

**Improving clinical information systems for mental health R&D in Cambridgeshire.**
As part of a national NIHR-funded network we implemented a new IT system for access to anonymised clinical records on CPFTs patients. With service user engagement and strict ethical oversight, CPFTs R&D database provides access to 154,000 patient records.

**Service-user led R&D on physical restraint in mental health.**
CPFT is supporting PROMISE, a service development programme focused on immediately reducing the incidence of physical restraint on acute mental health wards. Co-led by Dr Manaan Kar-Ray and Patient Leader, Ms Sarah Rae the PROMISE programme has already achieved a high profile nationally. For full details see [www.promise.global](http://www.promise.global)

### 3.3.6 Expenditure on consultancy
During the year CPFT spent £0.265m on Consultancy to support strategic reviews of Service provision and Estates.

### 3.3.7 Off payroll engagements

All existing off-payroll engagements outlined below had at some point been subject to a risk based assessment as to whether assurance was required that the individual was paying the right amount of tax and, where necessary, that assurance had been sought.

**Off-payroll engagements as of 31 Mar 2016, for more than £220 per day and that last for longer than six months.**

<table>
<thead>
<tr>
<th>No. of existing engagements as of 31 March 2016</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which...</td>
<td></td>
</tr>
<tr>
<td>No. that have existed for less than one year at time of reporting.</td>
<td>11</td>
</tr>
<tr>
<td>No. that have existed for between one and two years at time of reporting.</td>
<td>1</td>
</tr>
<tr>
<td>No. that have existed for between two and three years at time of</td>
<td>0</td>
</tr>
</tbody>
</table>
No. that have existed for between three and four years at time of reporting. 0
No. that have existed for four or more years at time of reporting. 0

New off-payroll engagements, or those that had reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months.

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of new engagements, or those that had reached six months in duration, between 1 April 2015 and 31 March 2016</td>
<td>16</td>
</tr>
<tr>
<td>No. of the above which include contractual clauses giving CPFT the right to request assurance in relation to income tax and National Insurance obligations</td>
<td>16</td>
</tr>
<tr>
<td>No. for whom assurance has been requested</td>
<td>16</td>
</tr>
<tr>
<td>Of which...</td>
<td></td>
</tr>
<tr>
<td>No. for whom assurance has been received</td>
<td>14</td>
</tr>
<tr>
<td>No. for whom assurance has not been received</td>
<td>2</td>
</tr>
<tr>
<td>No. that have been terminated as a result of assurance not being received.</td>
<td>0</td>
</tr>
</tbody>
</table>

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016.

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.</td>
<td></td>
</tr>
<tr>
<td>Number of individuals that have been deemed ‘board members and/or senior officials with significant financial responsibility’ during the financial year. This figure must include both off-payroll and on-payroll engagements.</td>
<td></td>
</tr>
</tbody>
</table>
### 3.3.8 Exit packages

**Staff Exit Packages –**

<table>
<thead>
<tr>
<th>EXIT PACKAGE COST BAND</th>
<th>NO. OF COMPULSORY REDUNDANCIES</th>
<th>NO. OF OTHER DEPARTURES AGREED</th>
<th>TOTAL NO. OF EXIT PACKAGES BY COST BAND</th>
<th>NO. OF COMPULSORY REDUNDANCIES</th>
<th>NO. OF OTHER DEPARTURES AGREED</th>
<th>TOTAL NO. OF EXIT PACKAGES BY COST BAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under £10,000</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>£10,000 - £25,000</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>£25,001 - £50,000</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>£50,001 - £100,000</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>£100,000 - £150,000</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>£150,000 - £200,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>£200,001 and over</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4</td>
<td>12</td>
<td>16</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>TOTAL RESOURCE COST £’000s</td>
<td>158</td>
<td>573</td>
<td>731</td>
<td>220</td>
<td>327</td>
<td>547</td>
</tr>
</tbody>
</table>

Exit packages: non-compulsory departure payments -

<table>
<thead>
<tr>
<th>CONTRACTUAL COSTS</th>
<th>FYE 2016</th>
<th>FYE 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO. OF AGREEMENTS</td>
<td>TOTAL COST £’000</td>
</tr>
<tr>
<td>Voluntary redundancies including early retirement</td>
<td>3</td>
<td>335</td>
</tr>
<tr>
<td>Mutually agreed resignations (MARS)</td>
<td>8</td>
<td>200</td>
</tr>
<tr>
<td>Early retirement in the efficiency of the service</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Payments in lieu of notice</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>OTHER COSTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exit payments following employment tribunals or court orders</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-contractual payments requiring HMT approval</td>
<td>1</td>
<td>38</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>573</td>
</tr>
<tr>
<td>Total no. of non-contractual payments requiring HMT approval where payment value was more than 12 months of annual salary</td>
<td>1</td>
<td>38</td>
</tr>
</tbody>
</table>
**Raising issues or concerns**
CPFT has established procedures enabling staff to raise any issues or concerns of a serious nature. A confidential whistleblowing hotline and email address exist through which any staff member can raise and/or discuss such matters.

‘Stop the Line’ continues to operate as a means for any staff member to raise an immediate patient safety concern at any time.

CPFTs Safety and Experience Lead, appointed in January 2015, has been extremely active in promoting the above channels and direct support to staff previously unable or lacking confidence in raising areas of concern.

**Service developments**

The highlight of the year was undoubtedly the CQC inspection in the spring and subsequent report published in the autumn rating the services as good.

A summary of CPFTs four main service directorates and key highlights FYE2016 are outlined below.

<table>
<thead>
<tr>
<th>DIRECTORATE</th>
<th>SUMMARY OF SERVICE PROVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Services</td>
<td>covers all in-patient wards and community mental health teams in Cambridgeshire and Peterborough, crisis resolution and home treatment teams, Psychological Wellbeing Service (IAPT) teams and our Advice and Referral Centre (ARC)</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>covers services such as prison mental health in-reach teams, eating disorders service, substance misuse, learning disability and Autism and ADHD services, criminal justice services and arts therapies.</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>covers all of our inpatient and community mental health teams in Cambridgeshire and Peterborough, for people over 65, as well as our community services for people over the age of 18.</td>
</tr>
<tr>
<td>Children’s services</td>
<td>covers all child and adolescent mental health community services in Cambridgeshire and Peterborough, children's community services in Peterborough, our adolescent intensive support team, and young people's drug and alcohol service.</td>
</tr>
</tbody>
</table>

**Adult Services Directorate**

**Advice and Referral Centre (ARC):**
The ARC provides a single point of access into CPFT services for GPs based in Peterborough and Cambridgeshire. Implementation of a revised operating policy combined with the introduction of key performance measures has positively impacted the referral process.

The ARC continued provision of in-house training and information sharing sessions across CPFT and voluntary sector providers.

ARC processes and operations were aligned with our ‘Choose and Book’ obligations.

Development of the role of Mental Health Liaison Practitioners (MHLP) continued throughout the year. MHLPs are now more engaged with their respective locality teams.
MHLP’s are also engaged with a number of service development projects – eg, enhanced primary care so that they can offer a senior clinical input.

October 2015 was the first prone restrain-free month for the directorate. In 2016 the directorate will be investing in sensory approaches training for six wards in the first wave for staff to have the skills to continue on this journey.

A single point of access for psychological wellbeing services was opened in the summer of 2015 making it possible for people to self-refer.

A consultant telephone advice clinic enabling GPs to contact their locality consultant for advice at a set time was introduced in January 2016.

Psychological Wellbeing Services (PWS):
PWS (formerly known as IAPT) was awarded the contract to increase the numbers of people accessing the service from 7.5% to 15% of eligible population. Psychological treatments have been delivered to more than 10,000 people in the past year.

Mental health locality teams: A program of new developments is currently in production to better reflect a stepped-care approach and further integration with primary care and non-statutory providers. Implementation will occur during FYE2017.

Personality Disorder Community Service (PDCS):
PDCS currently receives an average of 840 referrals a year. In addressing the capacity pressure that level of demand is creating, funding has been secured for a new consultant post. A business case to further increase resource is currently under review.

CAMEO early intervention for psychosis service:
The service team continue to provide high-quality, evidence-based interventions and are engaged in a number of national and international clinical research trials. Next year will be a telling year for Cameo as new Monitor targets are rolled out; a business case has been submitted for delivering NICE-compliant services.

Crisis Resolution and Home Treatment Teams (CRHT):
CRHTs implemented a number of significant operational changes following consultation on improving productivity and efficiency. This included all teams adopting new shift patterns, facilitating more effective use of resource and financial saving efficiencies and the merger of two Cambridge into a single unit creating further efficiencies.

136 health-based place of safety:
It was regrettable that following stakeholder consultation the health-based place of safety in Peterborough was closed. Poor environment and a lack of dedicated staffing the main reasons behind closure. Funding to fully staff the health-based place of safety in Cambridge was secured and remains open.

Senior medical staff
In an effort to strengthen clinical pathways in PDCS, additional senior posts have secured funding of up to £550k. To improve clinical productivity and support the medical workforce a further investment of £200k in administrative staff was secured.

Specialist Services Directorate
Criminal Justice Pathway;
CPFT, partnering with Sodexo, were awarded preferred bidder status for HMP Peterborough MHRT and Clare Lodge (secure children’s home for girls).

A one-year pilot Personality Disorder Offender Pathway also commenced.

**Eating Disorders Pathway:**
CPFT was awarded an extension of the Norfolk Community Eating Disorders Service (NCEDS) until April 2017.

CQUIN targets achieved for NCEDS and S3.

**Psychological medicine (liaison psychiatry and pediatric psychology):**
A 24-hour Liaison Psychiatry Service implemented at Peterborough City Hospital.

**Integrated Care Directorate (ICD)**
The ICD was formed in July 2015 as an integrated services provider for adults in the community.

Staff from CPFT and Cambridge Community Services NHS Trust working in older people’s mental and physical healthcare combined to deliver integrated care via a new Neighbourhood Team (NT) and Integrated Care Team (ICT) structure across the local system.

**Formation of Neighbourhood Teams (NTs) and Integrated Care Teams (ICTs):**
Sixteen new NTs went live from October 2015. Locality mental health services are now delivered through dedicated mental health staff within the NTs and the four ICTs. Specialist pathway services are also structured within the new ICTs across the directorate.

**Inpatient beds:**
Work is ongoing with ward managers to standardise internal ward processes to improve the average length of stay for older people in community rehabilitation units. The directorate works closely with the CCG as part of the post-discharge Vanguard work-stream supporting a shift from hospital based to home support services.

**Integration of Older People’s Mental Health (OPMH):**
A new clinical model and redesign of OPMH community services facilitated integration of mental health staff into NTs and ICTs alongside physical health colleagues.

Dedicated memory assessment services in each of four localities will now support delivery of prompt diagnosis of dementia and onward interventions.

**Crisis Resolution and Home Treatment**
A combination of additional resource and extension of operating hours, the Crisis Resolution and Home Treatment teams have expanded to provide an extended dementia intensive support service.

**Joint Emergency Teams (JET):**
The JET service became operational across the county in July 2015 following an extensive communications and engagement programme with GPs. The service was extended to nursing homes and care and residential homes during the remainder of the year.
**Children's Services Directorate**

**Core CAMH services:**
Additional funding secured from the CCG enabled the team to reduce routine referral waiting times for specialist child and adolescent mental health services to within the national 18-week target.

CAPA has been introduced to maintain waiting lists and waiting times by targets. CAPA (Choice and Partnership Approach) is a flow and efficiency model that combines collaborative and participatory practice with children, young people and their families to enhance engagement, effectiveness, leadership, skills modelling and demand and capacity management.

**Autism and ADHD Services:**
Working in tandem with Cambridge Community Services NHS Trust and local authorities, the team is developing a new integrated Autism and ADHD pathway in Cambridgeshire aimed at reducing unnecessary referrals to specialist services and providing early support for children and families before they enter the specialist pathway.

**Community Child Health Services:**
Additional funding has enabled the team to appoint additional staff to reduce waiting times for school aged children and reduce the number of children waiting for community pediatric appointments from nearly 300 to fewer than 30. The waiting time for the first appointment has come down from nine months to fewer than 12 weeks.

We have taken learnings from addressing CAMH waiting lists and applied the same rigor and focus to assessing and monitoring the SaLT waiting list data for pre-school and school aged children.

During the year a **complex health needs multi-disciplinary team** was developed. This has improved joint working and coordinated care. The CQC inspectors identified this as an area of good practice.

**Service user engagement**
Active engagement with service users is ongoing. Some key highlights during FYE2016 included:

- A recently completed research project in collaboration with the Collaboration for Leadership in Applied Research and Health Care (CLARHC) looking at the experience of young people moving from CAMH to adult services. These young people are now helping us to review and improve our transition processes.
- Young people are now full participants in recruitment panels for all new management and clinical staff interviews.
- Seeking young people and carers’ views in a variety of ways including a group format and ‘Magic Wand’ which has been very successful in both Cambridge and Huntingdon.
- Young people telling their stories/participating at conferences and workshops (including a very successful self-harm multi-agency workshop in Peterborough), and involving them in service re-design.

Providing instant feedback on services through comments boards in our reception areas (‘You Said, We Did’).
Nursing revalidation
The Nursing and Midwifery Council (NMC) announced the introduction of a mandatory requirement for all nurses and midwife to revalidate with the NMC every three years to remain on the professional register.

Revalidation is a new process that all nurses and midwives in the UK will need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). It becomes effective as of April 2016.

CPFTs recently launched Revalidation Project Group will provide relevant support to the organisations 1,263 nurses.

Cambridge University Health Partners (CUHP)

CUHP is a partnership between Papworth Hospital NHS Foundation Trust, the University of Cambridge, CPFT and Cambridge University Hospitals NHS Foundation Trust.

It is one of only six centres in England to be recognised as globally competitive due to the strength of its translational research, clinicians and academics. CUHPs objective being to support and promote world-class excellence in health care, research and clinical education.

CUHPs support of partner organisations over the past year has directly led to or influenced:

- AstraZeneca confirming plans to establish a new global Research and Development Centre on the campus during 2016
- the Papworth Hospital confirming plans to relocate to the campus from 2018
- CUH and CPFT securing the Older Adults UCP

CUHP additionally led a successful coordinated bid to become a Department of Health designated Genome Medicine Centre.
3.4 NHS Foundation Trust Code of Governance

Council of Governors (CoGs)
Established in 2008, the CoGs over riding role is to hold the Non-Executive Directors (individually and collectively) to account for the performance of the board of directors and to represent the interests of CPFT members and the wider public.

The council’s duties and how the council has actioned their duties in 2015-16 are outlined below:

<table>
<thead>
<tr>
<th>COG RESPONSIBILITY</th>
<th>ACTIONS IN FY 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approving appointment and, if appropriate, removal of the Chair</td>
<td>No required actions in year.</td>
</tr>
<tr>
<td>Approving appointment and, if appropriate, removal of other Non-Executive Directors</td>
<td>Approved the appointments of Mike Hindmarch and Sarah Hamilton.</td>
</tr>
<tr>
<td>Approving changes to remuneration and allowances for the Chair and Non-Executive Director</td>
<td>Approved the appointment of Julian Baust as Deputy Chair. Approved additional remuneration for the role of Deputy Chair. Approved additional remuneration for 3 Non-Executive Directors assigned additional tasks for UnitingCare. (Additional remuneration removed on cessation of the UnitingCare contract).</td>
</tr>
<tr>
<td>Approving the appointment of the Chief Executive</td>
<td>No required actions in year.</td>
</tr>
<tr>
<td>Appointing, reappointing or removal of CPFTs external auditors</td>
<td>No required actions in year</td>
</tr>
<tr>
<td>Approving amendments to the constitution</td>
<td>No required actions in year</td>
</tr>
<tr>
<td>Approving significant transactions</td>
<td>No required actions in year</td>
</tr>
</tbody>
</table>

COG meetings and Governor involvement
The COG met in full four times during the year and formally received CPFTs Annual Report and Accounts (FYE2015) at their September 2015 meeting.

CPFTs executive board directors are required to attend each COG meeting. They provide commentary on relevant areas of the organisations operational and financial performance over the past period. CPFTs non-executive board directors are required to attend each COG meeting and contribute as and where required.

Governors and members of the public attending the COG are able to ask questions of any director on any relevant matter.

The COG in conjunction with Governor attendance at board of director meetings and sub-committee meetings ensures their views and those of the members and public they represent are consistently heard by the board.
Comment on the development of the strategic direction and forward plans of CPFT
Being involved in numerous events and giving valuable contributions to CPFT’s future plans, the Governors are integral to the annual business planning process and longer term strategy development. The Council of Governors receive routine reports and updates on the development of the Trust’s Annual Plans at their quarterly meetings.

Composition of the Council of Governors
The Council of Governors consists of the following number by class:

- 15 Public Governors
- 6 Patient / Carer Governors
- 4 Staff Governors
- 9 Appointed Governor

Represent the interests of members of the Trust as a whole and the interests of the public
CPFT has a Membership Working Group which consists of a select number of Governors and members of the Trust Secretariat. A membership recruitment and engagement strategy was produced by this group and this continues to be implemented. Membership working papers are also presented to the whole Council every six months. CPFT also has two Governor Leads for membership. During FY2015/16 CPFT completed a membership survey in order to gather feedback from members on its engagement with them. The results from this survey were analysed and will be used to develop the FY17 membership recruitment and engagement strategy.

An email address (foundationtrust@cpft.nhs.uk) is available for Trust members to contact Governors. This is communicated on the CPFT’s website and in the Trust’s membership newsletters which contain a Governor update. There is also Governor representation at the quarterly member talks and events, as well as at the Annual Members’ Meeting.

The views of Governors and members are heard by the Board of Directors and Non-Executive Directors through their regular engagement at the Council of Governors’ meetings, Board of Directors’ meetings, Board sub-committees and through direct contact.
**Composition of the Council of Governors**
The Council of Governors hold formal public meetings four times a year. In 2015-16, these were held on: 13 May 2015, 8 September 2015, 9 December 2015 and 16 March 2016.

<table>
<thead>
<tr>
<th>NAME</th>
<th>CLASS OF GOVERNOR</th>
<th>DATE ELECTED</th>
<th>DATE(S) OF RE-ELECTION</th>
<th>CURRENT TERM ENDS</th>
<th>MEETINGS ATTENDED – out of 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Collier</td>
<td>Public (Cambridgeshire)</td>
<td>September 2013</td>
<td>September 2014</td>
<td>September 2016</td>
<td>4</td>
</tr>
<tr>
<td>Bernie Gold</td>
<td>Public (Cambridgeshire)</td>
<td>June 2008</td>
<td>July 2010; September 2013</td>
<td>September 2016</td>
<td>4</td>
</tr>
<tr>
<td>Margaret Johnson</td>
<td>Public (Cambridgeshire)</td>
<td>July 2011</td>
<td>July 2014</td>
<td>July 2017</td>
<td>4</td>
</tr>
<tr>
<td>Eric Revell</td>
<td>Public (Cambridgeshire)</td>
<td>May 2015</td>
<td>-</td>
<td>May 2018</td>
<td>3 (out of 3)</td>
</tr>
<tr>
<td>Ian Arnott</td>
<td>Public (Peterborough)</td>
<td>June 2008</td>
<td>July 2010; September 2013</td>
<td>September 2016</td>
<td>3</td>
</tr>
<tr>
<td>Drury Thompson</td>
<td>Public (Peterborough)</td>
<td>May 2014</td>
<td>-</td>
<td>May 2017</td>
<td>2</td>
</tr>
<tr>
<td>Chris York</td>
<td>Public (Peterborough)</td>
<td>July 2012</td>
<td>July 2015</td>
<td>July 2018</td>
<td>1</td>
</tr>
<tr>
<td>David Over</td>
<td>Public (Peterborough)</td>
<td>May 2015</td>
<td>-</td>
<td>May 2018</td>
<td>3 (out of 3)</td>
</tr>
<tr>
<td>Melica Martin</td>
<td>Public (Rest of England)</td>
<td>May 2014</td>
<td>-</td>
<td>May 2017</td>
<td>1</td>
</tr>
<tr>
<td>Kirsty Trigg</td>
<td>Patient/Carer: Service user (Cambridgeshire)</td>
<td>September 2013</td>
<td>-</td>
<td>September 2016</td>
<td>3</td>
</tr>
<tr>
<td>Mark Batey</td>
<td>Patient/Carer: Service user (Peterborough)</td>
<td>May 2015</td>
<td>-</td>
<td>May 2018</td>
<td>0 (out of 3)</td>
</tr>
<tr>
<td>Elizabeth Mitchell</td>
<td>Patient/Carer: Carer</td>
<td>July 2012</td>
<td>May 2014</td>
<td>May 2017</td>
<td>4</td>
</tr>
<tr>
<td>Keith Grimwade</td>
<td>Patient/Carer: Carer</td>
<td>May 2014</td>
<td>-</td>
<td>May 2017</td>
<td>4</td>
</tr>
<tr>
<td>Jane Powell</td>
<td>Staff</td>
<td>May 2014</td>
<td>-</td>
<td>May 2017</td>
<td>2</td>
</tr>
<tr>
<td>Anthony Hardy</td>
<td>Staff</td>
<td>May 2015</td>
<td>-</td>
<td>May 2018</td>
<td>0 (out of 3)</td>
</tr>
</tbody>
</table>

Current vacancies: Public Governors: 4 for Cambridgeshire & 1 for Peterborough; Patient/carer: service user: 1 for Cambridgeshire & 1 for Rest of England; Staff Governors: 2.
The following individuals ceased serving as elected Governors during 2015: Enister Ngala, Phil Staton, Carol Fernandez, Marcia Appleton, Colin Shaw and Tracey Tingey
### Appointed Governors

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION REPRESENTED</th>
<th>ORGANISATION TYPE</th>
<th>DATE OF APPOINTMENT</th>
<th>MEETINGS ATTENDED – out of 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lucy Nethsingha</td>
<td>Cambridgeshire County Council</td>
<td>Stakeholder</td>
<td>August 2015</td>
<td>2 (out of 3)</td>
</tr>
<tr>
<td>Wendi Ogle-Welbourn</td>
<td>Peterborough City Council</td>
<td>Stakeholder</td>
<td>February 2014</td>
<td>0</td>
</tr>
<tr>
<td>Diana Wood</td>
<td>University of Cambridge</td>
<td>Stakeholder</td>
<td>June 2008</td>
<td>2</td>
</tr>
<tr>
<td>Kevin Vanterpool</td>
<td>Cambridgeshire Police</td>
<td>Partner</td>
<td>October 2014</td>
<td>1</td>
</tr>
<tr>
<td>Lawrence Ashelford</td>
<td>Cambridge University Hospitals NHS Foundation Trust</td>
<td>Partner</td>
<td>June 2015</td>
<td>2 (out of 3)</td>
</tr>
<tr>
<td>Lesley Crosby</td>
<td>Peterborough and Stamford Hospitals NHS Foundation Trust</td>
<td>Partner</td>
<td>March 2015</td>
<td>4</td>
</tr>
<tr>
<td>Emily Gray</td>
<td>Voluntary sector</td>
<td>Partner</td>
<td>November 2014</td>
<td>3</td>
</tr>
</tbody>
</table>

Current vacancies (at time of writing): 1 Stakeholder Governor for Cambridgeshire and Peterborough Clinical Commissioning Group; 1 Partner Governor of Special Services.

The following individual ceased serving as an Appointed Governor as of July 2015: Sir Peter Brown (representing Cambridgeshire County Council)

### CPFT Board of Directors

<table>
<thead>
<tr>
<th>NAME</th>
<th>EXECUTIVE POSITION</th>
<th>MEETINGS ATTENDED – out of 4</th>
<th>NAME</th>
<th>EXECUTIVE POSITION</th>
<th>MEETINGS ATTENDED – out of 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aidan Thomas</td>
<td>Chief Executive</td>
<td>4</td>
<td>Julie Spence OBE</td>
<td>Chair</td>
<td>4</td>
</tr>
<tr>
<td>Deborah Cohen</td>
<td>Director of Service Integration</td>
<td>2</td>
<td>Julian Baust</td>
<td>Deputy Chair</td>
<td>2</td>
</tr>
<tr>
<td>Mel Coombs</td>
<td>Director of Nursing</td>
<td>4</td>
<td>Simon Burrows</td>
<td>Non-executive</td>
<td>3</td>
</tr>
<tr>
<td>Chess Denman</td>
<td>Medical Director</td>
<td>3</td>
<td>Diana Forsyth</td>
<td>Non-executive</td>
<td>1 (out of 3)</td>
</tr>
<tr>
<td>Scott Haldane</td>
<td>Director of Finance</td>
<td>4</td>
<td>Sarah Hamilton</td>
<td>Non-executive</td>
<td>1 (out of 1)</td>
</tr>
<tr>
<td>Stephen Legood</td>
<td>Director of People and Business Development</td>
<td>4</td>
<td>Mike Hindmarsh</td>
<td>Non-executive</td>
<td>3</td>
</tr>
<tr>
<td>Sarah Warner</td>
<td>Chief Operating Officer</td>
<td>4</td>
<td>Jo Lucas</td>
<td>Non-executive</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prof Sir Patrick Sissons</td>
<td>Non-executive</td>
<td>3</td>
</tr>
</tbody>
</table>
Governor elections
Electoral Reform Services Limited (ERS) acts as the Returning Officer and Independent Scrutineer of the Trust’s Governor election process.

Results of the annual election held in FY16 were published on 29 April 2015. In summary, the following Governors were elected: Eric Revell, David Over, Chris York and Anthony Hardy. The latter three being elected uncontested. A total of ten Governor vacancies existed at the time of election.

Governors’ Nominations Committee
A standing committee of the COG, the Nominations Committee is responsible for the appointment of Non-Executive Directors (NEDs). The Nominations committee held two meetings during the course of the year.

Membership of the committee consists of one appointed and three elected Governors and is chaired by CPFTs Chair.

The committees Terms of Reference were approved as in line with national best practice at the COG meeting in May 2015.

Register of interests
All Governors are asked to declare any interests at the time of their appointment or election. There is a standing agenda item on all Council of Governor meetings to ensure that all interests relevant to the meeting are declared and, if new, can be updated. The Council of Governors Register of Interest is held by the Trust Secretary and is available for inspection by members of the public. Anyone who wishes to see the Register of Interests should make enquiries to the Trust Secretary at the following address: Trust Secretary, Elizabeth House, Fulbourn Hospital, Cambridge, CB21 5EF.

CPFT membership
CPFT membership is divided into three constituencies: Public, Patient / Carer, and Staff.

Public membership
Any individual aged 14 years or over can be a member of the public constituency, assuming either:

- They live within the electoral areas of Cambridgeshire County Council;
- They live within the electoral areas of Peterborough City Council; or
- They live in the rest of England

This is subject to the exclusions for membership set out in the constitution.

Patient / carer membership
Any individual aged 14 years and over can be a member of the public / carer constituency, assuming either:

- They were a service user in the Trust after 1 April 2002 and live within the electoral areas of Cambridgeshire County Council.
• They were a service user in the Trust after 1 April 2002 and live within the electoral areas of Peterborough City Council.
• They were a service user in the Trust after 1 April 2002 and live within the rest of England; or
• They are a carer of a service user and live within the electoral areas of Cambridgeshire County Council, Peterborough City Council and the rest of England.

This is subject to the exclusions for membership set out in the constitution.

**Staff membership**
Employees who have a contract of employment with CPFT are automatically a member unless they choose to opt out.

**Membership numbers**
The Trust has 14,127 members (at time of writing): 9,324 public, 1,334 patient / carer and 3,469 staff.

**Membership Strategy**
CPFT’s membership strategy, ratified in May 2014, outlines the Trust’s three year plan for actively engaging current members and recruiting new members. Membership working papers are submitted to the Council of Governors twice a year.

**Membership recruitment and engagement**
In line with the Trust’s duty to recruit and engage members from its community, giving individuals a stake in the future of the services provided by CPFT, the Membership Working Group sent out a survey to all members in August 2015. This was to evaluate the Trust’s Membership Recruitment and Engagement Strategy and identify how well the Trust is engaging with its members and areas which required improvement.

The Trust sent out two surveys, one to public, patient and carer members and another to staff members. The majority of the questions were identical. However, as staff are automatically opted into the Trust’s membership, questions such as their motivations for joining the membership were irrelevant. Responses received were as follows:

<table>
<thead>
<tr>
<th>Survey Method</th>
<th>Distributed</th>
<th>Number of responses</th>
<th>Percentage response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public / Patient / Carer – by post</td>
<td>5198</td>
<td>214</td>
<td>4.1%</td>
</tr>
<tr>
<td>Public / Patient / Carer – online</td>
<td>2352</td>
<td>239</td>
<td>10.1%</td>
</tr>
<tr>
<td>Staff - online</td>
<td>3464</td>
<td>804</td>
<td>23.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11014</strong>(1)</td>
<td><strong>1257</strong></td>
<td><strong>11.4%</strong></td>
</tr>
</tbody>
</table>

(1) NB The total figure represents the number of members at the time of distributing the survey in August 2015.

The results and conclusions from the survey will be used to inform the FY17 Membership Strategy.
The Trust continues to interact with its members by hosting informative talks and events. The following took place during FY15/16

- OCD talk (Obsessive Compulsive Disorder)
- PTSD talk (Post Traumatic Stress Disorder)
- Spiritual Care Forum
- WAVET volunteering (Work, Advice, Volunteering, Education and Training)
- Afternoon musical tea
- Autism talk
- Mindfulness sessions
- Psychosis talk
- Suicide prevention talk

Members who wish to contact Governors can do so by contacting the Membership Office:

E-mail: foundationtrust@cpft.nhs.uk
Telephone: 0800 376 0101 (Freephone) or 01223 726768
By post: Assistant Trust Secretary, Elizabeth House, Fulbourn Hospital, Cambridge, CB21 5EF

Compliance with the Code of Governance
CPFT 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.

CPFT’s Board of Directors considers that overall it complies with the main and supporting principles outlined within the Code of Governance. The main exceptions to that being:

D.2.3 although the council should consult external professional advisers, the previous Trust Secretary undertook a bench-marking exercise regarding remuneration of Non-Executive Directors.

A brief summary of disclosures required under the Code of Governance are outlined below. Further details can be found in relevant sections of the Annual Report.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Trust Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1.1</td>
<td>Described in section 3</td>
</tr>
<tr>
<td>A.1.2</td>
<td>Described in section 3</td>
</tr>
<tr>
<td>A.5.3</td>
<td>Described in section 3</td>
</tr>
<tr>
<td>B.1.1</td>
<td>The Board considers that all Non-Executive Directors are independent in character and judgement despite the fact that a number of the Non-Executive Directors hold senior positions within charitable organisations. In the interests of probity any Non Executive member would be excused from discussing any matters of business where this relationship could be</td>
</tr>
</tbody>
</table>
interpreted as a conflict of interest.

| B.1.4   | Described in section 3 |
| B.2.10  | Described in section 3 |
| B.3.1   | The Chairperson disclosed other significant commitments before appointment and these have not changed during FY15-16 |
| B.5.6   | The Trust’s Forward Plan objectives and strategy is taken to Council of Governor meetings whilst it is being produced for their comments and suggestions. Members of the public are invited to our Council of Governor’s meetings so are also able to comment and ask questions, and Governors are also part of local community groups from which they gauge feedback. |
| B.6.1   | Described in section 3 |
| B.6.2   | There has not been an external evaluation of the Board during FY15-16 |
| C.1.1   | Described in section 3 |
| C.2.1   | Described in section 2 |
| C.2.2   | Described in section 2 |
| C.3.5   | External Auditors have not been appointed during FY15-16 |
| C.3.9   | Described in section 3 |
| E.1.4   | Described in section 3 |
| E.1.5   | Described in section 3 |
| E.1.6   | Described in section 3 |

The directors consider the annual report and accounts, taken as a whole, as fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust’s performance, business model and strategy.

### 3.5 Regulatory Report

**Monitor’s Regulatory Ratings**

From April 2013 all NHS foundation trusts required a licence from Monitor. Holding a licence requires each foundation trust to meet specific conditions in how they operate, including financial sustainability and governance requirements.

CPFTs Risk Assessment Framework (RAF) lays out the aims and approach used to identify:

- Significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or
- Poor governance at an NHS foundation trust, including poor financial governance and inefficiency.

A foundation trust’s governance rating is determined using information from a range of sources including national outcome and access measures, outcomes of Care Quality Commission (CQC) inspections and aspects related to financial governance and delivering value for money.
The award of the Adults and Older Peoples Integrated Care contract was considered sufficiently impactful to be classified as a significant transaction under the RAF, requiring a detailed review by Monitor.

During Monitors review, CPFTs Governance Rating was deemed as “Under Review”. The review ran from Q3 in FY2014-15 to Q3 in FY15/16. CPFTs rating was assessed at Green for Q4.

An updated Risk Assessment Framework was reissued in August 2015. The Continuity of Services Risk rating was replaced by a new Financial Sustainability Risk rating from that date

CPFT originally planned for a tbc Governance Rating and a yearend position to achieve a Financial Sustainability Risk Rating of 3. Ratings during are shown below.

<table>
<thead>
<tr>
<th>RATING</th>
<th>ANNUAL PLAN</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2015/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity of Service Rating / Financial Sustainability Risk Rating (1)*</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Governance Rating</td>
<td>tbc</td>
<td>Under Review</td>
<td>Under Review</td>
<td>Under Review</td>
<td>Green</td>
</tr>
<tr>
<td>FY2014/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity of Service Rating</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2 (2)*</td>
<td>3</td>
</tr>
<tr>
<td>Governance Rating</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Under Review</td>
<td>Under Review</td>
</tr>
</tbody>
</table>

*(1) Continuity of Service Rating applied for Q1 only. Financial Sustainability Risk Rating applied from Q2 onwards.
*(2) Monitor requested further information following a continuity of services risk rating of 2 for 3 quarters of the year.

Information on Serious Incidents (SIs) Involving Data Loss or Confidentiality Breach
During the course of FY2015/16, CPFT recorded the following number of SIs involving data loss or a breach of confidentiality.

<table>
<thead>
<tr>
<th>SI LEVEL</th>
<th>FY2015/16</th>
<th>FY2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level one</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>Level two</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

All incidents were thoroughly investigated and measures were put in place in order to learn the lessons, prevent and minimise recurrence.
The year-on-year increase is considered reflective of the growth in overall staffing levels as a result of transferring CCS staff as detailed earlier in this report. Additional Information Governance Awareness training was delivered to 15 clinical teams and 23 administration teams throughout the year, tailored to meet specific team requirements.

**Statement on the NHS Constitution**
The Trust has regard to the NHS Constitution in all of its operations, and is particularly robust in its safeguarding of the rights of patients and staff.
3.6 Statement of Chief Executive’s Responsibilities as the Accounting Officer of Cambridgeshire and Peterborough 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 Monitor.

Under the NHS Act 2006, Monitor has directed Cambridgeshire and Peterborough NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Cambridgeshire and Peterborough 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 NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgments and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance, and
- Prepare the financial statements on a going concern basis.

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

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

Signed ..................................................

Aidan Thomas
Chief Executive

Date: 25/5/16
3.7 Annual Governance Statement

Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Cambridgeshire and Peterborough 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 Cambridgeshire and Peterborough NHS Foundation Trust ('the Trust') is administered prudently and economically and that resources are applied efficiently and effectively.

I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the 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 Cambridgeshire and Peterborough NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk
Leadership within the Directorates is required to demonstrate a sound grasp of the key overarching risks for the Trust and how these relate to their own Directorate. Within Directorates, individual teams are expected to identify and understand local risks and ensure that these feed into the overall Directorate risk registers.

The Trust has historically produced a corporate risk register profile that is mapped to each Directorate – Adult, Integrated Care, Children’s and Specialist. Each Directorate risk register is reviewed and updated on a monthly basis by the General Manager and Clinical Director. It is then reviewed at the main performance management forum for Directorates within the Trust, the monthly Performance and Risk Executive (PRE). The Directorates report their key issues of risk at the monthly PRE and the Executive Directors hold Directorate leadership to account for their management and mitigation. This forum is also an opportunity for key Directorate issues posing a risk to the achievement of the Trust's strategic objectives to be added to the Corporate Risk Register (incorporating the Board Assurance Framework (BAF)). Directorate Governance arrangements are reviewed by the Trust’s Internal Auditors as part of the annual work plan. The Trust’s largest Directorate (Integrated Care) was reviewed during 2015-16.

Another key forum where information is shared between Directorates and the Executive Directors is the regular monthly Executive Management Group. This is attended by Clinical Directors, General Managers, Divisional Lead Nurses and Executive Directors.
It is used as an information sharing and problem solving forum, where good practice relating to management and mitigation of risks is also shared.

The Trust’s Corporate Risk Register (incorporating the Board Assurance Framework), includes clinical and non-clinical risks. This reflects the Board of Directors’ review of its risk appetite, which has been reviewed during the year. The Business and Commercial risks are reviewed on a regular basis by the Business and Performance Committee, with Clinical risks on Quality and Safety reviewed at the Quality, Safety and Governance Committee. These are both formally constituted sub-committees of the Trust Board. In addition, the Audit and Assurance Committee reviews the overall Register at each of their meetings. The Chairs of each Committee provide an update to the Trust Board in line with the agreed cycle of business.

All staff within the Trust who are Band 7 or over receive bespoke governance training. This highlights the importance of effective risk recognition, management, mitigation and reporting. There is a standard training programme for all staff as part of the Trust’s on-line mandatory training programme.

**The risk and control framework**
The Trust’s Risk Management Strategy describes the organisation’s values and strategic priorities against which key risks are identified and monitored. Key priorities for the management of those risks are defined, as well as performance measures against which the Trust will measure its success in the management of risk. The Trust’s strategic aims define the vision of the Board of Directors of how the organisation’s services should be delivered for those served by the Trust. They are the measure by which risk is assessed. The aims reflect the commitment made by the Trust to enhance stakeholder confidence in quality, safety and governance following CQC and Monitor interventions in previous years, with the intention that the aims will also take the Trust beyond simply restoring confidence.

The Corporate Risk Register (incorporating the BAF) sets out the key risks to the achievement of the Trust’s strategic objectives and the mitigations against each risk. This provides a simple, comprehensive, but constantly evolving document to inform discussions in regard to the management of strategic risk that could affect the delivery of strategic aims. The relevant sections are reviewed regularly by Board Sub-Committees. The Board Sub-Committees seek assurance on the effectiveness of controls in place to manage the strategic risks via the relevant Executive risk owner. In addition, annual internal audits are used to evaluate the successful day-to-day management of risk by the Trust. During the year, the Board of Directors held a session specifically aimed at formally considering the organisation’s risk appetite and ensuring that this is embedded in its management and escalation of risk.

The Business and Performance Committee and the Quality, Safety and Governance Committee hold the Trust and Directorates to account for performance. This includes performance against quality and governance targets and output from the Performance and Risk Executive meetings is shared with them. The Finance Report is considered by the Business and Performance Committee before presented to the Board, together with the Integrated Performance Report, incorporating clinical and other performance
targets. Trust Board Sub-Committees all have Governor representation in observer status at all meetings.

The Quality, Safety and Governance Committee ensure the Trust Board is better sighted on potential governance problems. Quality issues are dealt with as they emerge. This ensures the Board develops a better understanding of governance issues, which may not necessarily be reflected in performance targets. The Committee also ratifies the policy assurance process. This Committee leads on the Trust preparation for any CQC assessments that may be pending or have taken place.

The Audit and Assurance Committee has responsibility for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust’s strategic objectives. The Committee comprises three Non-Executive Directors, including a Chairperson, who must have significant recent financial experience.

The Patient Safety Committee is the Executive Group considering operational responses to Serious Incident reviews, Infection Control and Safeguarding, as well as ‘whistle-blowing’ and a ‘Stop the Line’ initiative (see below).

Risk and safety priorities for the year were to continue to strengthen and improve processes, systems and practices and to better support staff to identify and effectively manage risk. The objective being to focus on continued improvements in the quality and safety of Trust services. To enable the Trust to measure how successfully it is managing risk, a number of risk indicators are used. The Risk Register is updated monthly as a ‘live’ document to ensure it reflects up to date risks and mitigations. Operational risks are escalated through Directorate Performance and Risk Executive meetings on a monthly basis as described above, with appropriate actions discussed and agreed to reduce or manage operational risks.

In addition to the output from the Performance and Risk Executive meetings, the Executive Directors are held to account by the Non-Executive Directors through the Quality, Safety and Governance Committee and Business and Performance Committee, where detailed information is presented, as well as through the Board meetings. The Non-Executive Directors are held to account for their role in scrutinising performance by the Council of Governors, both informally on an on-going basis and formally at the quarterly Council meetings. Control measures are also in place to ensure that the organisation’s obligations under Equality, Diversity and Human Rights legislation are complied with.

Assurance relating to compliance with CQC registration requirements is provided via the Trust’s InCA (Integrated Compliance Assessment) tool, which is used to assess compliance against CQC Essential Standards throughout the Trust’s services. This tool has been further embedded this year and has increased the awareness of performance in relation to CQC Standards, allowing early identification of issues and therefore early implementation of mitigating actions. Periodic internal reviews of services are conducted, having been commissioned by the Board, as well as a planned series of Non-Executive Director visits to facilities as part of ensuring the quality of services is
The Trust remains fully compliant with the registration requirements of the Care Quality Commission.

Specifically, risks to data security are managed via the normal governance structure and reporting process. The Information Governance Steering Group is responsible for overseeing Information Governance within the organisation and is chaired by the Director of Finance in the capacity as Senior Information Risk Officer (SIRO). During the year information governance has also been reviewed as part of the process of preparation for the information governance toolkit submission. The Trust successfully recorded compliance with the NHS Information Governance Toolkit at Level 2 again this year, the second highest level available.

During the year the Trust was a Partner in a Joint Venture Limited Liability Partnership arrangement with Cambridge University Hospitals NHS Foundation Trust, trading as UnitingCare. This formal Partnership was set up to act as the integrator to commission a new model of service delivery following the success in winning the Cambridgeshire and Peterborough Clinical Commissioning Group’s (C&P CCG) tender for Adult and Older Peoples Services.

The UnitingCare LLP had its own Governance and Risk structure, with equal representation from both parties involved in these. The Trust was represented by the Chief Executive Officer, the Director of Service Integration and a Non-Executive Director. Declarations of Interest were made on all occasions during the year when issues related to UnitingCare were discussed at either Board of Directors Meetings or at Trust Board Sub-Committees.

The LLP took the decision to terminate its contract with the C&P CCG on 3rd December 2015, due to the financial viability of the agreement. The LLP is currently being wound down and will be formally dissolved in 2016-17.

The organisation’s major risks, as identified within the Corporate Risk Register reported to the Board of Directors as at the end of Quarter 4, are detailed below:

<table>
<thead>
<tr>
<th>Description of Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High levels of vacant posts and difficulties in both retention and recruitment in number of key service areas in particular District Nursing and community wards, mental health wards and teams impacting on service delivery.</td>
<td>Focussed recruitment management in place. Review and improvement plan for bank staff in place. Proposals for alternative staffing arrangements being considered.</td>
</tr>
<tr>
<td>Estates and IT Infrastructure does not match clinical requirements for Integrated Care Services, preventing service delivery.</td>
<td>Agile Working Project in place to co-ordinate and address gaps in current provision.</td>
</tr>
<tr>
<td>GP federations impact Trust services by taking over the provision of Mental Health and integrated care services from the Trust - requires cultural change in front line and middle managerial staff to focus on and understand general practice.</td>
<td>Trust to develop Plans to work more closely with emerging GP Federations. Cultural change in front line and middle managerial staff planned to focus on and understand general practice.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Reputational risk to Trust from patient incidents.</td>
<td>Develop proactive communications strategy to mitigate potential damage.</td>
</tr>
<tr>
<td>Baseline contractual agreements for Services with Commissioners do not allow for new planned models of care to be delivered, or cope with forecast demand and acuity.</td>
<td>Contracting discussions with Commissioners provide clarity on service expectations within agreed funding envelope.</td>
</tr>
</tbody>
</table>

In terms of the integration of equality impact assessments in to core Trust business, a policy for the production and management of Policies and Procedural documents is in place. This specifically requires those developing policies to have regard to the impact of their policy – and therefore the operation of the organisation – on equality. This takes the form of a statement within each policy relating to whether or not an equality assessment has taken place and, if it has been judged that one is not necessary, the reasoning for this. This cascades through the development and revision of all policies, underlining the Trust’s commitment to equality.

Incident reporting is openly encouraged throughout the Trust. A Serious Incident (SI) Group is in place, chaired by the Director of Nursing, to review all incidents and to ensure learning is shared throughout the organisation. This information is triangulated with complaints and other patient experience information at a specific Triangulation Meeting and at the Quality, Safety and Governance Committee, in order that themes can be identified across the Trust. The Board receives regular reports throughout the year on Serious Incidents.

The Trust has in place an innovative patient safety initiative called ‘Stop the Line’. The initiative is driven by pro-active Executive-led communication and encourages staff at all levels to ‘call a halt’ to any proceeding that is giving them cause for concern from a safety or quality perspective. From the most junior to the most senior members of staff ‘stopping the line’ is widely recognised throughout the Trust as a legitimate, non-confrontational way to pause proceedings and re-evaluate the situation. A structured process is in place, with rapid escalation of issues to divisional leadership and the Executive Directors, with an Executive response promised within 24 hours. Extra provision has been added to the incident reporting form so the Trust is able to track such incidents in a coherent manner. This process highlights to staff the willingness of the Board to support any employee who raises concerns in good faith. Twenty one ‘Stop the Line’ incidents were reported in 2015/16.
The Trust also operates a ‘whistle-blowing’ phone line, which is a way of all staff raising any concerns directly to Director level. This process has worked well during the year and has provided a simple and effective way for staff to raise concerns.

Public stakeholders are involved in the management of risks that impact upon them. This is effected via elected representatives on the Council of Governors who hold the Board, and in particular the Non-Executive Directors, to account for the identification and management of risks. Governors attend the Board of Directors’ meetings, reflecting the Trust’s commitment to openness as a matter of course. The Trust’s Patient Ambassadors have enhanced the involvement of public and patient stakeholders enormously, highlighting issues within the Trust’s facilities and assisting with the mitigation and resolution of issues identified, including risks.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. Services at Cambridgeshire and Peterborough NHS Foundation Trust were rated as ‘good’ following an inspection by the Care Quality Commission during the year. The inspection took place in May, and the overall summary of the report included the following points:

- Services were effective, responsive and caring
- Staff treated people with respect, listened to them and were compassionate
- Morale was found to be good in most areas and staff felt supported by local and senior management
- The Trust had undertaken positive engagement action with service users and carers
- A good range of information was available for people and the Trust was meeting the cultural, spiritual and individual needs of patients
- The inpatient environments were conducive to mental health care and recovery
- The Trust had an increasingly good track record on safety
- Effective incident, safeguarding and whistleblowing procedures were in place. Staff felt confident to report issues of concern
- There was a commitment to quality improvement and innovation
- The board and senior management had a vision with strategic objectives in place

The Trust welcomed the evaluation by CQC.

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

The key processes that have been applied to ensure that resources are used economically, efficiently and effectively involve a hierarchy of scrutiny of the use of resources throughout the Trust. The Audit and Assurance Committee has responsibility for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust's strategic objectives. The Committee receives and considers reports from both Internal and External Auditors and approves the Annual Report and Accounts for submission to the Board of Directors. The Committee exercises Non-Executive scrutiny over the Executive Directors for the efficient use of Public funds.
The Audit and Assurance Committee carries out an annual self-assessment of its performance and reports this formally to the Trust Board. Any changes that may be deemed necessary to its Terms of Reference are also made to reflect best practice.

Internal Audit presents a proposed schedule of audits to the Committee, which is then agreed, executed and reported upon. The Executive Directors are held to account for any actions arising as a result of audit findings through challenge at the Committee. In addition, each Executive attends the meeting in rotation, to update on issues within their area.

The Audit and Assurance Committee reports to the Trust Board of Directors. The Board seeks assurance from the Committee that it is satisfied that the Trust is using resources in an efficient and effective manner.

**Information governance**
The Trust continues to operate within a robust information governance framework, incorporating training, communication and effective monitoring of IG issues. During the 2015-16 financial year, there were 2 incidents classed as Level 2 on the Information Governance Incident Reporting Tool. Both of these incidents were reported to the Information Commissioners Office and notifications of ‘no action’ were received. Both incidents were thoroughly investigated and measures were put in place in order to learn the lessons, prevent and minimise recurrence.

The Trust has an Information Governance Steering Group. Members include the Caldicott Guardian and the Senior Information Risk Owner. The Trust monitors all IG incidents, including lower impact events, through this forum. Each incident that occurs is investigated, assessed, reported (where appropriate) and appropriate learning outcomes are taken forward. The Information Governance function continues to proactively review, revise and reissue guidance where necessary.

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

The Trust Board continuously strives for robust assurance over the quality of our clinical services in regard to the standards and performance targets. These include:

- national standards (e.g. CQC essential standards of quality and safety, NHSLA standards, national service standards etc.).
- targets set by the NHS Outcomes Framework.
- local commissioning targets such as CQUIN and contractual quality targets; local targets agreed by the Trust Board; Trust policy standards; and quality priorities.

The Trust has taken steps to assure the Board that the Quality Report presents a balanced view of quality and that there are appropriate controls in place to ensure the accuracy of data that it contains.
Our quality assurance framework is outlined below.

The Quality, Safety and Governance Committee has over-arching responsibility for quality in the Trust. It is chaired by a Non-Executive Director and meets regularly, in line with an agreed cycle of business. The Committee is supported by four executive groups: the Management Executive Group; Performance and Risk Executive; the Clinical Executive; and the Workforce Executive. The Management Executive Group, which is chaired by the Chief Executive, has a management role over the other four executive groups.

The Director of Nursing, working with the Medical Director, has the Executive Lead for clinical quality, governance and safety. Updates on this work are regularly reported into the Quality, Safety and Governance Committee and the Trust Board. Our Directorate leadership structure consists of a Clinical Director, General Manager and Nurse Lead, who are collectively responsible for quality and safety of our services at service level.

We have a quality dashboard that is mapped against the CQC Essential Standards of Quality and Safety, which includes national, contractual and local Quality, Safety and Clinical Governance indicators. Directorate dashboards are also in place so that each clinical team has its own set of measures and performance indicators that inform decision making and service developments. Quality, Safety and Clinical Governance data is collected, triangulated and reported monthly to provide the Trust Board with timely information on how well the Trust is meeting its objectives, priorities and targets. Each clinical team has a risk register that feeds into the Trust’s Corporate Risk Register. This enables the Trust to manage risks effectively and act on gaps in compliance in a timely manner. The Trust has a programme of clinical and non-clinical audit, both internal and external, to examine our compliance with standards of practice and service delivery and identify areas for improvement. The Trust has in place an Integrated Compliance Assessment (InCA) tool to enable us to monitor and report on our compliance with the CQC essential standards. We take part in national accreditation schemes to provide us with assurance that our services meet the highest standards set by professional bodies and that enables us to benchmark our services and practice with other Trusts across the Country.

Twelve Mental Health Act (MHA) Commission visits were also made, all with very positive reports. Practice is governed by a range of policies, protocols, guidelines and procedures that provide our staff with appropriate standards that meet national and professional requirements. There are mechanisms in place to monitor compliance with these policies and other procedural documents.

The Trust has appropriate systems and processes in place for the recording, collection, analysis and reporting of data. These are designed to ensure that data is accurate, reliable, timely and complete. They are also integrated into the management processes of the Trust and support day-to-day operations. Our information systems have built-in controls that are regularly reviewed to minimise the scope of human error or manipulation and reduce the incidence of erroneous data entry, missing data or unauthorised data changes. Roles and responsibilities in relation to data quality are clearly defined and, where appropriate, incorporated into job descriptions. Staff receive training to support them in implementing the appropriate policies and procedures.
relating to data collection and recording. We have implemented and continue to
develop, electronic patient records' systems (RiO and SystmOne) across the Trust to
help us ensure that data is recorded, shared, utilised and reported on to help us provide
safe and effective services. Internal and External Auditors have both identified specific
issues around compliance with the systems and processes that are currently being
addressed and will be reviewed as part of planned Internal Audit work and the year-end
independent review of the Quality Account (see below).

We also employ a range of measures to ensure open and effective communication
with our staff and promote engagement and ownership of matters that are important
to the Trust. We have discussed and consulted with our key stakeholders in the
development of our Quality Account, which includes our staff, Governors,
commissioners and relevant local Health bodies such as the local Healthwatch and the
Overview and Scrutiny Committees.

The Quality Account has been subjected to external scrutiny and limited assurance
review, conducted in accordance with the 2014/15 Detailed Guidance for External
Assurance on Quality Reports performed by our External Auditors, Grant Thornton.
Grant Thornton has confirmed an Unqualified Opinion on the Quality Account.

**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 Trust who have responsibility for the development and
maintenance of the internal control framework. I have drawn on the content of the
Quality Account attached to this Annual Report and other performance information
available to me. My review is also informed by comments made by the External Auditors
in their management letter and other reports. I have been advised on the implications of
the result of my review of the effectiveness of the system of internal control by the
Board, the Audit and Assurance Committee, the Business and Performance Committee
and the Quality, Safety and Governance and a plan to address weaknesses and ensure
continuous improvement of the system is in place.

The Board of Directors’ role is to determine the overall strategic direction and to provide
active leadership of the Trust within a framework of prudent, effective controls that
enable risk to be assessed and managed appropriately.

The Trust has a programme of both internal and clinical audit. This includes audits
relevant to quality, including data quality behind performance measures, CQC
compliance review, ‘Learning from Outcomes of Patient Safety Indicators’, Risk
Management and Safeguarding. Other internal audit reviews have focused on Financial
Controls, Cost Improvement Planning and Delivery, and Procurement.
These audit functions report to the Board Sub-Committees by exception, and the Sub-
Committees also review progress against plan.

The Directorate management teams have processes in place to ensure that whilst risks
can be escalated to the Board through the Directorate, services are supported to
manage their own risks where appropriate.
The Trust receives Internal Audit Services from RSM. The Head of Internal Audit Opinion (HoIAO) on the effectiveness of the system of internal control for the year states that:

“In accordance with the Public Sector Internal Audit Standards, the head of internal audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation’s risk management, control and governance processes. The opinion should contribute to the organisation’s annual governance statement.

This document provides our draft annual internal audit opinion for 2015/16

Head of internal audit opinion 2015/2016

The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

The internal audit reviews carried out during 2015/16 identified a number of recommendations across a range of areas. The Trust uses software tools to proactively manage implementation of all recommendations and reports on progress are made to the Executive management group and Audit and Assurance Committee and are independently validated by RSM.

Conclusion
As Accounting Officer and based on the review process outlined above, I conclude that the Trust has identified and has taken the necessary action on the control issues during the year which have been identified in detail in the body of the Annual Governance Statement above.
This Annual Governance Statement is signed by the Chief Executive as Accounting Officer.

Signed ........................................

Aidan Thomas                                  Date: 23/5/16
Chief Executive
This Accountability Report, including the Remuneration Report, is signed by the Chief Executive as Accounting Officer.

Signed .............................................

Aidan Thomas
Chief Executive

Date: 25/5/16
Independent auditor’s report to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust

Our opinion on the financial statements is unmodified
In our opinion the financial statements of Cambridgeshire and Peterborough NHS Foundation Trust (the ‘Trust’):

- give a true and fair view of the state of the financial position of the Trust’s affairs as at 31 March 2016 and of the Trust’s expenditure and income for the year then ended; and
- have been prepared properly in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the NHS Foundation Trust Annual Reporting Manual and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Who we are reporting to
This report is made solely to the Council of Governors of the Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 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.

What we have audited
We have audited the financial statements of Cambridgeshire and Peterborough NHS Foundation Trust for the year ended 31 March 2016 which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in equity, the statement of cash flows and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and IFRSs as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the NHS Foundation Trust Annual Reporting Manual (ARM) and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006 issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Overview of our audit approach
- Overall materiality: £3,721,000, which represents 2% of the Trust’s forecast gross revenue expenditure (pay cost, other operating expenses and depreciation) at month 7;
- Key audit risks were identified as:
  - financial reporting and accounting in relation to UnitingCare Partnership LLP;
  - occurrence and valuation of healthcare income, and existence of associated receivable balances; and
  - completeness of operating expenditure.
Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit:

<table>
<thead>
<tr>
<th>Audit risk</th>
<th>How we responded to the risk</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial reporting and accounting in relation to UnitingCare Partnership LLP</strong></td>
<td>Our audit work included, but was not restricted to:</td>
<td>How we responded to the risk</td>
</tr>
<tr>
<td>The Trust entered into a joint venture with Cambridge University Hospitals NHS Foundation Trust to provide adult and older people's services under UnitingCare Partnership LLP ('UnitingCare'). There have been a number of in year issues with UnitingCare which included the termination of the contractual arrangements.</td>
<td>• reviewing management's accounting judgements relating to UnitingCare and the impact on the accounting and disclosures in the financial statements;</td>
<td>How we responded to the risk</td>
</tr>
<tr>
<td>We therefore identified the financial reporting and accounting for these transactions and events as a significant risk requiring special audit consideration.</td>
<td>• gaining an understanding of the Trust's system for accounting for UnitingCare within the Trust's single entity financial statements;</td>
<td>How we responded to the risk</td>
</tr>
<tr>
<td></td>
<td>• testing, on a sample basis, UnitingCare transactions and balances included within the Trust's financial statements to supporting evidence; and</td>
<td>How we responded to the risk</td>
</tr>
<tr>
<td></td>
<td>• review of the adequacy of disclosures in relation to UnitingCare.</td>
<td>How we responded to the risk</td>
</tr>
<tr>
<td>The Trust's accounting policy on its joint venture is shown in note 1.1 to the financial statements and related disclosures are included in note 16.</td>
<td></td>
<td>How we responded to the risk</td>
</tr>
</tbody>
</table>

| Occurrence and valuation of healthcare income, and existence of associated receivables | Our audit work included, but was not restricted to:                                         | How we responded to the risk                                  |
| 85% of the Trust's healthcare income is from healthcare commissioners. The Trust invoices its commissioners throughout the year for services provided and at the year-end estimates and accues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the year-end and after the deadline for the production of the financial statements. This can involve further negotiation of contractual adjustments with commissioners. Given the scale of this income stream to the Trust we considered this to be an area of heightened risk of material misstatement in the financial statements. | • evaluating the Trust's accounting policy for revenue recognition of healthcare income for appropriateness and consistency with the prior year;  | How we responded to the risk                                  |
| We therefore identified the occurrence of healthcare income, and the existence of associated receivable balances as a significant risk requiring special audit consideration. We also identified the valuation of healthcare income as a risk requiring particular audit attention. | • gaining an understanding of the Trust's system for accounting for healthcare income and evaluating the design of the associated controls;  | How we responded to the risk                                  |
| | • using an analysis provided by the Department of Health to identify any significant differences in income and any associated receivable balances with contracting NHS bodies;  | How we responded to the risk                                  |
| | • agreeing, on a sample basis, amounts recognised as healthcare income in the financial statements to signed contracts;  | How we responded to the risk                                  |
| | • agreeing, on a sample basis, additional healthcare income to contract variations or supporting documentation; and  | How we responded to the risk                                  |
| | • agreeing, on a sample basis, receivable balances to supporting information, for example subsequent cash receipts.  | How we responded to the risk                                  |
| The Trust's accounting policy on healthcare income, including its recognition, is shown in note 1.2 to the financial statements and related disclosures are included in note 3. The Trust's accounting policy on healthcare receivables is shown in note 1.10 to the financial statements and related disclosures are included in note 18. | | How we responded to the risk                                  |
Audit risk

Complete completeness of operating expenditure
Expenditure on goods and services represents 25% of the Trust’s total expenditure. Management uses judgement to estimate accruals of expenditure for amounts not yet invoiced at the year end.

We therefore identified completeness of operating expenditure on goods and services as a risk requiring particular audit attention.

How we responded to the risk

Our audit work included, but was not restricted to:

- gaining an understanding of the systems used to recognise non-pay expenditure and year-end accruals, and evaluating the design of the associated controls;
- reviewing the year-end reconciliation of the subsidiary system interface and general ledger control accounts to ensure that all transactions from the subsidiary system are reflected in the financial statements;
- testing, on a sample basis, post year-end payments to confirm the completeness of year-end creditors and accruals; and
- considering the completeness of reported accruals and provisions by review of Trust Board and Committee minutes and papers and events subsequent to year end.

The Trust’s accounting policy on operating expenditure on goods and services is shown in note 1.4 to the financial statements and related disclosures are included in note 5.1.

Our application of materiality and an overview of the scope of our audit

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.

We determined materiality for the audit of the financial statements as a whole to be £3,721,000, which is 2% of the Trust’s forecast gross revenue expenditure at month 7. We have considered whether this level remained appropriate during the course of the audit and have made no changes to our overall materiality. This benchmark is considered the most appropriate because we consider users of the Trust’s financial statements to be most interested in how it has expended its revenue and other funding.

Materiality for the current year is at the same percentage level of gross revenue expenditure as we determined for the year ended 31 March 2015 to reflect our view that we had not identified any reason for users of the accounts to change their view of the appropriate level of materiality.

We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 75% of financial statement materiality for the audit of the financial statements.

We also determined a lower level of specific materiality for certain areas such as cash and disclosures of senior manager salaries and allowances in the Remuneration Report.

We determined the threshold at which we would communicate misstatements to the Audit and Assurance Committee to be £186,000. In addition we communicated misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant
accounting estimates made by the Chief Executive as Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

We conducted our audit in accordance with ISAs (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based, and in particular included an interim visit to evaluate the Trust's internal control environment including its IT systems and controls over key financial systems.

**Overview of the scope of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources**

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as those 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 2016 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 form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

**Other reporting required by regulations**

**Our opinion on other matters required by the Code is unmodified**

In our opinion:

- the part of the Remuneration Report and Staff Report subject to audit have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the NHS Foundation Trust Annual Reporting Manual; and
- the other information published together with the audited financial statements in the annual report is consistent with the audited financial statements.

**Matters on which we are required to report by exception**

Under the ISAs (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
• otherwise misleading.

In particular, we are required to report to you if:
• we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the annual report is fair, balanced and understandable; or
• the annual report does not appropriately disclose those matters that were communicated to the Audit and Assurance Committee which we consider should have been disclosed.

Under the Code of Audit Practice we are required to report to you if, in our opinion:
• the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust ARM or is misleading or inconsistent with the information of which we are aware from our audit; or
• we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:
As explained more fully in the Statement of 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 Direction issued by Monitor and for being satisfied that they give a true and fair view. The Accounting Officer is also responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

What we are responsible for:
Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

We are also required under Section 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. 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.

Certificate

We certify that we have completed the audit of the financial statements of Cambridgeshire and Peterborough 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.

Paul Hughes
Director
for and on behalf of Grant Thornton UK LLP
London
25 May 2016
Cambridgeshire and Peterborough NHS Foundation Trust

Cambridgeshire and Peterborough NHS Foundation Trust’s Annual Accounts Year Ended 31 March 2016

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006
Cambridgeshire and Peterborough NHS Foundation Trust

Annual Accounts for the year ended 31 March 2016
Foreword to the accounts

Cambridgeshire and Peterborough NHS Foundation Trust

These accounts, for the year ended 31 March 2016, have been prepared by Cambridgeshire and Peterborough NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

[Signature]

Name
Aidan Thomas
Job title
Chief Executive
Date
25 May 2016
Statement of Comprehensive Income

<table>
<thead>
<tr>
<th>Note</th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>177,492</td>
<td>111,135</td>
</tr>
<tr>
<td>4</td>
<td>16,474</td>
<td>15,722</td>
</tr>
<tr>
<td><strong>Total operating income from continuing operations</strong></td>
<td><strong>193,966</strong></td>
<td><strong>126,857</strong></td>
</tr>
<tr>
<td>5</td>
<td>(189,913)</td>
<td>(123,323)</td>
</tr>
<tr>
<td><strong>Operating surplus from continuing operations</strong></td>
<td><strong>4,053</strong></td>
<td><strong>3,534</strong></td>
</tr>
<tr>
<td>10</td>
<td>118</td>
<td>20</td>
</tr>
<tr>
<td>11</td>
<td>(1,775)</td>
<td>(1,699)</td>
</tr>
<tr>
<td>15, 16</td>
<td>(1,996)</td>
<td>(2,253)</td>
</tr>
<tr>
<td><strong>Net finance costs</strong></td>
<td><strong>(3,653)</strong></td>
<td><strong>(3,932)</strong></td>
</tr>
<tr>
<td>15, 16</td>
<td>(4,150)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Deficit for the year from continuing operations</strong></td>
<td><strong>(3,750)</strong></td>
<td><strong>(398)</strong></td>
</tr>
<tr>
<td>15, 16</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Deficit for the year</strong></td>
<td><strong>(3,750)</strong></td>
<td><strong>(398)</strong></td>
</tr>
</tbody>
</table>

Other comprehensive income

**Will not be reclassified to income and expenditure:**

<table>
<thead>
<tr>
<th>Note</th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>135</td>
<td>-</td>
</tr>
<tr>
<td>27</td>
<td>(282)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total other comprehensive income and expenditure for the period</strong></td>
<td><strong>(147)</strong></td>
<td><strong>-</strong></td>
</tr>
<tr>
<td><strong>Total comprehensive income and expenditure for the period</strong></td>
<td><strong>(3,897)</strong></td>
<td><strong>(398)</strong></td>
</tr>
</tbody>
</table>

The share of loss on Joint Venture relates to the consolidation of the loss relating to the Trust's interest in UnitingCare Partnership LLP. For further details on how this arose see notes 15 and 16.
## Statement of Financial Position

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets</strong></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>13</td>
<td>102,346</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td></td>
<td>102,346</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>17</td>
<td>59</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>18</td>
<td>13,633</td>
</tr>
<tr>
<td>Non-current assets for sale and assets in disposal groups</td>
<td>19</td>
<td>-</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>20</td>
<td>9,726</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
<td>23,418</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>21</td>
<td>(25,351)</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>22</td>
<td>(3,975)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>23</td>
<td>(737)</td>
</tr>
<tr>
<td>Provisions</td>
<td>25</td>
<td>(721)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
<td>(30,784)</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td></td>
<td>94,980</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other liabilities</td>
<td>22</td>
<td>(192)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>23</td>
<td>(26,335)</td>
</tr>
<tr>
<td>Provisions</td>
<td>25</td>
<td>(1,168)</td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td></td>
<td>(27,695)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td></td>
<td>67,285</td>
</tr>
<tr>
<td><strong>Financed by</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td></td>
<td>8,158</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td></td>
<td>25,058</td>
</tr>
<tr>
<td>Other reserves</td>
<td></td>
<td>33,732</td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td></td>
<td>337</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity</strong></td>
<td></td>
<td>67,285</td>
</tr>
</tbody>
</table>

The notes on pages 6 to 44 form part of these accounts.

Signed:

Name: Aidan Thomas  
Position: Chief Executive  
Date: 25 May 2016
## Statement of Changes in Equity for the year ended 31 March 2016

<table>
<thead>
<tr>
<th></th>
<th>Public dividend capital</th>
<th>Revaluation reserve</th>
<th>Other reserves</th>
<th>Income and expenditure reserve</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Taxpayers' and others' equity at 1 April 2015 - brought forward</td>
<td>8,658</td>
<td>25,058</td>
<td>33,732</td>
<td>4,234</td>
<td>71,682</td>
</tr>
<tr>
<td>Deficit for the year</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(3,750)</td>
</tr>
<tr>
<td>Remeasurements of the defined net benefit pension scheme liability/asset</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>135</td>
<td>135</td>
</tr>
<tr>
<td>Public dividend capital repaid</td>
<td>(500)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(500)</td>
</tr>
<tr>
<td>Other reserve movements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(282)</td>
<td>(282)</td>
</tr>
<tr>
<td><strong>Taxpayers' and others' equity at 31 March 2016</strong></td>
<td><strong>8,158</strong></td>
<td><strong>25,058</strong></td>
<td><strong>33,732</strong></td>
<td><strong>337</strong></td>
<td><strong>67,285</strong></td>
</tr>
</tbody>
</table>

## Statement of Changes in Equity for the year ended 31 March 2015

<table>
<thead>
<tr>
<th></th>
<th>Public dividend capital</th>
<th>Revaluation reserve</th>
<th>Other reserves</th>
<th>Income and expenditure reserve</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Taxpayers' and others' equity at 1 April 2014 - brought forward</td>
<td>8,658</td>
<td>25,761</td>
<td>33,732</td>
<td>3,929</td>
<td>72,080</td>
</tr>
<tr>
<td>Deficit for the year</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(398)</td>
</tr>
<tr>
<td>Transfer to retained earnings on disposal of assets</td>
<td>-</td>
<td>(703)</td>
<td>-</td>
<td>703</td>
<td>-</td>
</tr>
<tr>
<td><strong>Taxpayers' and others' equity at 31 March 2015</strong></td>
<td><strong>8,658</strong></td>
<td><strong>25,058</strong></td>
<td><strong>33,732</strong></td>
<td><strong>4,234</strong></td>
<td><strong>71,682</strong></td>
</tr>
</tbody>
</table>
Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
Other reserves within the Statement of Financial Position relate to the difference between the value of fixed assets taken over by the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust at inception on 1 April 2002 and the corresponding value of the Opening Capital Debt. The balance of Other Reserves will remain fixed for the foreseeable future.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.
## Statement of Cash Flows

<table>
<thead>
<tr>
<th>Note</th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating surplus</td>
<td>4,053</td>
<td>3,534</td>
</tr>
<tr>
<td>Non-cash income and expense:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>5.1</td>
<td>4,665</td>
</tr>
<tr>
<td>Gain on disposal of non-current assets</td>
<td>5.1</td>
<td>-</td>
</tr>
<tr>
<td>Non-cash movements in on-SoFP pension liability</td>
<td>45</td>
<td>-</td>
</tr>
<tr>
<td>(Increase)/decrease in receivables and other assets</td>
<td>(5,152)</td>
<td>3,024</td>
</tr>
<tr>
<td>Decrease in inventories</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Increase in payables and other liabilities</td>
<td>7,574</td>
<td>2,252</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>456</td>
<td>(34)</td>
</tr>
<tr>
<td>Other movements in operating cash flows</td>
<td>(10)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash generated from operating activities</strong></td>
<td>11,637</td>
<td>13,299</td>
</tr>
<tr>
<td><strong>Cash flows from investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>59</td>
<td>20</td>
</tr>
<tr>
<td>Purchase and sale of financial assets</td>
<td>(4,150)</td>
<td>-</td>
</tr>
<tr>
<td>Purchase of property, plant, equipment and investment property</td>
<td>(4,227)</td>
<td>(3,750)</td>
</tr>
<tr>
<td>Sales of property, plant, equipment and investment property</td>
<td>-</td>
<td>1,565</td>
</tr>
<tr>
<td><strong>Net cash used in investing activities</strong></td>
<td>(8,318)</td>
<td>(2,165)</td>
</tr>
<tr>
<td><strong>Cash flows from financing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital repaid</td>
<td>(500)</td>
<td>-</td>
</tr>
<tr>
<td>Capital element of finance lease rental payments</td>
<td>(37)</td>
<td>(33)</td>
</tr>
<tr>
<td>Capital element of PFI, LIFT and other service concession payments</td>
<td>(695)</td>
<td>(696)</td>
</tr>
<tr>
<td>Interest paid on finance lease liabilities</td>
<td>(65)</td>
<td>(68)</td>
</tr>
<tr>
<td>Interest paid on PFI, LIFT and other service concession obligations</td>
<td>(1,640)</td>
<td>(1,631)</td>
</tr>
<tr>
<td>PDC dividend paid</td>
<td>(2,233)</td>
<td>(2,306)</td>
</tr>
<tr>
<td><strong>Net cash used in financing activities</strong></td>
<td>(5,170)</td>
<td>(4,734)</td>
</tr>
<tr>
<td><strong>Increase/(decrease) in cash and cash equivalents</strong></td>
<td>(1,851)</td>
<td>6,400</td>
</tr>
<tr>
<td><strong>Cash and cash equivalents at 1 April</strong></td>
<td>11,577</td>
<td>5,177</td>
</tr>
<tr>
<td><strong>Cash and cash equivalents at 31 March</strong></td>
<td>9,726</td>
<td>11,577</td>
</tr>
</tbody>
</table>
Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury’s Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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.

Going concern

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

Note 1.1 Interests in other entities

Joint ventures

Joint Ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

During the year, the Trust has been involved in a joint venture with Cambridge University Hospitals NHS Foundation Trust under the umbrella of the UnitingCare Partnership LLP. The Trust has accounted for this joint venture under the equity method in the year.

Note 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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 1.3 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

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

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.
Local Government Pension Scheme
Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust’s accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Note 1.4 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 1.5 Research & Development Expenditure
Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Note 1.6 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and additions should be a minimum of £250 unless they relate to project costs that are clearly capital related projects;
- items form part of the initial equipping and setting-up cost of a new building, 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 economic lives.

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.

Subsequent measurement is as follows:
- Assets held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use.
- Specialised assets are held at current value in existing use which is interpreted as the present value of the asset’s remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential.
- Assets held for their service potential but are surplus are valued at current value in existing use, if there are restrictions on the Trust or the asset which will prevent access to the market at the reporting date. If the Trust can access the market then the surplus asset is valued at fair value using IFRS 13.
- Assets which are not held for their service potential are valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale.
- Assets which are not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and do not meet the IFRS 5 and IAS 40 criteria, these assets are considered surplus and are valued at fair value using IFRS 13.
IFRS 13 Fair Value is adopted in full; however, IAS 16 and IAS 38 have been adapted and interpreted for the public sector context which limits the circumstances in which a valuation is prepared under IFRS 13.

Land and buildings used for the trust’s services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on the basis of a modern equivalent asset.
- Leasehold improvements in respect of buildings for which the trust is a lessee under an operating lease will be depreciated over the lease duration (or other period deemed appropriate) and carried at depreciated historic cost, as this is not considered to be materially different from current value. Thus improvements are not revalued, and no indexation is applied as the adjustments which would arise are not considered material.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences on assets when they are brought into use, other than grouped information technology (IT) assets. Depreciation commences on grouped IT assets on receipt by the Trust and not when the separable parts are brought into use, as this is more practicable by alleviating the requirement to depreciate the assets individually.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

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. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction 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 FT ARM, 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 income 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.

**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 dropped or significant changes made to it.

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

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

**Donated, government grant and other grant funded assets**

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

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

**Private Finance Initiative (PFI) 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 and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

**Useful Economic lives of property, plant and equipment**

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

<table>
<thead>
<tr>
<th></th>
<th>Min life</th>
<th>Max life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Years</td>
<td>Years</td>
</tr>
<tr>
<td>Buildings, excluding dwellings</td>
<td>9</td>
<td>57</td>
</tr>
<tr>
<td>Plant &amp; machinery</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Information technology</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Furniture &amp; fittings</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>
Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT 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**

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

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

Expenditure on research is not capitalised.

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

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

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

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

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

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

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

**Note 1.8 Revenue government and other grants**

Government grants are grants from government bodies other than income from commissioners or NHS 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 1.9 Inventories**

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

**Note 1.10 Financial instruments and financial liabilities**

**Recognition**

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust’s normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

**De-recognition**

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

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

**Classification and Measurement**

The Trust’s financial assets are categorised either as loans and receivables or as available-for-sale financial assets. The classification depends on thenature and purpose of the financial assets and is determined at the time of initial recognition.

The Trust’s financial liabilities are categorised as "other" financial liabilities at amortised cost. The classification depends on the nature and purpose of the financial liability and is determined at the time of initial recognition.

**Loans and receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise - current investments, cash and cash equivalents, NHS receivables, other receivables and accrued income.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

**Financial liabilities**

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.
**Impairment of financial assets**

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at “fair value through income and expenditure” are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account.

**Note 1.11 Leases**

**Finance leases**

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

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

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

**Operating leases**

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

**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.

**The Trust as lessor**

Rental income from operating leases is recognised on a straight-line basis over the term of the lease.

**Note 1.12 Provisions**

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

**Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 25.1 but is not recognised in the NHS foundation trust's accounts.

**Non-clinical risk pooling**

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.
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 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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 trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (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 (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 NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.16 Corporation tax

The Cambridgeshire and Peterborough NHS Foundation Trust is a Health Service body within the meaning of s 519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly the 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 exceed £50,000pa. There is no tax liability arising in respect of the current or previous financial year.

Note 1.17Foreign exchange

The functional and presentational currencies of the trust are sterling.

Transactions denominated in a foreign currency are translated into Sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Statement of comprehensive income. At the Statement of financial position date, monetary assets & liabilities denominated in foreign currencies are retranslated at the rates prevailing at the Statement of financial position date.
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 NHS foundation 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 NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Transfers of functions from other NHS bodies

For functions that have been transferred to the trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

Note 1.22 Critical accounting estimates and judgements

Holiday pay

In accordance with the requirements of IAS 19, the Trust provides for unpaid holiday carried forward by staff at the year end. The Trust has a policy of allowing staff to carry forward only 5 days annual leave at any time. As the Trust does not have centralised holiday records, the estimated provision is based on a representative sample of staff at the end of the financial year. This sample has produced an estimated average carry forward of annual leave of 2.2 days.

Charitable Funds

From 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with bodies’ own returns was removed. Under the provisions of IFRS 10 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities’ returns.

IAS 1, Presentation of annual report and accounts, says that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material. In addition accounting policies need not be developed or applied if the impact of applying them would be immaterial. The Trust has concluded that in the current financial year that the accounts of the Charitable Fund are not material and have not therefore consolidated them in these accounts.

PFI Borrowing Costs

As recommended by Monitor and in accordance with IAS 23, the Trust does not capitalise its own borrowing costs incurred in connection with the construction of an asset, when it is to be subsequently held at fair value. However as those borrowing costs associated with the Trust’s PFI scheme are considered to be the borrowing costs of the operator rather than the Trust, the Trust has elected to capitalise the borrowing costs.
Joint Venture Accounting for UnitingCare Partnership LLP

UnitingCare Partnership LLP is a partnership limited by liability between the Trust and Cambridge University Hospitals NHS Foundation Trust, with neither entity having overall control. As such it is deemed to be a Joint Venture, and accounted for it under the equity method. The LLP’s Statement of Financial Position has not been consolidated on the grounds of materiality, as the Trust is satisfied through review of the entity’s financial position that the net assets of UnitingCare Partnership LLP were substantially nil at year end. The loss of UnitingCare, up to the value of the Trust’s investment in the entity has been consolidated into the Statement of Comprehensive Income. Further details are set out in note 16.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year:

<table>
<thead>
<tr>
<th>Change published</th>
<th>Published by IASB</th>
<th>Financial year for which the change first applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>IFRS 11 (amendment) – acquisition of an interest in a joint operation</td>
<td>May 2014</td>
<td>Not yet EU adopted. Expected to be effective from 2016/17.</td>
</tr>
<tr>
<td>IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation</td>
<td>May 2014</td>
<td>Not yet EU adopted. Expected to be effective from 2016/17.</td>
</tr>
<tr>
<td>IAS 16 (amendment) and IAS 41 (amendment) – bearer plants</td>
<td>June 2014</td>
<td>Not yet EU adopted. Expected to be effective from 2016/17.</td>
</tr>
<tr>
<td>IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets</td>
<td>September 2014</td>
<td>Not yet EU adopted. Expected to be effective from 2016/17.</td>
</tr>
<tr>
<td>IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception</td>
<td>December 2014</td>
<td>Not yet EU adopted. Expected to be effective from 2016/17.</td>
</tr>
<tr>
<td>IFRS 15 Revenue from contracts with customers</td>
<td>May 2014</td>
<td>Not yet EU adopted. Expected to be effective from 2017/18.</td>
</tr>
</tbody>
</table>
Note 2 Operating Segments

Segment information is presented on the same basis as that used for internal reporting purposes by the “Chief Operating Decisionmaker”. The operating segments to be disclosed in these accounts are therefore identified on the basis of internal reports regularly reviewed by the Board of Directors, the Board of Directors being considered to be the chief operating decision-maker for the Trust, in order to allocate resources to the segments and to assess their respective performance.

The Board considers the Trust from a service perspective, organised into one business segment, Healthcare.

The internal directorates of the healthcare reportable segment (Adult Directorate, Integrated Care Directorate, Children's Directorate, Specialist Directorate and the Corporate Services Directorate), do not qualify as reportable segments as decisions about the allocation of resources and the assessment of performance are not made at this level by the Board.

The Board assesses the performance of the operating segments based on gross expenditure and income where the service contract is discrete to that service. The Board do not receive a breakdown by segment for the Trust's performance in terms of interest receivable or payable, depreciation or amortisation and any other material non-cash items.

Other information provided to the Board is measured in a manner consistent with that in the accounts.
Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

<table>
<thead>
<tr>
<th></th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental health services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost and volume contract income</td>
<td>9,907</td>
<td>10,020</td>
</tr>
<tr>
<td>Block contract income</td>
<td>78,808</td>
<td>76,622</td>
</tr>
<tr>
<td>Clinical partnerships providing mandatory services (including S75 agreements)</td>
<td>12,749</td>
<td>11,116</td>
</tr>
<tr>
<td><strong>Community services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community services income from CCGs and NHS England</td>
<td>27,647</td>
<td>7,570</td>
</tr>
<tr>
<td>Community services income from other commissioners</td>
<td>42,238</td>
<td>1,181</td>
</tr>
<tr>
<td><strong>All services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional income for delivery of healthcare services</td>
<td>500</td>
<td>-</td>
</tr>
<tr>
<td>Private patient income</td>
<td>97</td>
<td>31</td>
</tr>
<tr>
<td>Other clinical income</td>
<td>5,546</td>
<td>4,595</td>
</tr>
<tr>
<td><strong>Total income from activities</strong></td>
<td><strong>177,492</strong></td>
<td><strong>111,135</strong></td>
</tr>
</tbody>
</table>

The additional income for delivery of healthcare services relates to a capital to revenue transfer as agreed with Monitor.

Note 3.2 Income from patient care activities (by source)

<table>
<thead>
<tr>
<th>Income from patient care activities received from:</th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCGs and NHS England</td>
<td>104,470</td>
<td>93,381</td>
</tr>
<tr>
<td>Local authorities</td>
<td>15,524</td>
<td>12,373</td>
</tr>
<tr>
<td>Other NHS foundation trusts</td>
<td>5,501</td>
<td>2,915</td>
</tr>
<tr>
<td>NHS trusts</td>
<td>701</td>
<td>373</td>
</tr>
<tr>
<td>NHS other</td>
<td>118</td>
<td>323</td>
</tr>
<tr>
<td>Non-NHS: private patients</td>
<td>97</td>
<td>31</td>
</tr>
<tr>
<td>Non NHS: other</td>
<td>50,581</td>
<td>1,739</td>
</tr>
<tr>
<td>Additional income for delivery of healthcare services</td>
<td>500</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total income from activities</strong></td>
<td><strong>177,492</strong></td>
<td><strong>111,135</strong></td>
</tr>
</tbody>
</table>

Of which:

- Related to continuing operations: 177,492 111,135
- Related to discontinued operations: - -

The additional income for delivery of healthcare services relates to a capital to revenue transfer as agreed with Monitor.
## Note 4 Other operating income

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Research and development</td>
<td>4,238</td>
<td>4,066</td>
</tr>
<tr>
<td>Education and training</td>
<td>6,256</td>
<td>6,301</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>2,794</td>
<td>2,441</td>
</tr>
<tr>
<td>Profit on disposal of non-current assets</td>
<td>-</td>
<td>228</td>
</tr>
<tr>
<td>Other income</td>
<td>3,186</td>
<td>2,686</td>
</tr>
<tr>
<td><strong>Total other operating income</strong></td>
<td><strong>16,474</strong></td>
<td><strong>15,722</strong></td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related to continuing operations</td>
<td>16,474</td>
<td>15,722</td>
</tr>
</tbody>
</table>

## Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, 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:

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from services designated (or grandfathered) as commissioner requested services</td>
<td>159,759</td>
<td>93,381</td>
</tr>
<tr>
<td>Income from services not designated as commissioner requested services</td>
<td>34,207</td>
<td>33,476</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>193,966</strong></td>
<td><strong>126,857</strong></td>
</tr>
</tbody>
</table>
### Note 5.1 Operating expenses

<table>
<thead>
<tr>
<th>Item</th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services from NHS foundation trusts</td>
<td>-</td>
<td>58</td>
</tr>
<tr>
<td>Purchase of healthcare from non NHS bodies</td>
<td>746</td>
<td>1,036</td>
</tr>
<tr>
<td>Employee expenses - executive directors</td>
<td>1,140</td>
<td>1,100</td>
</tr>
<tr>
<td>Remuneration of non-executive directors</td>
<td>148</td>
<td>126</td>
</tr>
<tr>
<td>Employee expenses - staff</td>
<td>137,358</td>
<td>87,761</td>
</tr>
<tr>
<td>Supplies and services - clinical</td>
<td>3,465</td>
<td>1,311</td>
</tr>
<tr>
<td>Supplies and services - general</td>
<td>11,132</td>
<td>7,363</td>
</tr>
<tr>
<td>Establishment</td>
<td>2,250</td>
<td>1,374</td>
</tr>
<tr>
<td>Research and development</td>
<td>4,236</td>
<td>4,141</td>
</tr>
<tr>
<td>Transport</td>
<td>2,982</td>
<td>1,376</td>
</tr>
<tr>
<td>Premises</td>
<td>13,759</td>
<td>6,581</td>
</tr>
<tr>
<td>Increase/(decrease) in provision for impairment of receivables</td>
<td>80</td>
<td>203</td>
</tr>
<tr>
<td>Drug costs</td>
<td>1,206</td>
<td>1,081</td>
</tr>
<tr>
<td>Inventories consumed</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Rentals under operating leases</td>
<td>1,795</td>
<td>1,093</td>
</tr>
<tr>
<td>Depreciation on property, plant and equipment</td>
<td>4,665</td>
<td>4,747</td>
</tr>
<tr>
<td>Audit fees payable to the external auditor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>audit services- statutory audit</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>other auditor remuneration (external auditor only)</td>
<td>35</td>
<td>-</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>497</td>
<td>490</td>
</tr>
<tr>
<td>Legal fees</td>
<td>410</td>
<td>255</td>
</tr>
<tr>
<td>Consultancy costs</td>
<td>265</td>
<td>896</td>
</tr>
<tr>
<td>Internal audit costs</td>
<td>90</td>
<td>95</td>
</tr>
<tr>
<td>Training, courses and conferences</td>
<td>714</td>
<td>378</td>
</tr>
<tr>
<td>Patient travel</td>
<td>166</td>
<td>167</td>
</tr>
<tr>
<td>Car parking &amp; security</td>
<td>93</td>
<td>57</td>
</tr>
<tr>
<td>Redundancy</td>
<td>694</td>
<td>220</td>
</tr>
<tr>
<td>Hospitality</td>
<td>29</td>
<td>40</td>
</tr>
<tr>
<td>Insurance</td>
<td>75</td>
<td>69</td>
</tr>
<tr>
<td>Losses, ex gratia &amp; special payments</td>
<td>39</td>
<td>331</td>
</tr>
<tr>
<td>Other</td>
<td>1,787</td>
<td>913</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>189,913</strong></td>
<td><strong>123,323</strong></td>
</tr>
<tr>
<td><strong>Of which:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related to continuing operations</td>
<td>189,913</td>
<td>123,323</td>
</tr>
</tbody>
</table>

### Note 5.2 Other auditor remuneration

<table>
<thead>
<tr>
<th>Item</th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other non-audit services</td>
<td>35</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

### Note 5.3 Limitation on auditor’s liability

The limitation on auditors' liability for external audit work is £2m (2014/15: £2m).

### Note 6 Impairment of assets

There was no impairment of assets in 2015/16 or 2014/15
Note 7 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Permanent</th>
<th>Other</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>105,967</td>
<td>3,804</td>
<td>109,771</td>
<td>74,704</td>
</tr>
<tr>
<td>Social security costs</td>
<td>7,181</td>
<td>207</td>
<td>7,388</td>
<td>5,339</td>
</tr>
<tr>
<td>Employer's contributions to NHS pensions</td>
<td>13,185</td>
<td>-</td>
<td>13,185</td>
<td>8,878</td>
</tr>
<tr>
<td>Pension cost - other</td>
<td>175</td>
<td>-</td>
<td>175</td>
<td>-</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>694</td>
<td>-</td>
<td>694</td>
<td>220</td>
</tr>
<tr>
<td>Agency/contract staff</td>
<td>-</td>
<td>11,910</td>
<td>11,910</td>
<td>3,830</td>
</tr>
<tr>
<td><strong>Total gross staff costs</strong></td>
<td><strong>127,202</strong></td>
<td>15,921</td>
<td>143,123</td>
<td>92,971</td>
</tr>
<tr>
<td>Recoveries in respect of seconded staff</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total staff costs</strong></td>
<td><strong>127,202</strong></td>
<td>15,921</td>
<td>143,123</td>
<td>92,971</td>
</tr>
<tr>
<td>Of which</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs capitalised as part of assets</td>
<td>288</td>
<td>-</td>
<td>288</td>
<td>299</td>
</tr>
</tbody>
</table>

Note 7.1 Retirements due to ill-health

During 2015/16 there were 4 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £246k (£114k in 2014/15).

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

Note 7.2 Directors remuneration

The aggregate amounts payable to directors were:

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Salary</td>
<td>1,147</td>
<td>1,028</td>
</tr>
<tr>
<td>Taxable benefits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Performance related bonuses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employer's pension contributions</td>
<td>141</td>
<td>122</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,288</strong></td>
<td><strong>1,150</strong></td>
</tr>
</tbody>
</table>

Further details of directors' remuneration can be found in the remuneration report.
Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The NHS and LGPS pension contributions for 2016/17 are expected to be broadly consistent with 2015/16.
Note 9 Operating leases

9.1 Cambridgeshire and Peterborough NHS Foundation Trust as a lessor
Nil for 2015/16 and 2014/15

9.2 Cambridgeshire and Peterborough NHS Foundation Trust as a lessee
This note discloses costs and commitments incurred in operating lease arrangements where Cambridgeshire and Peterborough NHS Foundation Trust FT is the lessee.

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating lease expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum lease payments</td>
<td>1,795</td>
<td>1,093</td>
</tr>
<tr>
<td>Total</td>
<td>1,795</td>
<td>1,093</td>
</tr>
<tr>
<td>31 March</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2015</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Future minimum lease payments due:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>1,312</td>
<td>684</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>1,181</td>
<td>438</td>
</tr>
<tr>
<td>Total</td>
<td>2,493</td>
<td>1,122</td>
</tr>
<tr>
<td>Future minimum sublease payments to be received</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Note 10 Finance income
Finance income represents interest received on assets and investments in the period.

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest on bank accounts</td>
<td>59</td>
<td>20</td>
</tr>
<tr>
<td>Other (LGPS Interest on Plan Assets)</td>
<td>59</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>118</td>
<td>20</td>
</tr>
</tbody>
</table>

Note 11 Finance expenditure
Finance expenditure represents interest and other charges involved in the borrowing of money.

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest expense:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance leases</td>
<td>65</td>
<td>68</td>
</tr>
<tr>
<td>Other (LGPS Finance cost)</td>
<td>69</td>
<td>-</td>
</tr>
<tr>
<td>Main finance costs on PFI and LIFT schemes obligations</td>
<td>1,230</td>
<td>1,230</td>
</tr>
<tr>
<td>Contingent finance costs on PFI and LIFT scheme obligations</td>
<td>411</td>
<td>401</td>
</tr>
<tr>
<td>Total interest expense</td>
<td>1,775</td>
<td>1,699</td>
</tr>
<tr>
<td>Other finance costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>1,775</td>
<td>1,699</td>
</tr>
</tbody>
</table>

Note 11.2 The late payment of commercial debts (interest) Act 1998
Amounts included within interest payable arising from claims made under this legislation | - | - |
Compensation paid to cover debt recovery costs under this legislation | - | - |
### Note 12 Intangible assets

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Software licences</strong></td>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
</tr>
<tr>
<td>Valuation/gross cost at - 1 April brought forward</td>
<td>239</td>
<td>282</td>
</tr>
<tr>
<td>Valuation/gross cost at start of period for new FTs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disposals / derecognition</td>
<td>-</td>
<td>(43)</td>
</tr>
<tr>
<td><strong>Gross cost at 31 March</strong></td>
<td>239</td>
<td>239</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amortisation at 1 April</td>
<td>239</td>
<td>282</td>
</tr>
<tr>
<td>Amortisation at start of period for new FTs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disposals / derecognition</td>
<td>-</td>
<td>(43)</td>
</tr>
<tr>
<td><strong>Amortisation at 31 March</strong></td>
<td>239</td>
<td>239</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net book value at 31 March 2016</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net book value at 1 April 2015</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
### Note 13.1 Property, plant and equipment - 2015/16

<table>
<thead>
<tr>
<th></th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant &amp; machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valuation/gross cost at 1 April 2015 - brought forward</strong></td>
<td>18,338</td>
<td>80,136</td>
<td>-</td>
<td>1,786</td>
<td>1,011</td>
<td>-</td>
<td>9,107</td>
<td>1,233</td>
<td>111,611</td>
</tr>
<tr>
<td><strong>Additions</strong></td>
<td>-</td>
<td>1,239</td>
<td>-</td>
<td>1,827</td>
<td>323</td>
<td>-</td>
<td>887</td>
<td>-</td>
<td>4,276</td>
</tr>
<tr>
<td><strong>Reclassifications</strong></td>
<td>-</td>
<td>292</td>
<td>-</td>
<td>(710)</td>
<td>13</td>
<td>-</td>
<td>405</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Transfers to/ from assets held for sale</strong></td>
<td>510</td>
<td>420</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>930</td>
</tr>
<tr>
<td><strong>Disposals / derecognition</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Valuation/gross cost at 31 March 2016</strong></td>
<td><strong>18,848</strong></td>
<td><strong>82,087</strong></td>
<td>-</td>
<td><strong>2,903</strong></td>
<td><strong>1,347</strong></td>
<td>-</td>
<td><strong>10,399</strong></td>
<td><strong>1,233</strong></td>
<td><strong>116,817</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant &amp; machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accumulated depreciation at 1 April 2015 - brought forward</strong></td>
<td>-</td>
<td>4,316</td>
<td>-</td>
<td>-</td>
<td>752</td>
<td>-</td>
<td>4,034</td>
<td>704</td>
<td>9,806</td>
</tr>
<tr>
<td><strong>Provided during the year</strong></td>
<td>-</td>
<td>2,921</td>
<td>-</td>
<td>-</td>
<td>96</td>
<td>-</td>
<td>1,530</td>
<td>118</td>
<td>4,665</td>
</tr>
<tr>
<td><strong>Accumulated depreciation at 31 March 2016</strong></td>
<td><strong>-</strong></td>
<td><strong>7,237</strong></td>
<td>-</td>
<td>-</td>
<td><strong>848</strong></td>
<td>-</td>
<td><strong>5,564</strong></td>
<td><strong>822</strong></td>
<td><strong>14,471</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant &amp; machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net book value at 31 March 2016</strong></td>
<td><strong>18,848</strong></td>
<td><strong>74,850</strong></td>
<td>-</td>
<td><strong>2,903</strong></td>
<td><strong>499</strong></td>
<td>-</td>
<td><strong>4,835</strong></td>
<td><strong>411</strong></td>
<td><strong>102,346</strong></td>
</tr>
<tr>
<td><strong>Net book value at 1 April 2015</strong></td>
<td><strong>18,338</strong></td>
<td><strong>75,820</strong></td>
<td>-</td>
<td><strong>1,786</strong></td>
<td><strong>259</strong></td>
<td>-</td>
<td><strong>5,073</strong></td>
<td><strong>529</strong></td>
<td><strong>101,805</strong></td>
</tr>
</tbody>
</table>
## Note 13.2 Property, plant and equipment - 2014/15

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Buildings excluding dwellings</th>
<th>Dwellings</th>
<th>Assets under construction</th>
<th>Plant &amp; machinery</th>
<th>Transport equipment</th>
<th>Information technology</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Valuation/gross cost at 1 April 2014 - as previously stated</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18,649</td>
<td>79,990</td>
<td>-</td>
<td>1,096</td>
<td>1,478</td>
<td>63</td>
<td>11,480</td>
<td>2,536</td>
<td>115,294</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>666</td>
<td>-</td>
<td>1,085</td>
<td>67</td>
<td>-</td>
<td>1,390</td>
<td>-</td>
<td>3,208</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>85</td>
<td>-</td>
<td>(291)</td>
<td>19</td>
<td>-</td>
<td>187</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>(311)</td>
<td>(605)</td>
<td>-</td>
<td>(106)</td>
<td>(553)</td>
<td>(63)</td>
<td>(3,950)</td>
<td>(1,303)</td>
<td>(6,891)</td>
</tr>
<tr>
<td><strong>Valuation/gross cost at 31 March 2015</strong></td>
<td>18,338</td>
<td>80,136</td>
<td>-</td>
<td>1,786</td>
<td>1,011</td>
<td>-</td>
<td>9,107</td>
<td>1,233</td>
<td>111,611</td>
</tr>
<tr>
<td><strong>Accumulated depreciation at 1 April 2014 - as previously stated</strong></td>
<td>-</td>
<td>1,945</td>
<td>-</td>
<td>1,262</td>
<td>63</td>
<td>6,386</td>
<td>1,877</td>
<td>-</td>
<td>11,533</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>2,990</td>
<td>-</td>
<td>43</td>
<td>-</td>
<td>1,584</td>
<td>130</td>
<td>-</td>
<td>4,747</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>(14)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>14</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>(605)</td>
<td>-</td>
<td>(553)</td>
<td>(63)</td>
<td>(3,950)</td>
<td>(1,303)</td>
<td>-</td>
<td>(6,474)</td>
</tr>
<tr>
<td><strong>Accumulated depreciation at 31 March 2015</strong></td>
<td>-</td>
<td>4,316</td>
<td>-</td>
<td>752</td>
<td>-</td>
<td>4,034</td>
<td>704</td>
<td>9,806</td>
<td></td>
</tr>
<tr>
<td><strong>Net book value at 31 March 2015</strong></td>
<td>18,338</td>
<td>75,820</td>
<td>-</td>
<td>1,786</td>
<td>259</td>
<td>-</td>
<td>5,073</td>
<td>529</td>
<td>101,805</td>
</tr>
<tr>
<td><strong>Net book value at 1 April 2014</strong></td>
<td>18,649</td>
<td>78,045</td>
<td>-</td>
<td>1,098</td>
<td>216</td>
<td>-</td>
<td>5,094</td>
<td>659</td>
<td>103,761</td>
</tr>
</tbody>
</table>
### Note 13.3 Property, plant and equipment financing - 2015/16

<table>
<thead>
<tr>
<th></th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant &amp; machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net book value at 31 March 2016</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owned</td>
<td>18,848</td>
<td>43,526</td>
<td>2,903</td>
<td>448</td>
<td>-</td>
<td>4,835</td>
<td>411</td>
<td>70,971</td>
</tr>
<tr>
<td>Finance leased</td>
<td>-</td>
<td>3,139</td>
<td>-</td>
<td>51</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,190</td>
</tr>
<tr>
<td>On-SoFP PFI contracts and other service concession arrangements</td>
<td>-</td>
<td>28,148</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>28,148</td>
</tr>
<tr>
<td>Donated</td>
<td>-</td>
<td>37</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>37</td>
</tr>
<tr>
<td><strong>NBV total at 31 March 2016</strong></td>
<td><strong>18,848</strong></td>
<td><strong>74,850</strong></td>
<td><strong>2,903</strong></td>
<td><strong>499</strong></td>
<td><strong>-</strong></td>
<td><strong>4,835</strong></td>
<td><strong>411</strong></td>
<td><strong>102,346</strong></td>
</tr>
</tbody>
</table>

### Note 15.4 Property, plant and equipment financing - 2014/15

<table>
<thead>
<tr>
<th></th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant &amp; machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net book value at 31 March 2015</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owned</td>
<td>18,338</td>
<td>43,886</td>
<td>1,786</td>
<td>183</td>
<td>-</td>
<td>5,073</td>
<td>529</td>
<td>69,795</td>
</tr>
<tr>
<td>Finance leased</td>
<td>-</td>
<td>3,236</td>
<td>-</td>
<td>76</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,312</td>
</tr>
<tr>
<td>On-SoFP PFI contracts and other service concession arrangements</td>
<td>-</td>
<td>28,660</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>28,660</td>
</tr>
<tr>
<td>Donated</td>
<td>-</td>
<td>38</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>38</td>
</tr>
<tr>
<td><strong>NBV total at 31 March 2015</strong></td>
<td><strong>18,338</strong></td>
<td><strong>75,820</strong></td>
<td><strong>1,786</strong></td>
<td><strong>259</strong></td>
<td><strong>-</strong></td>
<td><strong>5,073</strong></td>
<td><strong>529</strong></td>
<td><strong>101,805</strong></td>
</tr>
</tbody>
</table>
Note 14 Revaluations of property, plant and equipment

All the freehold properties owned by the Foundation Trust were valued by Boshier & Company Chartered Surveyors in the 2013/14 financial year. This valuation represented the Trust’s Quinquennial valuation.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of financial position date. In practice, the Trust will ensure that there is a full quinquennial valuation and an interim valuation in the third year of each quinquennial cycle. In any intervening year the Trust will carry out a review of movements in appropriate land and building indices and where material fluctuations occur, will engage the services of a professional valuer to determine appropriate adjustments to the valuations of assets to ensure that book values reflect fair values. Fair values are determined as follows:

Land and non specialised buildings – market value for existing use/modern equivalent asset
Specialised building - Depreciated Replacement Cost

The valuations were in accordance with the requirements of the RICS valuation standards sixth edition and the international valuation standards. The valuation of each property was on the basis of market value, subject to the following assumptions

i) For owner occupied property: that the property would be sold as part of the continuing enterprise in occupation;
ii) For investment property: that the property would be sold subject to any existing leases;
iii) For surplus property and property held for development: that the property would be sold with vacant possession in its existing condition;

The Valuer’s opinion of market value was primarily derived using:

i) Comparable recent market transactions on arm’s length terms;
ii) The depreciated replacement cost method of valuation as the specialised nature of the asset means that there is no market transactions of this type of asset except as part of the enterprise in occupation and is subject to the prospect and viability of the continued occupation and use.

Plant and equipment that have not been revalued are shown at their depreciated value.
Note 15 Investments

<table>
<thead>
<tr>
<th></th>
<th>2015/16 Investments in associates (and joint ventures)</th>
<th>2014/15 Investments in associates (and joint ventures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrying value at 1 April</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Acquisitions in year</td>
<td>4,150</td>
<td>-</td>
</tr>
<tr>
<td>Share of profit/(loss)</td>
<td>-</td>
<td>(4,150)</td>
</tr>
<tr>
<td>Carrying value at 31 March</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The acquisition and share of loss relate to the same investment in UnitingCare Partnership LLP. For further details see note 16 below.

Note 16 Disclosure of interests in other entities

UnitingCare Partnership LLP

UnitingCare Partnership LLP is a partnership set up between the Trust and Cambridge University Hospitals NHS Foundation Trust to bid for the Adults and Older People’s services put out to tender by the Cambridgeshire and Peterborough Clinical Commissioning Group. For further details on the services included in the tender see note 31. The LLP was successful in securing this contract and as such took responsibility for the provision of these services from 1 April 2015.

On the 3rd December 2015 UnitingCare served notice on its contract with the CCG due to the financial viability of the arrangement. At this time the LLP was loss making with a net liability balance sheet. Both partners made a further investment of £4.15m each into the organisation to allow it to pay its creditors and return the LLP to solvency. The decision was made to wind up the LLP and at year end this process is still ongoing.

UnitingCare is a partnership limited by liability with neither entity having overall control. As such it is deemed to be a Joint Venture. As the Trust’s liability is limited it has no obligation to make good the loss of the LLP, other than up to the value of its investment in the entity and therefore this value of loss has been consolidated in the Trust’s financial statements. The LLP’s Statement of Financial Position has not been consolidated on the grounds of materiality.

Cambridge University Health Partnership

Cambridge University Health Partners (CUHP) was designated an Academic Health Science Centre by the Department of Health in March 2009. The entity became fully established as a company limited by guarantee on 11th September 2009, with CPFT (as one of the four partners) underwriting 25% of the guarantee costs. The objectives of CUHP are to drive forward the partnership between the National Health Service (NHS) and the University of Cambridge.

The Trust has accepted as part of the members agreement a recurrent funding requirement of £103,300 (2014/15: £103,000), however the agreement requires unanimous confirmation of partners for any additional funding.

In view of the arrangements set out in the members agreement with CUHP, the Trust considers CUHP to be an Associate. However it has not been accounted for under the equity method as it is the Trust’s view that the investment is not material.
Note 17 Inventories

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>31</td>
<td>34</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>31</td>
</tr>
<tr>
<td>Total inventories</td>
<td>59</td>
<td>65</td>
</tr>
</tbody>
</table>

Inventories recognised in expenses for the year were -£6k (2014/15: -£7k). Write-down of inventories recognised as expenses for the year were £0k (2014/15: £0k).

Note 18 Trade receivables and other receivables

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade receivables due from NHS bodies</td>
<td>6,943</td>
<td>3,961</td>
</tr>
<tr>
<td>Other receivables due from related parties</td>
<td>3,928</td>
<td>2,712</td>
</tr>
<tr>
<td>Provision for impaired receivables</td>
<td>(465)</td>
<td>(389)</td>
</tr>
<tr>
<td>Prepayments (non-PFI)</td>
<td>546</td>
<td>751</td>
</tr>
<tr>
<td>Accrued income</td>
<td>422</td>
<td>590</td>
</tr>
<tr>
<td>PDC dividend receivable</td>
<td>204</td>
<td>-</td>
</tr>
<tr>
<td>VAT receivable</td>
<td>-</td>
<td>161</td>
</tr>
<tr>
<td>Other receivables</td>
<td>2,055</td>
<td>491</td>
</tr>
<tr>
<td>Total current trade and other receivables</td>
<td>13,633</td>
<td>8,277</td>
</tr>
</tbody>
</table>
### Note 18.2 Provision for impairment of receivables

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>At 1 April as previously stated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in provision</td>
<td>80</td>
<td>217</td>
</tr>
<tr>
<td>Amounts utilised</td>
<td>(4)</td>
<td>(23)</td>
</tr>
<tr>
<td>Unused amounts reversed</td>
<td>-</td>
<td>(14)</td>
</tr>
<tr>
<td><strong>At 31 March</strong></td>
<td>465</td>
<td>389</td>
</tr>
</tbody>
</table>

### Note 18.3 Analysis of impaired receivables

<table>
<thead>
<tr>
<th></th>
<th>Trade receivables</th>
<th>Other receivables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ageing of impaired receivables</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>0 - 30 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30-60 Days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>60-90 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>90- 180 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Over 180 days</td>
<td>465</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>465</td>
<td>389</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Trade receivables</th>
<th>Other receivables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ageing of non-impaired receivables past their due date</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>0 - 30 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30-60 Days</td>
<td>1,464</td>
<td>-</td>
</tr>
<tr>
<td>60-90 days</td>
<td>699</td>
<td>-</td>
</tr>
<tr>
<td>90- 180 days</td>
<td>2,418</td>
<td>-</td>
</tr>
<tr>
<td>Over 180 days</td>
<td>501</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,082</td>
<td>1,420</td>
</tr>
</tbody>
</table>
Note 19 Non-current assets for sale and assets in disposal groups

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Property, plant &amp; equipment Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NBV of non-current assets for sale and assets in disposal groups at 1 April</td>
<td>930</td>
<td>1,850</td>
</tr>
<tr>
<td>NBV of non-current assets for sale and assets in disposal groups at 1 April - restated</td>
<td>930</td>
<td>1,850</td>
</tr>
<tr>
<td>At start of period for new FTs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers by absorption</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Plus assets classified as available for sale in the year</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Less assets sold in year</td>
<td>-</td>
<td>(920)</td>
</tr>
<tr>
<td>Less impairment of assets held for sale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Plus reversal of impairment of assets held for sale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Less assets no longer classified as held for sale, for reasons other than disposal by sale</td>
<td>(930)</td>
<td>-</td>
</tr>
<tr>
<td>NBV of non-current assets for sale and assets in disposal groups at 31 March</td>
<td>-</td>
<td>930</td>
</tr>
</tbody>
</table>

The asset held for sale in 2014/15 Vinery Road is no longer for sale and has been transferred back to Property, Plant and Equipment.
Note 20.1 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.

<table>
<thead>
<tr>
<th></th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At 1 April</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in year</td>
<td>(1,851)</td>
<td>6,400</td>
</tr>
<tr>
<td><strong>At 31 March</strong></td>
<td>9,726</td>
<td>11,577</td>
</tr>
<tr>
<td><strong>Broken down into:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash at commercial banks and in hand</td>
<td>131</td>
<td>4,281</td>
</tr>
<tr>
<td>Cash with the Government Banking Service</td>
<td>9,595</td>
<td>7,296</td>
</tr>
<tr>
<td><strong>Total cash and cash equivalents as in SoFP</strong></td>
<td>9,726</td>
<td>11,577</td>
</tr>
</tbody>
</table>

Note 20.2 Third party assets held by the NHS foundation trust

Cambridgeshire and Peterborough NHS Foundation 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.

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016 £000</th>
<th>31 March 2015 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank balances</td>
<td>90</td>
<td>2,155</td>
</tr>
<tr>
<td><strong>Total third party assets</strong></td>
<td>90</td>
<td>2,155</td>
</tr>
</tbody>
</table>

The Trust held cash at bank and in hand at 31 March 2016 of £90,000 (31 March 2015: £79,000) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

The Trust also held cash at bank and in hand at 31 March 2015 of £2,076,000 on behalf of the UnitingCare LLP (31 March 2016: Nil)
### Note 21 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS trade payables</td>
<td>1,807</td>
<td>1,533</td>
</tr>
<tr>
<td>Amounts due to other related parties</td>
<td>1,015</td>
<td>1,005</td>
</tr>
<tr>
<td>Other trade payables</td>
<td>-</td>
<td>797</td>
</tr>
<tr>
<td>Capital payables</td>
<td>259</td>
<td>210</td>
</tr>
<tr>
<td>VAT payable</td>
<td>1,034</td>
<td>-</td>
</tr>
<tr>
<td>Other taxes payable</td>
<td>2,422</td>
<td>1,686</td>
</tr>
<tr>
<td>Other payables</td>
<td>4,982</td>
<td>4,762</td>
</tr>
<tr>
<td>Accruals</td>
<td>13,832</td>
<td>7,364</td>
</tr>
<tr>
<td>PDC dividend payable</td>
<td>-</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total current trade and other payables</strong></td>
<td><strong>25,351</strong></td>
<td><strong>17,390</strong></td>
</tr>
</tbody>
</table>

### Note 22 Other liabilities

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other deferred income</td>
<td>3,975</td>
<td>4,346</td>
</tr>
<tr>
<td>Deferred PFI credits</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lease incentives</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total other current liabilities</strong></td>
<td><strong>3,975</strong></td>
<td><strong>4,346</strong></td>
</tr>
</tbody>
</table>

**Non-current**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deferred grants income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Deferred goods and services income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Deferred rent of land income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other deferred income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Deferred PFI credits</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lease incentives</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net pension scheme liability</td>
<td>192</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total other non-current liabilities</strong></td>
<td><strong>192</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>
Note 23 Borrowings

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>41</td>
<td>37</td>
</tr>
<tr>
<td>Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)</td>
<td>696</td>
<td>696</td>
</tr>
<tr>
<td><strong>Total current borrowings</strong></td>
<td>737</td>
<td>733</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-current</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>262</td>
<td>303</td>
</tr>
<tr>
<td>Obligations under PFI, LIFT or other service concession contracts</td>
<td>26,073</td>
<td>26,767</td>
</tr>
<tr>
<td><strong>Total non-current borrowings</strong></td>
<td>26,335</td>
<td>27,070</td>
</tr>
</tbody>
</table>

Note 24 Cambridgeshire and Peterborough NHS Foundation Trust as a lessee
Obligations under finance leases where Cambridgeshire and Peterborough NHS Foundation Trust is the lessee.

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Gross lease liabilities</strong></td>
<td>752</td>
<td>854</td>
</tr>
<tr>
<td>of which liabilities are due:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>101</td>
<td>101</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>304</td>
<td>338</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>347</td>
<td>415</td>
</tr>
<tr>
<td><strong>Finance charges allocated to future periods</strong></td>
<td>(449)</td>
<td>(514)</td>
</tr>
<tr>
<td><strong>Net lease liabilities</strong></td>
<td>303</td>
<td>340</td>
</tr>
<tr>
<td>of which payable:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>41</td>
<td>37</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>108</td>
<td>125</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>154</td>
<td>178</td>
</tr>
</tbody>
</table>
Note 25. Provisions for liabilities and charges analysis

<table>
<thead>
<tr>
<th></th>
<th>Pensions - other staff</th>
<th>Other legal claims</th>
<th>Agenda for change</th>
<th>Redundancy</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>At 1 April 2015</td>
<td>252</td>
<td>91</td>
<td>36</td>
<td>-</td>
<td>1,054</td>
<td>1,433</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>57</td>
<td>265</td>
<td>-</td>
<td>224</td>
<td>83</td>
<td>629</td>
</tr>
<tr>
<td>Utilised during the year</td>
<td>(69)</td>
<td>(4)</td>
<td>-</td>
<td>-</td>
<td>51</td>
<td>(124)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>-</td>
<td>-</td>
<td>(36)</td>
<td>-</td>
<td>13</td>
<td>(49)</td>
</tr>
<tr>
<td>At 31 March 2016</td>
<td>240</td>
<td>352</td>
<td>-</td>
<td>224</td>
<td>1,073</td>
<td>1,889</td>
</tr>
</tbody>
</table>

Expected timing of cash flows:
- not later than one year; 69 352 - 224 76 721
- later than one year and not later than five years; 167 - - - 319 486
- later than five years. 4 - - - 678 682
Total 240 352 - 224 1,073 1,889

Pension - Other staff - This reflects the liabilities arising from early retirements.

Other Legal claims - This reflects potential claims against the NHSLA scheme and provision for employer tribunal costs.

Agenda for change - This reflects provisions in respect of potential equal pay claims resulting from the introduction of agenda for change.

Redundancy - Provision for redundancy costs

Other - reflects provisions arising from injury benefit claims and dilapidations for Trust properties.

Note 25.1 Clinical negligence liabilities

At 31 March 2016, £12,948k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Cambridgeshire and Peterborough NHS Foundation Trust (31 March 2015: £4,197k).

Note 26 Contractual capital commitments

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property, plant and equipment</td>
<td>-</td>
<td>93</td>
</tr>
</tbody>
</table>
Note 27 Defined benefit pension schemes

The Trust also employs a number of staff that transferred from Cambridgeshire Community Services NHS Trust on 1 April 2015 as members of the Local Government Pension Scheme (LGPS). These staff formerly worked for Cambridgeshire County Council but transferred into the NHS in April 2004 as part of the Cambridgeshire wide section 75 agreement for the provision of Health and Social Care for Older People.

The LGPS is a defined benefit statutory scheme administered in accordance with the Local Government Pension Scheme Regulations. The Trust became an admitted body to the scheme effective on 1 April 2015.

Financial transactions arising from contributions to and the costs of the scheme, along with the changing valuation of the assets of the scheme affect the Statement of Comprehensive Income, the Statement of Changes in Taxpayers Equity, and both Reserves and Non Current Trade Payables within the Statement of Financial Position.

Contribution rates are determined by the scheme's actuary based on triennial actuarial valuations. The last full valuation was at 31 March 2013.

The liabilities of the Cambridgeshire County Council pension scheme attributable to the Trust are included in the Statement of Financial Position on an actuarial basis using the projected unit method i.e. an assessment of the future payments that will be made in relation to retirement benefits earned to date by employees, based on assumptions about mortality rates, employee turnover rates etc, and projections of earnings for current employees.

The post-retirement mortality assumptions are in line with Club Vita analysis carried out by the Actuaries as part of the formal funding valuation as at 31 March 2013. These are a bespoke set of VitaCurves specifically tailored to the membership profile of the Fund and based on the data provided for the purposes of the last formal valuation. These are in line with the CMI 2010 model assuming the rate of longevity improvements has reached a peak and will converge to a long term rate of 1.25% p.a.

The major assumptions used by the actuary were:

<table>
<thead>
<tr>
<th></th>
<th>At 31/03/16</th>
<th>At 1/04/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of increase in salaries</td>
<td>4.20%</td>
<td>4.30%</td>
</tr>
<tr>
<td>Rate of increase in pensions in payment</td>
<td>2.20%</td>
<td>2.40%</td>
</tr>
<tr>
<td>Discount rate</td>
<td>3.50%</td>
<td>3.20%</td>
</tr>
</tbody>
</table>

The assets in the scheme and the expected rate of return were:

<table>
<thead>
<tr>
<th></th>
<th>Long-term rate of return expected at 31/03/16</th>
<th>Long-term rate of return expected at 1/04/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equities</td>
<td>3.50%</td>
<td>3.20%</td>
</tr>
<tr>
<td>Bonds</td>
<td>3.50%</td>
<td>3.20%</td>
</tr>
<tr>
<td>Property</td>
<td>3.50%</td>
<td>3.20%</td>
</tr>
<tr>
<td>Cash</td>
<td>3.50%</td>
<td>3.20%</td>
</tr>
</tbody>
</table>

The expected return on assets is based on the long term future expected investment return for each asset class as at the beginning of the period (i.e. as at 1 April 2015 for the year to 31 March 2016).

The average future life expectancies at age 65 are summarised below:

<table>
<thead>
<tr>
<th></th>
<th>31/03/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Current Pensioners</td>
<td>22.5 years</td>
</tr>
<tr>
<td>Future Pensioners</td>
<td>24.4 years</td>
</tr>
</tbody>
</table>

The scheme assets and liabilities attributable to those employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value and the liabilities at present value of the future obligation.
Note 27.1 Changes in the defined benefit obligation and fair value of plan assets during the year

<table>
<thead>
<tr>
<th></th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfers by normal absorption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current service cost</td>
<td>(105)</td>
<td>-</td>
</tr>
<tr>
<td>Interest cost</td>
<td>(69)</td>
<td>-</td>
</tr>
<tr>
<td>Contribution by plan participants</td>
<td>(20)</td>
<td>-</td>
</tr>
<tr>
<td>Remeasurement of the net defined benefit (liability) / asset:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Actuarial (gains)/losses</td>
<td>224</td>
<td>-</td>
</tr>
<tr>
<td>Business combinations</td>
<td>(2,085)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Present value of the defined benefit obligation at 31 March</strong></td>
<td><strong>(2,055)</strong></td>
<td>-</td>
</tr>
<tr>
<td>Interest income</td>
<td>59</td>
<td>-</td>
</tr>
<tr>
<td>Remeasurement of the net defined benefit (liability) / asset</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Actuarial gain/(losses)</td>
<td>(89)</td>
<td>-</td>
</tr>
<tr>
<td>Contributions by the employer</td>
<td>70</td>
<td>-</td>
</tr>
<tr>
<td>Contributions by the plan participants</td>
<td>20</td>
<td>-</td>
</tr>
<tr>
<td>Business combinations</td>
<td>1,803</td>
<td>-</td>
</tr>
<tr>
<td><strong>Plan assets at fair value at 31 March</strong></td>
<td><strong>1,863</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Plan deficit at 31 March</strong></td>
<td><strong>(192)</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

Note 27.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

<table>
<thead>
<tr>
<th></th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present value of the defined benefit obligation at 31 March</td>
<td>(2,055)</td>
<td>-</td>
</tr>
<tr>
<td>Plan assets at fair value at 31 March</td>
<td>1,863</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net liability recognised in the SoFP at 31 March</strong></td>
<td><strong>(192)</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

Note 27.3 Amounts recognised in the SoCI

<table>
<thead>
<tr>
<th></th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current service cost</td>
<td>(105)</td>
<td>-</td>
</tr>
<tr>
<td>Interest expense</td>
<td>(10)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total net charge recognised in SOCI</strong></td>
<td><strong>(115)</strong></td>
<td>-</td>
</tr>
</tbody>
</table>
Note 28 On-SoFP PFI, LIFT or other service concession arrangements

Note 28.1 Imputed finance lease obligations

The trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Gross PFI, LIFT or other service concession liabilities</td>
<td>45,231</td>
<td>47,125</td>
</tr>
<tr>
<td>Of which liabilities are due</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>1,847</td>
<td>1,894</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>7,341</td>
<td>7,353</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>36,043</td>
<td>37,878</td>
</tr>
<tr>
<td>Finance charges allocated to future periods</td>
<td>(18,462)</td>
<td>(19,662)</td>
</tr>
<tr>
<td>Net PFI, LIFT or other service concession arrangement obligation</td>
<td>26,769</td>
<td>27,463</td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>696</td>
<td>696</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>2,965</td>
<td>2,859</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>23,108</td>
<td>23,908</td>
</tr>
</tbody>
</table>

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The trust's total future obligations under these on-SoFP schemes are as follows:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Total future payments committed in respect of the PFI, LIFT or other service concession arrangements</td>
<td>154,500</td>
<td>158,635</td>
</tr>
<tr>
<td>Of which liabilities are due:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>4,162</td>
<td>4,135</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>17,715</td>
<td>17,283</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>132,623</td>
<td>137,217</td>
</tr>
</tbody>
</table>

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's expenditure in 2015/16:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Unitary payment payable to service concession operator</td>
<td>4,135</td>
<td>4,089</td>
</tr>
<tr>
<td>Consisting of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Interest charge</td>
<td>1,230</td>
<td>1,230</td>
</tr>
<tr>
<td>- Repayment of finance lease liability</td>
<td>696</td>
<td>696</td>
</tr>
<tr>
<td>- Service element</td>
<td>1,713</td>
<td>1,693</td>
</tr>
<tr>
<td>- Capital lifecycle maintenance</td>
<td>85</td>
<td>69</td>
</tr>
<tr>
<td>- Contingent rent</td>
<td>411</td>
<td>401</td>
</tr>
<tr>
<td>Total amount paid to service concession operator</td>
<td>4,135</td>
<td>4,089</td>
</tr>
</tbody>
</table>

The Trust is committed to make payments in relation to service charges on its PFI scheme. The charges are subject to an index linked inflation adjustment each year.

On 19th June 2007 the Trust concluded contracts under the Private Finance Initiative (PFI) with Peterborough (Progress Health) PLC for the construction of a new 102 bed hospital and the provision of hospital related services.
The PFI scheme was approved by the NHS Executive and HM Treasury as being better value for money than the public sector comparator. Under IFRIC 12, the PFI scheme is deemed to be on statement of Financial Position, meaning that the hospital is treated as an asset of the Trust, being acquired through a finance lease. The payments to Progress Health in respect of the facility (Cavell Centre) have therefore been analysed into finance lease charges and service charges. The accounting treatment of the PFI scheme is detailed in the accounting policies note.

The service element of the contract was £1,713,000 (2014/15: £1,693,000). The Cavell Centre was handed over to the Trust in two phases in November 2008 and May 2009. Payments under the scheme commenced in November 2008. The agreement is due to end in November 2042.

The estimated value of the scheme at inception was £25,700,000.

**Note 29 Financial instruments**

**Note 29.1 Financial risk management**

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period 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 clinical commissioning groups and the way those clinical commissioning groups 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. 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.

**Note 29.2 Market Risk**

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. A significant proportion of the Trust’s transactions are undertaken in sterling and so its exposure to foreign exchange risk is minimal. It holds no significant investments other than short-term bank deposits. Other than cash balances, the Trust’s financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cashflows are substantially independent of changes in market interest rates.

**Note 29.3 Interest rate risk**

The Trust exposure to interest rate risk is primarily in relation to the PFI details which are set out in Note 28.

**Note 29.4 Credit risk**

Because the majority of the Trust revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

**Note 29.5 Liquidity risk**

The Trust operating costs are incurred under contracts with healthcare commissioners which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.
### Note 29.3 Financial assets

<table>
<thead>
<tr>
<th>Loans and receivables</th>
<th>Assets at fair value</th>
<th>Liabilities at fair value through the I&amp;E</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Loans and receivables</td>
<td>Held to maturity</td>
<td>Available-for-sale</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

#### Assets as per SoFP as at 31 March 2016
- **Trade and other receivables excluding non financial assets**: £12,883
- **Cash and cash equivalents at bank and in hand**: £9,726

**Total at 31 March 2016**: £22,609

#### Assets as per SoFP as at 31 March 2015
- **Trade and other receivables excluding non financial assets**: £7,526
- **Cash and cash equivalents at bank and in hand**: £11,577

**Total at 31 March 2015**: £19,103

### Note 29.4 Financial liabilities

<table>
<thead>
<tr>
<th>Loans and receivables</th>
<th>Liabilities at fair value through the I&amp;E</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Loans and receivables</td>
<td>Held to maturity</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

#### Liabilities as per SoFP as at 31 March 2016
- **Obligations under finance leases**: £303
- **Obligations under PFI, LIFT and other service concession contracts**: £26,769
- **Trade and other payables excluding non financial liabilities**: £25,351
- **Provisions under contract**: £1,889

**Total at 31 March 2016**: £54,312

#### Liabilities as per SoFP as at 31 March 2015
- **Obligations under finance leases**: £340
- **Obligations under PFI, LIFT and other service concession contracts**: £27,463
- **Trade and other payables excluding non financial liabilities**: £17,390
- **Provisions under contract**: £1,433

**Total at 31 March 2015**: £46,626
### Note 29.5 Maturity of financial liabilities

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>In one year or less</td>
<td>26,617</td>
<td>18,433</td>
</tr>
<tr>
<td>In more than one year but not more than two years</td>
<td>867</td>
<td>959</td>
</tr>
<tr>
<td>In more than two years but not more than five years</td>
<td>2,692</td>
<td>2,441</td>
</tr>
<tr>
<td>In more than five years</td>
<td>24,136</td>
<td>24,793</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54,312</strong></td>
<td><strong>46,626</strong></td>
</tr>
</tbody>
</table>

### Note 30 Losses and special payments

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of cases</td>
<td>Total value of cases</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Losses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash losses</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total losses</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Special payments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation payments</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Special severance payments</td>
<td>1</td>
<td>38</td>
</tr>
<tr>
<td>Ex-gratia payments</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total special payments</strong></td>
<td>6</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total losses and special payments</strong></td>
<td>6</td>
<td>39</td>
</tr>
<tr>
<td>Compensation payments received</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Note 31 Transfers by absorption

On 1st April 2015 CPFT took responsibility for the provision of a variety of services for Adults and Older People previously provided by Cambridgeshire Community Services NHS Trust (CCS). This was as the result of the decision of Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) to change its commissioning arrangements for the following services, putting them out to open market tender;

- Urgent care for adults aged over 65 including inpatients as well as A&E services
- Mental Health Services for people aged over 65
- Adult (all people over 18) community health services for example, district nursing, rehabilitation and therapy after injury or illness, speech and language therapy, care for patients with complex wounds, support for people with respiratory disease or diabetes
- Other health services which support the care of people aged over 65.

The successful bidder was a Limited Liability Partnership, UnitingCare Partnership LLP, who then awarded the sub-contract for the provision of the community health services to CPFT, as well as the provision of Mental Health Services, which the Trust was already responsible for providing.

This contract commenced on the 1st April 2015 and was worth approximately £63million of additional income per annum to the Trust. Approximately 1350 staff transferred from CCS responsible for the delivery of these services, however Assets and Liabilities relating to the services prior to this date have remained with CCS with the exception of an immaterial transfer of working balances relating to the future operation of the services.

On the 3rd December 2015 UnitingCare Partnership LLP gave notice on their contract with the CCG to deliver these services, and from this date the Trust have been commissioned directly with the CCG to continue to provide the services it was subcontracted to deliver under the UnitingCare contract.
Note 32 Related parties

All bodies within the scope of the Whole Government Accounts (WGA) are treated as related parties of an NHS Foundation Trust including the Department of Health as the Trust's parent organisation. Significant Income and expenditure for the reporting period and significant year-end Receivable and Payable balances are set out below.

<table>
<thead>
<tr>
<th>Receivables</th>
<th>Payables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March</td>
</tr>
<tr>
<td></td>
<td>2016</td>
</tr>
<tr>
<td></td>
<td>£000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Health Education England</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>950</td>
<td>661</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Cambridgeshire &amp; Peterborough CCG</td>
<td>1,469</td>
<td>813</td>
<td>15</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>East of England Ambulance Services</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>NHS England East Anglia Area Team</td>
<td>361</td>
<td>410</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Cambridge University Hospital NHS Foundation Trust</td>
<td>1,240</td>
<td>800</td>
<td>471</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Cambridgeshire Community Services NHS Trust</td>
<td>192</td>
<td>72</td>
<td>95</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td>Peterborough &amp; Stamford Hospital NHS Foundation Trust</td>
<td>900</td>
<td>640</td>
<td>233</td>
<td>518</td>
</tr>
<tr>
<td></td>
<td>NHS Pensions</td>
<td>-</td>
<td>-</td>
<td>1,823</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>National Insurance Fund</td>
<td>-</td>
<td>-</td>
<td>2,422</td>
<td>1,686</td>
</tr>
<tr>
<td></td>
<td>Peterborough City Council</td>
<td>1,628</td>
<td>1,023</td>
<td>63</td>
<td>136</td>
</tr>
<tr>
<td></td>
<td>Cambridgeshire County Council</td>
<td>2,223</td>
<td>1,800</td>
<td>916</td>
<td>841</td>
</tr>
<tr>
<td></td>
<td>University of Cambridge</td>
<td>15</td>
<td>25</td>
<td>21</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>UnitingCare Partnership</td>
<td>446</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>9,424</strong></td>
<td><strong>6,244</strong></td>
<td><strong>6,059</strong></td>
<td><strong>3,357</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Income</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015/16</td>
<td>2014/15</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

|                      | Health Education England | 7,035 | 8,200 | 3     | -    |
|                      | Cambridgeshire & Peterborough CCG | 86,013 | 72,695 | 77   | 57   |
|                      | NHS England East Anglia Area Team | 15,337 | 17,684 | -    | -    |
|                      | Cambridge University Hospital NHS Foundation Trust | 3,478 | 2,026 | 941  | 405  |
|                      | Cambridgeshire Community Services NHS Trust | 482  | 286  | 5,264 | 354  |
|                      | Peterborough & Stamford Hospital NHS Foundation Trust | 1,735 | 914  | 1,052 | 806  |
|                      | Peterborough City Council | 3,957 | 2,435 | 0     | 332  |
|                      | Cambridgeshire County Council | 11,029 | 9,460 | 0     | 392  |
|                      | University of Cambridge | 100  | 95   | 2,157 | 1,757 |
|                      | East of England Ambulance Service NHS Trust | -    | -    | 126  | 115  |
|                      | NHS Pensions            | -    | -    | 13,185 | 8,878 |
|                      | National Insurance Fund  | -    | -    | 7,388 | 5,136 |
|                      | UnitingCare Partnership | 49,783 | -    | -    | -    |
|                      | Department of Health     | 3,478 | 2,746 | 2     | -    |
|                      | **Total**               | **182,427** | **116,541** | **30,195** | **18,232** |

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Note 33 Cambridgeshire Mental Health and Primary Care Trust Charitable Fund

The Trust is currently Corporate Trustee to Cambridgeshire Mental Health and Primary Care Trusts Charitable Fund, a Charity registered with the Charities Commission (Charity No 1099485). The Charitable Fund includes funds in respect of all the Cambridgeshire and Peterborough NHS Foundation Trust (formerly Cambridgeshire and Peterborough Mental Health Partnership NHS Trust) services.

For 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with bodies’ own returns is removed. Under the provisions of IFRS10 Consolidated Financial Statement, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities’ returns.

IAS 1, Presentation of Financial Statements, says that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material. In addition accounting policies need not be developed or applied if the impact of applying them would be immaterial. The Trust has concluded that the accounts of the Charitable Fund are not material and have not therefore consolidated them in these accounts.
Quality Report
2015-16

“Continuing growth and celebrating success”

A member of Cambridge University Health Partners
We acquired the following services from Cambridgeshire Community Services NHS Trust (CCS) on 1 April 2015, forming part of the Integrated Care Directorate (ICD):

1. Podiatry
2. Dietetics
3. Community Nursing/Planned Care/Unplanned Care/Out of Hours services
4. Intermediate Care services
5. Heart Failure Services (Cardiac Rehabilitation/Pulmonary Rehabilitation)
6. Diabetes
7. Respiratory
8. Tissue Viability
9. Continence
10. Parkinson’s Disease
11. Lymphoedema
12. Community Acquired Brain Injury Rehabilitation (Peterborough)
13. CFS-ME (Chronic fatigue syndrome and myalgic encephalitis)
14. Community Rehabilitation
15. Speech and Language Therapy
16. Tuberculosis (Peterborough)
17. Intermediate Care Unit (Peterborough)
18. Community Inpatient units
19. Long Term Conditions
Our mission, vision and values…

In April 2015, we welcomed over 1,300 community staff as part of our integrated community services. This brought about some very fundamental changes in the way we did things and how we viewed ourselves as an organisation.

In July 2015 we launched a Trustwide consultation on our Trust values to reflect the views and aspirations of all our staff and services, and foster a more supportive culture while retaining our focus on the delivery of high quality care. Workshops were held across CPFT throughout July to September. Staff were then asked to vote from three options and the winner was named in December 2015.

This new set of values sets out how we behave and will be embedded in our day to day work and support our decision-making processes moving forward.

**Our mission**

…is to put people in control of their care. We will maximise opportunities for individuals and their families by enabling them to look beyond their limitations to achieve their goals and aspirations. In other words…to offer people the best help to do the best for themselves.

**Our vision**

We want to give those people who need our services the best possible chance to live a full and happy life, despite their condition or circumstances

<table>
<thead>
<tr>
<th>Recovery</th>
<th>We will empower patients to achieve independence and the best possible life changes, removing dependence and giving them and their families (in the case of children) control over their care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>We will work closely with providers along pathways to deliver integrated person-centered care and support to local people close to their homes principally in non-institutional settings. We will integrate with key partners to improve efficiency and effectiveness and simplify access.</td>
</tr>
<tr>
<td>Specialist services</td>
<td>We are one of England’s leading providers of key specialist mental health services with particular expertise in eating disorders, children and young people’s mental health, autistic spectrum disorders and female personality disorders.</td>
</tr>
</tbody>
</table>

**Our values - PRIDE**

<table>
<thead>
<tr>
<th>Professionalism</th>
<th>We will maintain the highest standards and develop ourselves and others ...by demonstrating compassion and showing care, honesty and flexibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect</td>
<td>We will create positive relationships ...by being kind, open and collaborative</td>
</tr>
<tr>
<td>Innovation</td>
<td>We are forward thinking, research focused and effective ...by using evidence to shape the way we work</td>
</tr>
<tr>
<td>Dignity</td>
<td>We will treat you as an individual ... by taking the time to hear, listen and understand</td>
</tr>
<tr>
<td>Empowerment</td>
<td>We will support you ...by enabling you to make effective, informed decisions and to build your resilience and independence</td>
</tr>
</tbody>
</table>
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   3.5.3 An Effective Healthcare Organisation 86
<table>
<thead>
<tr>
<th>Annex</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annex 1</td>
<td>Definitions of Key National Quality Indicators</td>
<td>92</td>
</tr>
<tr>
<td>Annex 2</td>
<td>Glossary</td>
<td>95</td>
</tr>
<tr>
<td>Annex 3</td>
<td>Statements from External Bodies</td>
<td>103</td>
</tr>
<tr>
<td>Annex 4</td>
<td>Statement of Directors’ Responsibilities in Respect of the Quality Report</td>
<td>109</td>
</tr>
<tr>
<td>Annex 5</td>
<td>External Auditor’s Report</td>
<td>111</td>
</tr>
</tbody>
</table>
1. Statement on quality from the Chief Executive

Welcome to our 2015-16 Annual Account. This has been yet another challenging year for CPFT but I am pleased to say that we have come out with our heads held high, deservedly and proud for what we have achieved as an organisation over the last 12 months.

2015-16 has been a year of continued growth and consolidation for CPFT, as well as for celebrating successes and great achievements at all levels of the organisation – from individual staff to teams and services, and the Trust as a whole.

It goes without saying that I am extremely proud and honoured to be the Chief Executive Officer of CPFT. When I work in teams across The Trust, I am struck by how much great work is going on. On a daily basis, I am shown ground-breaking projects and told of inspiring colleagues. But the nature of the NHS – and CPFT is no different – is that people are naturally modest about their achievements. So in December 2015 we launched Pride in CPFT which reflects our new values (Professionalism, Respect, Innovation, Dignity, Empowerment). It will be a way for our staff to share stories of success, promote successful initiatives which could be used by other teams across CPFT, and for colleagues to share what they enjoy about their roles.

An overview of 2015-16
We started the year by welcoming over 1,300 community staff from Cambridgeshire Community Services NHS Trust (CCS) on 1 April 2015, almost doubling the size of the organisation overnight! This led to a comprehensive reorganisation for these services and for our existing older people’s mental health services to form the new Integrated Care Directorate (ICD), as part of the new contract with Uniting-Care. Our other services remained the same as the Adults, Children’s and Specialist Directorates.

Just a few weeks later, on 18 May, we welcomed around 80 inspectors from the Care Quality Commission (CQC) who examined our mental health, children’s services, social care, and learning disability services. The hard work and dedication of our staff shone through and we were delighted to be given a ‘Good’ (Green) rating overall which places us among one of the few healthcare Trusts to have a rating as high as this. In particular, the CQC praised our staff as being “unequivocally good”. We are very proud of our CQC rating, especially as it was achieved at a time of great change. Needless to say, we have been on an incredible journey over the last few years and I cannot underestimate the effort made by our staff to bring us to this point. I would like to take this opportunity to pay tribute to our staff and formally thank them for their support, dedication and commitment to continually improve our services.

On 1 October, following the restructure, we launched our new neighbourhood teams (NTs) and the Integrated Care Teams (ICTs) across Cambridgeshire and Peterborough. This was made possible by an extraordinary amount of work behind the scenes by our integrated care staff who ensured stability in the service during the reorganisation despite uncertainty about their own roles. This is a new model of care but the principles of putting patients and service users at the heart of everything remain paramount in everything we do. Only two months later in December, we saw an 18% reduction in the number of older people in the emergency departments (ED) since the new model was introduced indicating the benefits of this new model of care.
Sadly, Uniting-Care terminated their contract with the CCG due to affordability problems. Nevertheless the commitment of all in the health economy to the new model remains and the development of the new model is being taken forward, albeit more slowly, by all partners and the integrated care staff.

On 23 February 2016 the results of the 2015 National NHS Staff Survey were published. Our scores showed significant improvement overall and in particular, improved or were the same as the 2014 scores in 21 of the 22 comparable key findings! This shows that we are clearly moving in the right direction, particularly when you consider the unprecedented change and pressures CPFT faced over the past year. However, I recognise that we still have some way to go to improve the experience of our employees and I am committed to working with our staff to make these improvements.

We have had many other achievements and successes during the year that we are proud to share with you, and these are presented in section 1.1 of this report.

Our priorities for improvement

I am pleased to say that we have achieved seven out of 11 of our quality priorities for 2015-16 – achieving our target scores for the Friends and Family Test (FFT) for patients and staff, the PLACE assessments, and also our target compliance rate for the recording of diagnosis. We also achieved the objectives we set around Positive and Proactive Care (PPC), the Triangle of Care and safer staffing. We achieved 94.05% against a target of 95% for mandatory training, and have made very good progress on the development of our quality framework and outcomes of care. We will continue to work towards improving or compliance on the assessment of key cardio metabolic parameters of people with psychosis in the coming year.

Of our CQUIN targets, we achieved four out of five – including three local schemes around enhanced primary care services, enhanced third sector partnership working, and enhanced mental health training; as well as the national scheme on carer support. We achieved one of the two targets for the national scheme on physical health (4a: communication with GPs), and did not fully achieve the target on cardio metabolic assessments of patients with psychosis (4b).

We are continually striving to improve our services and the way we do things. Earlier this year, we launched our Service User and Carer Involvement Strategy which was developed with representatives from our service users, carers, governors, non-executive directors and staff. In 2016-17, we will launch our new Quality Improvement Strategy, as well as our Clinical Effectiveness Strategy and Research and Development Strategy. These are all aimed at strengthening and embedding the culture of integration, innovation and quality improvement in CPFT.

With the CQC rating of good for our services, our ambition must now be to push towards a rating of ‘outstanding’ and I have no doubt in my mind that together we will achieve this.

Statement of Accuracy

I confirm that to the best of my knowledge, the information in this document is accurate.

Aidan Thomas
Chief Executive Officer
25 May 2016
1.1 An overview of 2015-16 – continuing growth and celebrating successes…

**April 2015**

Welcoming new services
We welcomed over 1,300 community staff and the transfer of adults and older people community services from Cambridgeshire Community Services NHS Trust (CCS) on 1 April 2015. This enabled us to provide integrated mental health, community and primary care services to the people of Cambridgeshire and Peterborough.

Pilot Care Certificate scheme
The Care Certificate pilot scheme was launched on 1 April. This forms a key component of the induction of newly-appointed health and social care clinical support staff (Bands 1 to 4) to give them the necessary skills and knowledge to undertake their role.

UNICEF accreditation for health visiting service
CPFT’s health visiting service maintained its full accreditation after undergoing a UNICEF Baby Friendly Initiative re-assessment. UNICEF carried out an audit of staff, parents and clinical areas and announced it was satisfied that the full “baby friendly standards” are being implemented. Inspectors also added that “families are receiving excellent care and advice with regards to feeding their babies”.

**May 2015**

A visit from the CQC
We welcomed around 80 inspectors from the Care Quality Commission (CQC) who examined our mental health, children’s services, social care, substance misuse and learning disability services. At the initial feedback session, the CQC praised our staff as being “unequivocally good”.

Launch of new JET and OneCall services
The new Joint Emergency Teams (JET) and OneCall services were launched as part of the UnitingCare programme. JET is a two-hour community response service, accessed via the new single point of co-ordination – OneCall. JET provides a two-hour community response service for people aged 65 and over. They assess people and can call on other community services, such as the district nursing team, to ensure people don’t end up in hospital unnecessarily.

CPFT signs up to Triangle of Care scheme
CPFT joined the Triangle of Care scheme - set up by the Carers’ Trust and the National Mental Health Development Unit to improve the involvement of carers and families in care planning and treatment.

**June 2015**

AIMS accreditation for Oak wards
The work of staff at the Cavell Centre was recognised again by the Royal College of Psychiatrists. Following rigorous reviews for AIMS (Accreditation for Inpatient Mental Health Services), Oak 1 maintained its accreditation and Oak 2 was accredited as "excellent". Oak 1 has 14 beds for women, while Oak 2 has 16 beds for men.

**August 2015**

Launch of CPFT Academy
CPFT launched the new CPFT Academy of Learning, Development and Leadership. The eCademy became the CPFT Academy online bringing all the training and development needs of our staff together in one site.
Home’s Best campaign
Uniting Care - the CPFT partnership with Addenbrookes - started Home’s Best, an intensive programme designed to help older people to stay at home. The aim is to prevent 18 unnecessary admissions of older people to hospital a day when there is no clinical need by increasing the support available to people in their own homes and providing it in different ways - and cut down the time older people stay in hospital when they have been admitted.

Self-refer to CPFT’s Psychological Wellbeing Service
From August 2015, people who want to improve their mental health were able to refer themselves directly to CPFT’s Psychological Wellbeing Service (previously known as IAPT - Improving Access to psychological Therapy). This has had a significant impact on the number of self-referrals received by the service. The number of self-referrals increased dramatically from just 151 between April to July 2015, to 4,621 in the eight months from August 2015 to March 2016, thus helping the service to achieve 11,867 against the target of 12,000 referrals for the year.

Six-year CPFT study published in The Lancet
A CPFT study which shows the benefits of early liaison between GPs and CPFT was published in *The Lancet*. Led by consultant psychiatrist Dr Jesus Perez, the six-year study of people with early signs of mental illnesses has proved that earlier intervention not only leads to improved outcomes for patients, but also saves GP practices £2,000 per patient, per year.

Praise follows CQC ‘good’ rating…
Chief Executive Aidan Thomas and chair Julie Spence led the praise as the Care Quality Commission’s report gave CPFT a rating of ‘good’ which places us among one of the few healthcare Trusts in the county to have a rating as high as this.

Launch of new Neighbourhood Teams
We launched our new Neighbourhood Teams (NTs), which are the physical and mental health care hub of the local community for over 65 year olds and adults with long term conditions, integrated with GPs, primary care, social care and the third and independent sector, providing responsive, expert care and treatment.

CPFT tops poll for research studies
CPFT topped a new league table for mental health research studies being carried out by its experts. New figures released by the National Institute of Health Research (NIHR) show that 48 studies were undertaken by CPFT in 2014/2015, up from 42 a year earlier. The number of trials – which aim to find better treatments for patients with conditions such as dementia, psychosis, and Alzheimer’s now and in the future – makes CPFT the best-performing Trust involved in mental health care in the East of England.

New CPFT values launched with PRIDE
The new CPFT values were launched following a series of consultation meetings and a vote among staff. The winner was PRIDE which stands for Professionalism, Respect, Innovation, Dignity and Empowerment.
Accreditation joy
Two Trust teams were both declared ‘excellent’ by the Royal College of Psychiatrists. CPFT’s Liaison Psychiatry Service, based at Addenbrooke’s Hospital, Cambridge, and the ECT (electro-convulsive therapy) Team at the Cavell Centre, Peterborough. Both achieved their accreditations following wide-ranging examinations of their patient care and procedures. The Mulberry 3 team at Fulbourn also achieved their Accreditation for Inpatient Mental Health Services (AIMS) award.

High-quality library services in CPFT
CPFT’s Knowledge, Library and Information Service was applauded following a recent inspection, scoring an incredible 97% in the Library Quality Assurance Framework (LQAF) assessment. The rigorous process, which tested all areas the library offers, was carried out by Health Education East of England.

Launch of e-referral system
From February 2016, GPs were able to refer patients to CPFT mental health services for adults and older people more easily thanks to the introduction of a new online system. NHS e-referrals (previously Choose and Book) is a secure system which allows GPs to send details of a patient’s condition and required treatment to CPFT’s Advice and Referral Centre (ARC).

CPFT project wins top patient award – and that’s a Promise!
CPFT’s Promise Project which sets out a new mental healthcare vision won a prestigious award at the Patient Experience Awards in Birmingham. The Promise Project was named the winner of the Strengthening The Foundation category.

Trust’s ‘good’ rating in new Learning from Mistakes league table
CPFT was rated ‘good’ in the Government’s new Learning From Mistakes league table. CPFT has been praised for its openness and transparency over reporting and investigating errors. The league table was published for the first time this month and CPFT was placed 73rd out of the total of 230 health and hospital trusts.

ADHD Team wins £10,000 grant for hoarding study
CPFT’s ADHD (Attention Deficit Hyperactivity Disorder) Team was awarded nearly £10,000 for a new research project. Led by Dr Ulrich Muller, the team will use the money from the British Academy’s Research Awards Committee to look at hoarding behaviour of those with ADHD.

Vanguard sets sail
The first phase of the Mental Health Vanguard programme was launched 4 April. The programme aims to improve the way urgent mental health care is delivered locally by making it easier for people to access 24/7 crisis support and treatment.
2. Priorities for Improvement and Statements of Assurance from the Board

2.1. Priorities for Improvement

In this section we present our over-arching strategy for quality improvement in CPFT.

We also report on our performance in 2015-16 against the quality priorities set in the beginning of the year, and our CQUIN targets.

Finally, we present our quality priorities and CQUIN targets for 2016-17 and outline how we are going to monitor our progress against these during the year.

2.1.1. Quality Improvement in CPFT

Quality lies at the heart of everything we do, and our over-arching approach to quality improvement builds upon our drive for innovation and our commitment to provide high quality care that is informed by the views of our patients and carers, making best use of research-based evidence and delivered by a highly skilled and dedicated workforce.

We recognise that high quality care is only possible when the three equally important dimensions are present –

- care that is **clinically effective and outcome focussed** – both in the eyes of the clinicians and the patients themselves;
- care that is **safe**; and
- care that provides a **positive experience** for patients.

These need to be underpinned by strong leadership at all levels of the organisation, and robust quality improvement framework and processes.

In March 2015, we held a workshop to revisit our whole approach towards quality improvement, attended by key representatives from our Clinical Directorates, corporate services, service users, governors and non-executive directors, and external agencies.

Throughout 2015-16, we have worked on the various elements that support our over-arching strategy for quality improvement, ensuring that these are informed by the views of our staff, our governors and most importantly, our service users and carers.

CPFT’s strategy for quality improvement is underpinned by CPFT’s five-year strategic plan, developed in 2014 and hinges upon the three main themes in our vision – **recovery, integration** and **specialist services**. This is supported by our IT (Information Technology) and Estates strategies.

It is informed by and supports the implementation of our new values – **PRIDE** - and will inform our Quality Priorities moving forward.

The Quality Improvement Strategy is still under development and will be launched in 2016-17. Early discussions indicate that it will centre around three over-arching corporate aims with specific focus on improving practice and the quality of our services.
Corporate aim 1: We will provide safe, high quality and clinically effective interventions that are in line with nationally recognised standards.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Strategic Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical effectiveness</td>
<td>We will strengthen our processes around the implementation of NICE guidelines and evidence-based interventions.</td>
</tr>
<tr>
<td>Patient safety</td>
<td>We will reduce avoidable harm and improve early detection of the deteriorating patient.</td>
</tr>
<tr>
<td>Patient experience</td>
<td>We will ensure that care is delivered with compassion, kindness and respect.</td>
</tr>
<tr>
<td>Workforce and Leadership</td>
<td>We will develop effective and capable teams supported by a competent and confident workforce.</td>
</tr>
</tbody>
</table>

Corporate aim 2: Where learning is identified these will be embedded into practice and lead to demonstrable improvements in outcomes of care.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Strategic Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical effectiveness</td>
<td>We will strengthen the culture of research and practice development, and improve our processes on embedding knowledge into practice.</td>
</tr>
<tr>
<td>Patient safety</td>
<td>We will strengthen the processes around the development of improvement actions from incidents and near misses and embedding change.</td>
</tr>
<tr>
<td>Patient experience</td>
<td>We will improve our processes around acting upon feedback and using it to improve and shape services.</td>
</tr>
<tr>
<td>Workforce and Leadership</td>
<td>We will strengthen clinical leadership and accountability structures at every level of the organisation – from Board to service delivery.</td>
</tr>
</tbody>
</table>

Corporate aim 3: We will transform care, develop sustainable services and make best use of resources that are available to us.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Strategic Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical effectiveness</td>
<td>Decisions that impact on the quality of our services will be based on the latest knowledge and evidence of cost effective care.</td>
</tr>
<tr>
<td>Patient safety</td>
<td>Our services will have safe staffing levels with appropriate skill mix to deliver high quality care.</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Our services, interventions, pathways and outcomes of care will be informed by the experience and feedback of our patients and their carers.</td>
</tr>
<tr>
<td>Workforce and Leadership</td>
<td>We will improve partnership and multi-agency working to deliver safe, high quality and clinically effective care across a wide range of providers.</td>
</tr>
</tbody>
</table>

Assurance at Trust level
The Audit and Assurance Committee (AAC) has the primary responsibility for obtaining assurance, on behalf of CPFT Board, that CPFT is discharging its duties properly and that it is meeting its strategic objectives.

The Quality, Safety and Governance Committee (QSGC) is the main Board sub-committee responsible for monitoring our compliance against quality improvement priorities throughout the year.

Assurance at Directorate level
The Performance Review Executive (PRE) is responsible for monitoring performance and holding our Clinical Directorates to account. This is supported by a robust directorate governance framework that ensures delivery of its strategic objectives and quality improvement priorities.
2.1.2. Looking back – our priorities for improvement for 2015-16
In choosing our priorities for improvement for 2015-16, we were mindful of the staff and services that transferred to CPFT on 1 April 2015, and the opportunities as well as the challenges this brought to our staff and CPFT as a whole.

Our performance on our quality priorities and CQUIN targets for 2015-16 is presented below.

A. Our performance on our quality priorities for 2015-16
To foster our vision of integration, we agreed 11 quality priorities that were grounded on the principles of recovery, focusing on the areas that we believed would make the most impact on the experience and wellbeing of our patients, their carers and our staff, while being broad enough to be meaningful to our new staff and services.

These quality priorities reflect our commitment to provide high quality, safe and clinically effective care.

Our quality priorities and performance against the targets for 2015-16 are summarised in Table 1 below.

During the year we achieved seven of our 11 quality priorities, and partially/not fully achieved 4.

Table 1: Performance on quality priorities for 2015-16

<table>
<thead>
<tr>
<th>Improvement Priority</th>
<th>Target</th>
<th>Performance at year end (as of Q3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area 1: Over-arching priorities</td>
<td>These have been carried over from the previous years and apply to all of our clinical services and staff.</td>
<td></td>
</tr>
<tr>
<td>1.1 Quality Framework</td>
<td>To improve systems and processes for monitoring the quality of our services and ensure prompt and timely remedial action.</td>
<td>Partially achieved</td>
</tr>
<tr>
<td>1.2 Friends and Family Test (FFT) patients</td>
<td>To improve the experience of our patients, and the processes for reporting of patient survey scores and outcomes.</td>
<td>✓</td>
</tr>
<tr>
<td>1.3 Friends and Family Test (FFT) staff</td>
<td>To improve the experience of our staff working environment and their confidence in CPFT services.</td>
<td>✓</td>
</tr>
<tr>
<td>1.4 Mandatory training</td>
<td>To deliver excellent care through highly skilled and competent staff.</td>
<td>Almost achieved</td>
</tr>
<tr>
<td>Priority Area 2: Patient experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 PLACE (Patient Led Assessment of Care Environments)</td>
<td>To improve the experience of our patients by providing care in environments that support recovery.</td>
<td>✓</td>
</tr>
<tr>
<td>2.2 Triangle of Care</td>
<td>To improve carer engagement and involvement.</td>
<td>✓</td>
</tr>
<tr>
<td>Priority Area 3: Patient safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Positive and Proactive Care</td>
<td>To reduce the use and need for restrictive interventions and improve the use of positive and proactive approaches to care.</td>
<td>✓</td>
</tr>
<tr>
<td>3.2 Safer Staffing</td>
<td>To provide care in a safe environment through safe staffing levels in our services</td>
<td>✓</td>
</tr>
<tr>
<td>3.3 Physical Health</td>
<td>To reduce premature death in patients with severe mental illness and ensure physical health needs are identified and treated.</td>
<td>Not fully achieved</td>
</tr>
<tr>
<td>Priority Area 4: Clinical effectiveness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Diagnosis</td>
<td>To improve the effectiveness of interventions through accurate and timely recording of diagnosis</td>
<td>✓</td>
</tr>
<tr>
<td>4.2 Outcomes of Care</td>
<td>To establish better measures and processes for demonstrating the effectiveness and outcomes of our interventions.</td>
<td>Partially achieved</td>
</tr>
</tbody>
</table>

Details are provided overleaf.
Priority Area 1: Over-arching priorities

These priorities are those that have been set in previous years and not achieved as of the end of 2014-15, or those that had been achieved and we wanted to improve upon our previous years’ performance for 2015-16. These apply to all of our clinical teams and/or staff.

1.1 Quality Framework
To improve systems and processes for monitoring the quality of our services and ensure prompt and timely remedial action.

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>This was our quality priority for 2014-15 which we did not fully achieve and so was carried through to 2015-16. This is also a quality metric from our commissioners and was identified by the Clinical Directorates as their priority.</th>
</tr>
</thead>
</table>
| What did we aim to achieve? | • To develop quality dashboards for all clinical teams that reflects specific quality indicators for their service.  
                             • The dashboards will be reported and monitored monthly  
                             • The dashboards will be accessible by patients and the public |
| This applies to | All clinical teams |
| How did we monitor our progress? | Progress was monitored and reported through our governance framework, specifically to the Clinical Governance and Patient Safety Group (CGPSG) and the Quality, Safety and Governance Committee (QSGC). This is also reported to our commissioners though our monthly Clinical Quality Review (CQR) meetings. |
| How well did we do? | **Partially achieved**  
                               ✓ Service-specific inpatient dashboards for mental health services were developed and launched in June 2015. This was reviewed in December 2015 and a new template developed in March 2016 to be launched in 2016-17.  
                               • Community clinical dashboards were developed and launched in January 2016. Further work is needed to develop service-specific integrated quality and safety dashboards in 2016-17.  
                               • Work is ongoing to develop service-specific dashboards for our new Integrated Care services, with an inpatient dashboard template already under development. |
| What next? | We will continue to work with our community mental health teams, children’s services and the integrated care teams to develop service-specific quality and safety dashboards. The aim is to provide our clinical teams with timely information to help them manage their services and support the development of improvement actions as required. This will also provide CPFT Board assurance about the quality of our services, and the processes that support. This will continue as a quality priority in 2016-17. |
1.2 Friends and Family Test (FFT) patients
To improve the experience of our patients, and the processes for reporting of patient survey scores and outcomes.

Why did we focus on this?
This was our quality priority for 2014-15, based on the principles of transparency and openness as recommended by the Francis report, which we achieved in the year. For 2015-16, we wanted to improve upon our performance from the previous year and set a conservative target on the overall Trust score to take account of the possible impact of our new services, based on the Meridian Patient Experience Survey as we felt the national groupings do not reflect the totality of CPFT’s services. The Clinical Directorates identified this as their priority. This is also a national priority and a quality metric from our commissioners.

What did we aim to achieve?
✓ To increase CPFT wide FFT scores by 2% by end of 2015-16.
✓ To review and revise Trust patient survey questions in order to meaningfully reflect the new adult and older people (AOP) services transferred from Cambridgeshire Community Services
✓ The Clinical Directorates will improve the processes for reporting outcomes and improvements made following patient and carer feedback within their services.

This applies to
All clinical teams

How did we monitor our progress?
The directorate FFT scores are reported and monitored through the monthly Performance and Review Executive (PRE) meetings. Progress is reported regularly through our Trust’s governance framework, and in particular, to the CGPSG and QSGC. This is also reported to our commissioners though our monthly CQR meetings.

Achieved
From a starting position of 85.4% as of Q4 2014-15, CPFT scores initially went down to 83% in Q1, and then steadily improved throughout the year reaching 91% in March 2016 largely due to the consistently high scores from the Integrated Care Directorate (ICD),

How well did we do?
Directorate level patient experience reports were produced, as part of the wider integrated Quality & Safety reports, during the year which were shared with the teams to increase awareness.

What next?
This remains a priority of CPFT. For 2016-17 we will focus on improving upon those areas in the survey where we have had consistently low scores over the past year, both at Trust and Directorate level.
### 1.3 Friends and Family Test (FFT) staff

To improve the experience of our staff working environment and their confidence in CPFT services.

**Why did we focus on this?**

We believe that staff FFT is a good measure and indicator of the quality of our services and are committed to improving the experience and engagement of our staff. This was our quality priority for 2014-15, and we set ourselves a stretch target with a three-year trajectory which was too ambitious and unrealistic. We carried this priority through to 2015-16 with a more realistic target, taking account of the possible impact of the new services on CPFT score. Qualitative measures were also added to reflect the priorities raised by our clinical Directorates in 2014-15. This is a national priority and a quality metric of our commissioners.

**What did we aim to achieve?**

- **55%** of our staff will recommend CPFT to care for their friends and family
- To improve team-level reporting of staff survey scores
- To make FFT scores more relevant and meaningful to staff by adding a question specific to their team/service

**This applies to**

All CPFT staff

**How did we monitor our progress?**

The directorate FFT scores are reported and monitored through the monthly PRE meetings, while the overall Trust scores are reported and monitored by the QSGC. This is also reported to our commissioners though our monthly CQR meetings.

**How well did we do?**

- **Achieved**
  - In the National NHS Staff Survey 2015, we scored 62% (from 45% in 2014) on the question “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.”
  - CPFT wide score on the cultural barometer, our quarterly in-house staff survey, on staff recommendation to care was 68% as of March 2016 (60.6% as of March 2015).
  - The team specific question was included in the December survey. This was subsequently removed in the March survey as it was felt that we needed to understand the context behind the question better and address this as part of the consultation on the development of the Workforce Strategy before we made changes to the cultural barometer (staff) survey questions

**What next?**

Our score on the recommendation of the organisation as a place to work in the National NHS Staff Survey was 49% 2015 (from 35% in 2014), and 53% in the cultural barometer survey as of March 2016 (from 50.1% as of March 2015). We aim to improve on this area for 2016-17. We have updated our Workforce Strategy and Trust action plan to address the areas that need improvement from our staff survey.
### 1.4 Mandatory training

To deliver excellent care through highly skilled and competent staff

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>The delivery of high quality care that promotes the principles of recovery is largely dependent on having highly skilled and competent staff. This is embedded in the CQC’s fundamental standards of quality and safety, and is also a quality metric from our commissioners. This was our quality priority in 2012-13 which we had not achieved by 2014-15. We carried this priority through to 2015-16.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did we aim to achieve?</td>
<td>To achieve 95% compliance with mandatory training across all Clinical Directorates by end of FY 2015-16.</td>
</tr>
<tr>
<td>This applies to</td>
<td>All CPFT staff</td>
</tr>
<tr>
<td>How did we monitor our progress?</td>
<td>The directorate FFT scores are reported and monitored through the monthly PRE meetings, while the overall Trust scores are reported and monitored by the QSGC. This was also reported to our commissioners through our monthly CQR meetings.</td>
</tr>
</tbody>
</table>

**Almost achieved**

From a starting point of 92% as of March 2015, the overall Trust mandatory training scores went up to 94.99% in April and 94.77% in May, but since then have remained largely static ranging between 91% - 93% for the rest of the year.

![Trust wide Mandatory Training 2015/16](image)

Mandatory training score as of March 2016 is **94.05%** which is 0.95% below our target.

| What next? | The challenge for us has largely been around getting staff from the new services through CPFT’s training programme during the year. Other challenges include transferring the manual training records of the new services on to CPFT’s electronic system, and ensuring that staff training from external providers is reflected in CPFT’s training records in a timely manner. This remains a priority of CPFT, and will be reported in Part 3 of this report moving forward. This is monitored monthly through the Performance Review Executive meetings with the Clinical Directorates and our Quality and safety dashboard. |

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### 2.1 PLACE (Patient Led Assessment of Care Environments)

To improve the experience of our patients by providing care in environments that support recovery.

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>Good environments matter and every NHS patient should be cared for with compassion and dignity in a clean, safe environment to promote their recovery. In CPFT, we have fallen short of the national average scores for ‘food’ in the last two years and the scores from our internal patient survey supports the need for improvement in this area. We also needed to improve our scores on the ‘condition, appearance and maintenance’ of our environments. This is embedded in the CQC’s fundamental standards of quality and safety, and has been a theme from comments and feedback from our patients.</th>
</tr>
</thead>
</table>
| What did we aim to achieve? | To improve overall Trust PLACE scores in 2015-16 to be at least equal to or higher than the national average in all four headings across all our inpatient services:  
- Cleanliness (C)  
- Food and hydration (FH)  
- Privacy, dignity and well-being (PDW)  
- Condition, appearance and maintenance (CAM) |
| This applies to | All mental health inpatient units only  
Rationale: PLACE assessments took place in the new services (transferred to CPFT on 1 April) in May so we were unable to influence the outcome for the 2015 scores. |
| How did we monitor our progress? | This is a national programme and scores are reported as part of our governance framework. Directorate scores are reported to the PRE meetings, while the overall Trust scores was reported to QSGC. The PLACE action plans are monitored by CPFT’s Nursing Leadership Group (NLG) and QSGC. |
| **Achieved** | **C** | **FH** | **PDW** | **CAM** | **Dementia (new domain for 2015)** |
| Nat’l Average Scores | 97.57% | 88.49% | 86.03% | 90.11% | 74.51% |
| Overall CPFT | 98.25% | 88.92% | 89.09% | 91.99% | 79.09% |
| How well did we do? | While the overall Trust average scores on all four headings are higher than the national average, some of the individual sites scored below the national average. We will work with our teams and commissioners to implement the PLACE action plan. For 2016-17, we are aiming to have scores to be at least equal to or higher than the national average in all four headings for all individual sites across CPFT. This is an extremely stretching target as some of the services we acquired require significant improvement. |
| What next? | |
### 2.2 Triangle of care

To improve carer engagement and involvement.

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>Carers are vital partners in the provision of health and social care services, and are increasingly recognised for their expertise and knowledge and the fact that they can be essential partners in the treatment and recovery process. This is a national priority and will support the implementation of the Care Act 2014. Issues around carer involvement has also been a theme running through our serious incidents and complaints, and was identified by the Clinical Directorates as a quality priority.</th>
</tr>
</thead>
</table>
| What did we aim to achieve? | To strengthen the framework and processes around the engagement and involvement of carers, within the overarching principles of patient confidentiality through:
- implementation of the principles of ‘Triangle of Care’ and working towards achieving the ‘Quality Mark’ in 2016.
- development of a Carers’ Strategy that reflects the principles of the Triangle of Care |
| This applies to | All clinical teams |
| How did we monitor our progress? | Progress was reported regularly through our Trust’s governance framework, to the Clinical Governance and Patient Safety Group (CGPSG) and the QSGC. |
| How well did we do? | **Achieved**
- The Triangle of Care work for the Mental Health and Learning Disability Community Services commenced in CPFT with a series of workshops in October 2015. A Carers’ Programme Board was established and a series of carer awareness training was offered to all staff in relevant services.
- Self-assessments were undertaken, repeated in April 2016, and action plans developed to address the gaps identified. The final submission for the accreditation is due on 31 May 2016.
- General carer awareness sessions continue to be supported by Carers’ Trust Cambridgeshire, and facilitated at various training venues. We are also co-producing an e-learning package for all staff.
- The Carers’ Charter was launched in November 2015, and a Carers’ Survey was developed.
- The Carers’ Policy was ratified in February 2016 and co-produced with input from staff, carers and external partners. This supports our commitment under the Carers’ Charter and aids practice compliance against the Care Act standards.
- A Carers’ Conference is planned in June 2016 during Carers’ Week to celebrate the work that has taken place within CPFT since the programme commenced, and all the initiatives that staff and teams have implemented. |
| What next? | This remains a priority for CPFT and for 2016-17. We will continue to work on improving the framework and processes around the engagement and involvement of carers. |
### 3.1 Positive and proactive care

**To reduce the use and need for restrictive interventions and improve the use of positive and proactive approaches to care.**

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and staff. In CPFT, we started on this journey in 2014-15 when we launched the PROMISE Project which served as a solid foundation for taking this work forward into 2015-16. This is a national priority, the principles of which are embedded in the CQC’s fundamental standards of quality and safety; and is also reflected in our patient feedback. The Adults Directorate led on this piece of work, with the other Directorates signing up to the over-arching objective.</th>
</tr>
</thead>
</table>
| What did we aim to achieve? | ✓ To improve the reporting of restrictive practice in Datix (our electronic incident management system) to provide more meaningful information  
 ✓ To review and improve staff training on the safe management of violence and aggression and promotion of proactive care  
 ✓ To demonstrate clear improvements in practice in line with the national guidance on positive and proactive care. |
| This applies to | All mental health inpatient units |
| How did we monitor our progress? | We established a Positive and Proactive Care Steering Group to drive this work forward and ensure achievement of the objectives. Progress is reported regularly through our Trust’s governance framework, in particular, to the CGPSG and the QSGC. |
| How well did we do? | ✓ Achieved  
  CPFT has made excellent progress in the implementation of positive and proactive care in our services. A summary of our achievements is outlined below.  
 ✓ Incidents of prone restraint are now recorded in Datix, our electronic incident reporting system and reported in the monthly ward dashboards. Incidents of prone restraint have gone down significantly during the year.  
 ✓ CPFT’s physical interventions training programme was reviewed to bring it in line with new national guidance. As of March 2016, **100%** of all eligible staff had been trained in the new techniques. This has included developing a bespoke IM (Intramuscular) administration training programme to skill up nurses to administer rapid tranquillisation in alternative sites to avoid the use of prone restraint. This will be launched in May 2016.  
 ✓ We have strengthened our process of debriefing through the introduction of debriefing proformas and guidance to clinical teams to further support both service users and staff following restrictive practice interventions. |
Prone Retraint Incidents

2015/16

What next?

This remains a priority of CPFT and for 2016-17 and will be reported in part 3 of this report moving forward. Moving forward, we will consider how service users can be involved in post-incident monitoring in order to be fully compliant with NICE’s debriefing guidance and continue to improve our reporting of incidents on Datix.

Embedding positive and proactive care in CPFT

We started on a good foundation, having embarked on the PROMISE Project two years previously.

PROMISE, or Proactive Management of Integrated Services and Environments, was launched in 2013-14 and aims to eradicate the use of force in mental health care. Dr Manaan Kar-ray, consultant psychiatrist and Clinical Director of the Adults Directorate, and Sarah Rae, Patient Leader, have spearheaded this movement.

This has since grown into a global movement, with collaborations between Cambridge, Yale, Brisbane, Prague, Cape Town and others, working together to break through frontiers of humane mental health care, with a goal of eradicating reliance on the use of force within 10 years by using the principles of recovery, and positive and proactive care. More information is available on www.promise.global.

The Promise Project was the winner in the ‘Strengthening the Foundation’ category of the national Patient Experience Awards in March 2016. It also won the Research Innovation of the Year Award in our Annual Staff Awards held in April 2016. More recently, the project made it through to the finals of the Value in Healthcare Awards, run by the industry magazine Health Service Journal, and the winners will be announced in the end of May 2016 (The results are not yet available as of the date of this report).

In CPFT, we have embraced the implementation of positive and proactive care and have made excellent progress in the year towards eliminating the use of prone restraint in our services.

We established a Positive and Proactive Care (PPC) Group and worked closely with the Prevention and Management of Violence and Aggression (PMVA) Team and the Datix Web Team to ensure successful implementation in our services. A clinical audit was undertaken in July 2015, which indicated a need to improve clinical record keeping. Consequently, a clinical nurse specialist, service user advisor and ward manager produced examples of documentation in the areas of Datix recording, risk assessment, care planning and debriefing. These good practice examples included the importance of considering what could have been done differently to prevent the use of restrictive practice. The guidance was disseminated to teams in addition to being publicised throughout CPFT’s Patient Safety Lessons in Practice Bulletin.

The number of prone restraint incidents in CPFT has gone down significantly during the year, with just one incident recorded in March 2016. This involved a prone restraint in the adult community locality team, administered by a police officer.
# 3.2 Safer staffing

To provide care in a safe environment through safe staffing levels in our services.

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>Recent high profile events have focused the national attention on the shortage of nursing staff and this is a UK-wide concern. Unsafe levels of staffing affect the workload of existing staff and pose a potential threat to the continuity of care and safety of patients. In CPFT, we are committed to the provision of safe staffing levels to safeguard the safety of our patients and promote their recovery. We also recognise that this is one of the factors that impact upon our Staff Survey scores. This has been a common theme in our incidents and complaints, particularly in the adult and children community services.</th>
</tr>
</thead>
</table>
| What did we aim to achieve? | ✓ To repeat the establishment review of our mental health inpatient services, and undertake an establishment review of our mental health community services
✓ To implement the recommendations from the establishment review and NICE guidance on safer staffing
- To work towards bringing our services in line with the NICE guidance on safer staffing when this is published. |
| This applies to | All clinical teams |
| How did we monitor our progress? | Daily safer staffing reports are posted on our website and monthly reports are presented to CPFT Board and our commissioners. Progress is monitored through our governance framework, and in particular through regular reporting to the QSGC. |
| How well did we do? | ✓ Achieved
Whilst this was already an agreed action point of CPFT prior to the CQC inspection which took place in May 2015, the report published in October 2015 highlighted gaps in our staffing establishment particularly in some inpatient areas and our children’s community services. As part of our CQC action plan, the inpatient safer staffing establishment review was repeated and the outcome was reported to CPFT Board and our commissioners in December 2015. Our community services are also undertaking establishment reviews as part of the wider service specification reviews.
NICE has not published safe staffing guidelines for mental health services, publishing guidelines for acute hospitals, A&E and maternity services during the year. We have reviewed staffing levels in the new services as part of the service redesign, and have taken account of relevant national guidelines, where this is available. |
| What next? | Staffing establishments are being discussed as part of the contract negotiations for 2016-17. We are working with our commissioners to ensure that our services have safe staffing levels, and will continue to do so in the coming year. |
### 3.3 Physical health

To reduce premature death in patients with severe mental illness and ensure physical health needs are identified and treated

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>Chronic enduring mental illness is associated with high prevalence rates of metabolic syndrome regardless of diagnosis or use of antipsychotic medication, and individuals with severe mental illnesses such as schizophrenia or bipolar disorder have a reduced life expectancy compared with the general population, especially related to cardiovascular disease. This gap has increased in recent years, especially with regard to schizophrenia and bipolar affective disorder. Issues around physical health monitoring have been a common theme for CPFT in national clinical audits over the years and we recognise that this is an area that we need to focus our efforts and resources on. Moreover, this is a national priority and is embedded in the NICE guidelines and quality standards. It is also a CQUIN target.</th>
</tr>
</thead>
</table>
| What did we aim to achieve? | • To demonstrate implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in inpatients with psychoses and community patients in Early Intervention Psychosis (EIP) teams.  
• For 90% of eligible inpatients audited during the period and 80% of community EIP patients audited during the period, the key cardio metabolic parameters will be assessed with the results recorded in the clinical records as appropriate together with a record of associated interventions. The parameters are:  
  ➢ smoking status  
  ➢ Lifestyle, including diet, exercise, alcohol and drugs  
  ➢ Body mass index  
  ➢ Blood pressure  
  ➢ Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)  
  ➢ Blood lipids  

**Note:** This will be measured through a national audit. |
| This applies to | Inpatient and community EIP teams with eligible patients |
| How did we monitor our progress? | Progress is reported through our Trust’s governance framework, and in particular, to the CGPSG. |
| How well did we do? | **Not fully achieved**  
• A Trust Physical Health Lead was appointed in November 2015, and a Physical Health action plan is in place.  
• A Physical and Mental Health Strategic Group was established in October 2015 to lead on the implementation of the physical health action plan.  
• 65% of eligible EIP patients had documented assessments for all seven parameters  
**Note:** The results of the national inpatient audit was not yet available at the date of this report. |
| What next? | This remains a priority of CPFT and will be reported in part 3 of this report moving forward. |
## Priority Area 4: Clinical effectiveness

### 4.1 Diagnosis
To improve the effectiveness of interventions through accurate and timely recording of diagnosis

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>While the concept that one must have a diagnosis in order to be properly treated comes from a medical model and one that not everyone prescribes to, there is evidence that having a diagnosis and an understanding of one’s illness and therefore how to manage and live with it effectively has been found to be helpful by many people. It supports the development of a collaborative plan of care, treatment and support and will help us in the full implementation of our pathway services. CPFT and our clinical directorates identified this as a priority for 2015-16, which was supported by our commissioners.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What did we aim to achieve?</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase the documentation of diagnosis in the patient’s clinical records (ICD10 and/or working diagnosis) to 60% by end of FY 2015-16 (baseline 47% as of March 2015).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>This applies to</th>
</tr>
</thead>
<tbody>
<tr>
<td>All clinical teams <strong>Exception:</strong> New services transferred to CPFT in April 2015. For mental health services, where a patient is only seen by a nurse, a working diagnosis is sufficient.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How did we monitor our progress?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress is monitored through our Trust Quality and Safety Dashboard, with monthly reporting to the PRE meetings and to the QSGC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How well did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achieved</strong> From a starting point of 47% as of March 2015, we have made steady progress during the year achieving a score of 61.7% in November 2015. Compliance rates went down slightly in the next 3 months before meeting the target by March 2016 at 60.3%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What next?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The challenge that we have around recording diagnosis is partly due to patients that are only being seen in nurse-led services, and partly the reluctance of nurses to record patient diagnosis. This is a practice and cultural issue that we will continue to work with our staff to highlight the importance of recording diagnosis and how this supports patient care. This remains a priority of CPFT and will be reported in Part 3 of future reports.</td>
</tr>
</tbody>
</table>
**4.1 Outcomes of care**

To establish better measures and processes for demonstrating the effectiveness and outcomes of our interventions.

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>The Department of Health’s over-arching aim is to enable people to live better for longer, which will be achieved by improving the health and care outcomes that matter to them. Across health and care settings, these outcomes are wide ranging and focus on improving outcomes. For CPFT, we recognise that we need to improve upon the use of outcome measures to demonstrate the effectiveness of our interventions and services. This is embedded in the CQC’s fundamental standards of quality and safety. This has been raised by the Clinical Effectiveness, Audit and Research Group (CEARG) and the directorates as a priority and has been endorsed by CPFT.</th>
</tr>
</thead>
</table>
| What did we aim to achieve? | • To implement Trust approved clinical outcomes measures across CPFT  
• To finalise and formally launch relevant Pathway Protocols  
• To establish a robust electronic process for recording and reporting of clinical outcome measures across CPFT  
• To work towards developing a framework for reporting of non-clinical outcome measures across CPFT |
| This applies to | All clinical services |
| How did we monitor our progress? | Progress is reported regularly through our Trust’s governance framework, and in particular to the CEARG, CGPSG and the QSGC. |
| How well did we do? | **Partially achieved**  
✓ Mandatory outcome measures agreed and launched in October 2015 across the adults’ directorate. Additional outcome measures have also been identified and agreed as part of the pathway protocols.  
✓ Within the specialist directorate, mandatory outcome measures have been agreed for the learning disability (LD) and forensic services.  
• A range of outcome measures are already in place across the Children’s services. The Directorate needs to agree consistent mandatory measure(s) across their services.  
• Work is ongoing with the new Integrated Care Directorate services to identify mandatory outcome measures.  
• Ongoing development of electronic recording and reporting in RiO and PC-mis, our electronic patient records systems. Folders have been created for each Directorate and a range of outcome measures are already loaded into the system to enable electronic recording and reporting.  
• Options are being explored in SystmOne, the electronic patient records being used by our community children’s services and the new Integrated Care services, to enable electronic recording and reporting. |
| What next? | This remains a priority of CPFT and has been carried forward as a priority for 2016-17. |
B. Our performance on our CQUIN Targets for 2015-16

In April 2015 we agreed 5 CQUIN (Commissioning for Quality and Innovation) targets with our commissioners. Two of these are NHS Standard Schemes and build upon existing practices within CPFT and the remaining three were as a result of a set of proposals from CPFT to our commissioners that were accepted.

Our performance on our quality goals as of Q3 outlined in Table 2 below shows that we achieved 4 of the five targets for the year, and partially achieved 1.

<table>
<thead>
<tr>
<th>CQUIN 2014-15 GOALS</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1</strong> Enhanced Primary Care Services (local scheme)</td>
<td>✓</td>
</tr>
<tr>
<td>Improve awareness and diagnosis of Mental Health conditions and how best to manage them, by offering and supplying Enhanced Mental Health training to all Accident and Emergency staff in our local area.</td>
<td></td>
</tr>
<tr>
<td><strong>Goal 2</strong> Enhanced Third Sector Partnership Working (local scheme)</td>
<td>✓</td>
</tr>
<tr>
<td>To work with the Commissioner to develop effective working relationships with the Third Sector throughout the CCG area in order to improve service user experience and outcomes.</td>
<td></td>
</tr>
<tr>
<td><strong>Goal 3</strong> Enhanced Mental Health Training (local scheme)</td>
<td>✓</td>
</tr>
<tr>
<td>All patients admitted to all provider Trusts should have their medicines reconciled within 24 hours of admission.</td>
<td></td>
</tr>
<tr>
<td><strong>Goal 4</strong> Carer support (national scheme)</td>
<td>✓</td>
</tr>
<tr>
<td>To improve the support offered to carers generally throughout CPFT services particularly in relation to care planning and discharge processes, carer support and sharing of information in the best interest of the patient.</td>
<td></td>
</tr>
<tr>
<td><strong>Goal 5</strong> Improving Physical Health Care to Reduce Premature Mortality in People with Severe mental Illness (National Scheme)</td>
<td>Partially achieved</td>
</tr>
<tr>
<td><strong>Part 1</strong> Cardio Metabolic Assessment for Patients with Schizophrenia:</td>
<td>✓</td>
</tr>
<tr>
<td>To demonstrate, through a national audit process similar to the National Audit of Schizophrenia, full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with schizophrenia (inpatient units and Early Intervention in Psychosis services).</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> As of the date of the report, the results of the national audit in inpatient services have not been published.</td>
<td></td>
</tr>
<tr>
<td><strong>Part 2</strong> Communication with GPs:</td>
<td>✓</td>
</tr>
<tr>
<td>Completion of a programme of local audit of communication with patients’ GPs, focussing on patients on CPA, demonstrating by quarter 4 that, for 90% of patients audited, an up-to-date care plan has been shared with the GP, including ICD codes for all primary and secondary mental and physical health diagnoses, medications prescribed and monitoring requirements, physical health condition and ongoing monitoring and treatment needs.</td>
<td></td>
</tr>
<tr>
<td>As of date of writing this report, we have not received feedback on the final outcome of our Q4 submission of evidence from our commissioners.</td>
<td></td>
</tr>
</tbody>
</table>
2.1.3. Looking forward – our priorities for improvement for 2016-17
We place our patients and the people who use our services at the very heart of everything we do.

Our priorities for improvement for 2016-17 are underpinned by our new values and over-arching strategy for quality improvement.

A. Our quality priorities for 2016-17
We have worked closely with our Clinical Directorate management teams to identify areas for improvement both at Trust wide level and also those that are specific to their services. We have focused on those areas that we believe will make the most impact on the safety and quality of our services and improve the experience of our patients and staff.

In doing so, we considered feedback from a range of sources, including our staff, our patients and their carers and other key stakeholders. We also reviewed Trust data and other information, including patient and staff surveys, incidents and complaints, clinical audit and our CQC inspection reports among others.

The quality priorities for 2016-17 include both quantitative and qualitative targets.

Our performance and progress on these priorities will be monitored primarily through the Performance Review Executive (PRE) and Clinical Governance & Patient Safety Group (CGPSG) meetings, with oversight from the Quality, Safety & Governance Committee (QSGC).

Priority Area 1: Over-arching priorities

1.1 Quality Framework
This was our priority for 2015-16 which did not fully achieve in the year. This is still a priority for the Trust and has been carried forward to 2016-17.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>All clinical teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do we aim to achieve?</td>
<td>a. To develop team-specific integrated quality and safety dashboards that feed into the Directorate and Trust over-arching dashboards, to be in place by January 2017. b. Review and strengthen the quality assurance framework which will include the processes for monitoring compliance with the CQC standards and performance against the quality &amp; safety indicators from team to Board.</td>
</tr>
</tbody>
</table>

1.2 Staff FFT (Friends & Family Test)

We firmly believe that the way our staff feel about the Trust is a good indicator of the quality of our services. Improving staff recommendation of the Trust to care for their friends and family was our priority for 2015-16, and we exceeded our target for the year. For 2016-17 we aim to improve upon our achievement in the previous year and expand this to include the recommendation of the Trust as a place to work. In addition to the over-arching Trust target, our Clinical Directorates have identified improvement priorities pertinent to their services that require improvement.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>All teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>This applies to</td>
<td></td>
</tr>
</tbody>
</table>
## What do we aim to achieve?

**Trust wide target**
3% increase on our national staff survey scores on recommendation to care and place to work.

**Directorate-specific targets**

a. Adults Directorate
   5% improvement on the national staff survey questions on ‘good communication between senior management and staff’ and ‘organisation and management interest in action on health and wellbeing’.

b. Specialist Directorate
   To improve and strengthen staff recruitment and retention strategies in the service.

c. Integrated Care
   5% improvement in appraisal rate compliance

d. Children’s Directorate
   3% improvement on the national staff survey questions on ‘ability to contribute towards improvements at work’

### Priority Area 2: Patient and carer experience

#### 2.1 Our patients will be treated in clinical environments that are compliant with national standards

<table>
<thead>
<tr>
<th>Rationale</th>
<th>The environment in which people are cared for have a significant impact on their experience and recovery. Our priority in the previous year was to ensure that the Trust overall scores were at least equal to or higher than the national average, which we achieved. For 2016-17, we aim to improve upon our achievement in 2015-16.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This applies to</td>
<td>Inpatient clinical areas</td>
</tr>
<tr>
<td>What do we aim to achieve?</td>
<td>To improve our PLACE (Patient Led Assessments of Care Environments) scores so that all wards will have scores at least equal to or higher than the national average.</td>
</tr>
</tbody>
</table>

#### 2.2 Continue to strengthen implementation of the Triangle of Care programme

<table>
<thead>
<tr>
<th>Rationale</th>
<th>We recognise that carers are vital partners in the provision of care and the patient’s recovery, and in 2015-16 we set specific targets on the implementation of the Triangle of Care programme in the Trust, which we achieved. For 2016-17, we aim to improve upon our achievement in the previous year with the targets below.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This applies to</td>
<td>Clinical teams</td>
</tr>
</tbody>
</table>
| What do we aim to achieve? | a. At least 60% of service users will have an identified carer recorded in RiO (where there is a carer present)  
  b. At least 60% of carers identified will have a carer record completed on RiO  
  c. All teams will complete at least 2 carer experience surveys per month  
  d. At least 75% of carers surveyed will report feeling involved in the care of the cared for  
  e. 100% of identified carers will be offered/signposted for a carer’s assessment |

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### 2.3 We will address specific areas in our patient experience survey that showed consistently low scores in the previous year

| Rationale | Continually improving the experience of our patients is a constant priority for the Trust, and whilst we exceeded our target to improve the patient’s FFT (Friends and Family Test) scores in the previous year, we know that there are areas that we need to do better on. For 2016-17, we are focusing on those areas with consistently low scores during 2015-16. It is worth noting that:  
  - The Children’s Directorate, which consists of community services, have had consistently high scores on their patient survey throughout 2015-16 and therefore is focusing on improved reporting of the patient's experience for 2016-17.  
  - The patient survey questionnaire was introduced in the Integrated Care Directorate in January 2016 and therefore does not yet have enough data to identify improvement priorities in this area. |
| This applies to | All clinical teams |
| Trust wide targets | 5% improvement in the patient survey scores on the following areas:  
  - Food  
  - Activities in evenings and weekends  
  - Information about medication side effects |
| Directorate-specific targets | a. Adults Directorate  
  - 5% improvement for ‘information on keeping healthy’ (inpatients)  
  - 3% improvement for ‘out of hours contact’ (community)  
  b. Children’s Directorate  
  - Establish a process for routine reporting of patient experience across the service using the Graduation forms used by Family Nurse Partnership (FNP) and Experience of Service Questionnaires (ESQ) used by Child & Adolescent mental health (CAMH) services. |

### 2.4 Specific targets for the Integrated Care Directorate related to improving the patient’s experience of care.

| Rationale | Being admitted into hospital can be a stressful and anxious time, especially for older people. One of the key targets of the NHS is to reduce the length of time patients spend in hospital. Reducing hospital admissions and caring for people more appropriately in the community is a key aspect of this objective. However, when hospital care is needed, it is equally important to minimise that time whilst ensuring that patient safety and quality of care is not undermined. A key factor in achieving this is improving levels of care so that patients avoid unnecessary admissions or recover more quickly. The Directorate is therefore focusing their improvement priorities on two specific areas – admission avoidance and reducing hospital length of stay (LoS) – which is one of the seven mandated health outcomes of the NHS Outcomes Framework. |
| What do we aim to achieve? | a. Increase the number of people supported by the Dementia Intensive Support Team (DIST) in the community to avoid unnecessary admissions into hospital. |
b. Reduce LoS in these services (from 33 days) to bring it in line with the national average and improve patient outcomes
   - 19 days for rehabilitation wards
   - 28 days for stroke wards

## Priority Area 3: Patient safety

### 3.1 Reduce avoidable harm

**Rationale**

Patient safety is the number one priority of the NHS, and in 2015 NHS organisations were invited to ‘Sign up to Safety’ as part of the government’s ambition to reduce avoidable harm over the next three years. In CPFT, the top three patient safety incidents reported in 2015-16 were pressure ulcers, self harm and falls. We are committed to make improvements in these areas and for 2016-17 we will work with our clinical services to develop and implement strategies to reduce the number of incidents in these areas, while maintaining the levels of high reporting in the Trust. In addition, the Integrated Care and Children’s Directorates have identified improvement priorities in areas that are pertinent to their services.

**This applies to**

Clinical teams

**Trust over-arching targets**

a. 10% reduction in the number of avoidable grade 3 or 4 pressure ulcers acquired in CPFT (all clinical services)

b. 5% reduction in the number of self harm incidents in our mental health services

c. 5% reduction in proportion of falls that lead to moderate and severe harm

**Directorate-specific targets**

d. Integrated Care Directorate - reduction in missed insulin injections for those patients where it is the responsibility of the service to administer as part of their plan of care
   - To improve reporting of missed insulin injections and establish a baseline
   - From October 2016, reduce the number of missed insulin injections to 1 per month, with an aspirational target of 0%

e. Children’s Directorate – reduction of Serious Incidents and/or Clinical Reviews relating to information governance breaches to no more than 2 in the year

**Note:** Information Governance breach was one of the top reported incidents and is of particular concern to the Directorate.

### 3.2 Improve practice and Trust processes relating to the management of violence and aggression in the Trust

**Rationale**

Violence and aggression are relatively common and serious occurrences in health and social care settings, and occur most frequently in inpatient psychiatric units in mental health settings. The impact is significant and diverse, adversely affecting the health and safety of the patient and other patients in the vicinity as well as carers and staff (NICE 2015). In CPFT, physical outburst and assaults were the fourth and fifth highest reported incidents in 2015-16. We are committed to making further improvements in this area, having made
significant progress in staff practice relating to positive and proactive care in the previous year (use of prone restraint – see section 2.1.2, priority 3.1). For 2016-17, we will aim to improve upon our achievement in the previous year and address other areas relating to the management of violence and aggression.

What do we aim to achieve?

- a. Restraint
  - Adults & Specialist Services – 5% reduction in other forms of restrictive physical interventions
- b. Physical assaults
  - 5% reduction in the number of patient to patient and patient to staff physical assault incidents in CPFT
- c. Seclusion
  - Agreement of the approach to be implemented in CPFT with NHS Improvement (previously called Monitor) and the CQC, taking account of national guidance and evidence-based good practice
  - Implementation of the agreed approach
- d. Children’s Directorate - all administrative staff will be trained in managing verbal abuse on the telephone to reduce the impact on staff

Priority Area 4: Clinical effectiveness

4.1 Implement the Clinical Effectiveness Strategy across the Trust

Rationale

Clinical effectiveness and the implementation of evidence-based interventions is the foundation of providing high quality care. During 2015-16, we made significant progress in the development of the Trust Clinical Effectiveness Strategy, focusing on four areas wherein we believed would make the most impact on improving the effectiveness of practice and outcomes of care. For 2016-17, we aim to focus our improvement actions on the four priorities areas in the strategy.

This applies to All clinical teams

- a. All services will be using Trust-approved Patient Reported Outcome Measures (PROM), recorded and reported upon by the end of the year
- b. To strengthen implementation of evidence-based interventions in CPFT
- c. To strengthen the culture of research in CPFT
  - Provide research training accessible by all staff
  - To increase staff involvement in research and development activities
  - To strengthen processes for translating research into practice
  - To further improve service user and carer involvement in research and development activities
- d. To improve the physical health monitoring processes in our mental health services
  - Review and update the Physical Health Policy
  - Develop health and wellbeing standards and governance
Review and strengthen recording and reporting of physical health parameters  
- Review and strengthen physical health care skills training for staff

### 4.2 Learning and embedding change to improve outcomes of care

| Rationale | Identification of learning and embedding change is a key aspect of quality improvement, and we recognise that this is an area we need to improve upon. |
| This applies to | All clinical teams |
| What do we aim to achieve? | Improve processes for identifying learning in these areas and embedding change to demonstrate improved outcomes of care.  
  a. Incidents, near misses and complaints  
  b. Clinical audit, service improvement and research projects  
  c. External service reviews |

#### B. Our CQUIN Goals for 2015-16

As part of our contractual agreement with Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England for 2016-17, CPFT will work towards the achievement of a range of quality goals which will support further improvements in patient experience, patient safety and clinical effectiveness. We will report on our achievements in meeting these goals as part of next year’s quality report.

The final details for the CQUIN goals for 2016-17 are still under discussion as of the date of this report. We have, however, agreed the broad themes which are outlined below. This includes 2 targets from the local scheme and 2 from the national scheme, details of which are available from the national website [https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/](https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/)

**Goal 1: NHS Staff health and wellbeing (national scheme)**

**Indicators:**
- 1a: Introduction of health and wellbeing initiatives
- 1b: Healthy food for NHS staff, visitors and patients
- 1c: Improving the uptake of flu vaccinations for front line staff

**Goal 2: Enhanced mental health and IAPT Primary Care services (local scheme)**

To work with the commissioners to develop an Integrated Enhanced Primary Care Mental Health service to include Prism, Recovery coaches, Third Sector and IAPT

**Goal 3: Improving physical healthcare to reduce premature mortality in people with severe mental illness (national scheme)**

**Indicators:**
- 3a: Cardio metabolic assessment and treatment for patients with psychosis in inpatient wards, Early Intervention Psychosis services and community mental health services (patients on CPA)  
- 3b: Communication with General Practitioners (GPs)

**Goal 4: Integrated Personality Disorder (local scheme)**

To work collaboratively with the commissioners, Third Sector and primary Care to develop an Integrated Personality Disorder Pathway across primary and secondary care.
2.2. Statements of Assurance from the Board

We have reviewed the data available to us during the year covering the three dimensions of quality of patient safety, clinical effectiveness and patient experience.

There have not been any significant concerns with the data that have impeded us in the preparation of this Quality Report.

2.2.1. Review of services

During 2015-16 CPFT provided and/or sub-contracted nine relevant NHS health services (listed in page 2).

CPFT has reviewed all the data available to us on the quality of care in all nine of these relevant NHS health services.

The income generated by the relevant health services reviewed in 2015-16 represents 100% of the total income generated from the provision of relevant health services by CPFT for 2015-16.

During 2015-16, we produced monthly Integrated Quality and Safety reports, initially at a Trust wide level only, and then at directorate level from October 2015 which reflected combined data from the ‘old’ and ‘new’ services. The Integrated Quality and Safety reports contained additional data and narrative to complement the monthly Trust Quality and Safety dashboards. These reports improved communication on the quality of our services to the Board and clinical directorates, and facilitated improvement actions when required. It also improved data quality by enabling timely scrutiny by the clinical teams of the data produced for their services.

2.2.2. Clinical audit

Clinical audit is a key component of clinical governance and an essential tool for quality improvement, providing practitioners with a powerful tool to facilitate reflection on their own and their team’s practice. It also provides assurances about the quality of services.

During 2015-16, six national clinical audits and one national confidential enquiry covered relevant health services that CPFT provides.

During that period CPFT 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 CPFT was eligible to participate in during 2015-16 are as follows:

1. Prescribing Observatory for Mental Health (POMH) UK
   - POMH-UK 13b: Prescribing for ADHD in Children, adolescents and adults
   - POMH-UK 14b: Prescribing for substance misuse: alcohol detoxification
   - POMH-UK 15a: Prescribing sodium valproate for people with bipolar disorder
2. 2015 UK Parkinson’s audit
3. National EIP (Early Intervention in Psychosis) audit
4. Mental Health Conditions in young people (NCEPOD - National Confidential Enquiry into Patient Outcome and Death)
5. National Confidential Inquiry into Suicide and Homicide by People with Mental illness (NCISH)
The national clinical audits and national confidential inquiries that CPFT participated in, and for which data collection was completed during 2015-16, 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 inquiry.

Table 3: National audits that CPFT participated in during 2015-16

<table>
<thead>
<tr>
<th>Audit</th>
<th>% Cases submitted</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Programme of Prescribing Observatory for Mental Health (POMH) UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POMH-UK 13b: Prescribing for ADHD in Children, adolescents and adults</td>
<td>7 participating teams 113 questionnaires submitted</td>
<td>Action planning stage</td>
</tr>
<tr>
<td>POMH-UK 15a: Prescribing sodium valproate for people with bipolar disorder</td>
<td>11 participating teams 102 questionnaires submitted</td>
<td>National report received on 12 May 2016</td>
</tr>
<tr>
<td>National EIP (Early Intervention in Psychosis) audit</td>
<td>1 participating teams (North and South) 50 questionnaires submitted</td>
<td>Report not yet received. Data submitted 18 December 2015</td>
</tr>
<tr>
<td>Mental Health Conditions in young people (NCEPOD)</td>
<td>17 eligible participating teams No relevant sample were identified meeting the criteria identified during the prescribed period</td>
<td>Stage 1: identification of sample in March 2016</td>
</tr>
</tbody>
</table>
| 2015 UK Parkinson's Audit                                             | • 2 participating teams  
- questionnaires submitted  
- Elderly care - 20 (100%)  
- SaLT – 25 (250%) | National report received on 24 April 2016                              |
| University of Manchester                                              |                                         |                                                                          |
| National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) | • 25 suicide questionnaires sent by NCISH between April 2015 and March 2016, 18 completed and submitted by CPFT (72%).  
• 2 homicide questionnaires sent by NCISH and 1 completed and submitted by CPFT (50%)  
• 1 SUD (Sudden Unexplained Death) questionnaire sent by NCISH, completed and submitted by CPFT (100%) | Note: Of the 8 questionnaires still outstanding as of 31 March 2016, 1 was sent in November 2015, 3 in December 2015, 3 in February 2016 and 1 in March 2016. |

In addition, we completed three national audits under the CQUIN (Commissioning for Quality and Innovation) programme during 2015-16:
- Communicating with GPs audit
- National Cardio metabolic Assessment audit - Inpatients
- National Cardio metabolic Assessment audit - EIP service

The reports of two national clinical audits were reviewed by CPFT in 2015-16:
- POMH 9c: Antipsychotic prescribing in people with learning disability
- POMH 14a: Prescribing for substance misuse

CPFT intends to take the following actions to improve the quality of healthcare provided.
**POMH 9c: Antipsychotic prescribing in people with learning disability (LD)**

- Doctors will keep a list of the audit standards on display by their desktop as a prompt of the information that needs to be documented in the patient records and GP letters
- We will work with local partners (primary care and acute hospitals) to enable access to pathology results for CPFT staff
- Set up a register of patients taking antipsychotics
- Ensure weight, girth and blood pressure are measured and recorded at every CPA review/outpatient appointments for patients taking antipsychotics
- Promote the use of patient easy read medication records within LD services
- Link with the Physical Health work stream to improve recording of medication in RiO and SystmOne (e.g., reasons for prescribing, side effects monitored, physical parameters monitored, etc.)

**POMH 14a: Prescribing for substance misuse**

- The inpatient alcohol detoxification prescribing guideline will be updated to incorporate findings from the audit.
- The referral form from DrinkSense will be amended to include the heading ‘relapse prevention’ and will be completed
- For re-audit in 2016, the lead consultants will identify and instruct audit data collectors on the correct use of the audit tool and where to find the information required to ensure more accurate data collection

The reports of five national CQUIN audits were reviewed by CPFT in 2015-16:
- Communicating with GPs (General Practitioners) audit 2014-15 (CQUIN 4b)
- National Cardio metabolic Assessment audit 2014-15 - Inpatients (CQUIN 4a)
- Medicines Reconciliations audit 2014-15 Q2
- Medicines Reconciliations audit 2014-15 Q3
- Communicating with GPs audit 2015-16 (CQUIN 4b)

CPFT has taken/intends to take the following actions to improve the quality of healthcare provided:

**Communicating with GPs audit 2014-15 (CQUIN 4b)**

- Agree the antipsychotic (excluding Clozapine) prescribing support in the community with the CCG
- Investigate how RiO and other electronic systems can support medicines prescribing and monitoring arrangements
- Clarify with CCG what specific information is required by GPs regarding prescribed medication (physical and mental health)
- Work with the CCG to develop enhanced primary care mental health services
- Maintain the Physical Health Task and Finish Group to oversee the 2015-16 physical health CQUIN

**National Cardio metabolic Assessment audit – inpatients 2014-15 (CQUIN 4a)**

- Secure funding and appoint a Trust Physical Health Lead
- Establish a Physical and Mental Health Strategic Group from the CQUIN Physical Health Task and Finish Group
- Review guidance for junior doctors for undertaking physical health assessments
- At CCG request, develop and submit a business case for phlebotomy service
- Develop a Depot LES (Local Enhanced Service) in primary care with CCG
- Secure funding for enhanced primary care service to support monitoring of physical health in the community and link with LES work
- Review and improve documentation in RiO around physical health screening
Medication Reconciliation audit 2014-15 Q2
- Feedback the results of the audit to education meetings of junior doctors
- The Clinical Director of Adult Services will send an email to all doctors to remind them of the importance of undertaking medicines reconciliation

Medication Reconciliation audit 2014-15 Q3
- Disseminate guidance on medicines reconciliation to all doctors to raise awareness and improve practice
- Complete review of Medicines Reconciliation Policy in line with upcoming NICE Medicines Optimisation guideline
- Remind administrative hub managers to upload the medicines reconciliation forms into RiO and keep a hard copy with the medicines charts

Communicating with GPs audit 2015-16 (CQUIN 4b)
- Invite membership from Primary Care and Public Health in the Physical and Mental Health Strategic Group
- Provide feedback to teams on areas of good practice and areas for improvement
- Identify options for strengthening the profile of physical health in all mental health teams
- Review and improve the audit tool to collect more meaningful information to further improve clinical practice in this area
- Improve physical health monitoring arrangements in the mental health services in CPFT, to include better working arrangements with primary care
- Ensure this work links with CPFT overarching review on care planning

The reports of 10 local clinical audits were reviewed by CPFT in 2015-16 and CPFT has taken/intends to take the following actions to improve the quality of healthcare provided:

1. Improvement in practice and service delivery
   - Undertake research to explore the impact of classroom-based training in the assessment and management of suicide risk in practice
     - Undertake a Trust wide review of the Care Planning Policy, to include a review of compliance with the principles of the Care Programme Approach (CPA)
     - Establish a Trust Suicide Prevention Group to take lead responsibility for reviewing results of the Suicide Prevention audit and other work related to self-harm, and oversee the implementation of actions to embed change
   - Organise a Trust wide audit of medical devices to ensure a thorough and up to date inventory is taken
   - Add a column in the weekly Medical Devices cleaning template for ‘availability’ to ensure all items are present in the clinic room during the weekly inspection
   - Establish a clinical engineering contract for CPFT in relation to the management of medical devices
   - Review Clozapine physical monitoring guidelines
   - Produce a CPFT Register of Clinical Supervisors
   - Produce best practice guidelines for clinical supervision
   - Utilise strategies to promote clinical supervision in CPFT (e.g, corporate induction, nursing intranet page, posters and supervision charter)
   - Identify supervision leads in clinical teams
   - Arrange quarterly meetings for clinical supervisors, facilitated by clinical supervision leads to share challenges and good practice
   - Produce an evaluation tool for supervisees to establish the effectiveness and impact of clinical supervision
✓ Revise the existing Supervision Policy to incorporate actions from the audit
✓ Develop debriefing tools and guidance to clinical teams to support both service
users and staff following restrictive practice interventions
• Undertake a practice evaluation on the use of the debriefing tools
✓ Refine the data collection tool for the re-audit of restrictive practice, and agree
the care planning areas to be included in future audit or restrictive practice

2. Training and development
✓ Review and update the clinical risk training to reflect findings from the suicide
prevention audit, to incorporate training on the use of RiO
✓ Include sharps care in the Infection Prevention and Control (IPaC) training
✓ Ensure all staff are trained in resuscitation as appropriate to their role
✓ Ensure all staff are trained in the use of NEWS (National Early Warning Score)
chart as appropriate to their role
✓ Ensure all staff are trained in the correct usage, care and disposal of medical
devices (related to sharps)
✓ Review and develop the current training package for clinical supervision

During the year, we built upon the success of the quarterly Improving Practice Events
which were launched in the previous year to share good practice and findings from audit
projects, and involve the wider teams and clinicians in exploring reasons behind poor
practice in order to develop improvement actions.

In 2015-16, we expanded the scope of the events to include presentations on research
projects, serious incidents and complaints, service improvement projects and examples
of good practice from our clinical teams. These events have been very well received
and promote staff engagement and networking, among other things.

2.2.3. Participation in clinical research

A. Research and Development (R&D)
Within CPFT, we recognise that clinical research is a major driver of innovation which
leads to more cost effective treatments. It is central to the maintenance and
development of high standards of patient care and contributes to improvements in
outcomes of care.

Over the past few years, the number and quality of research studies being undertaken
in and by CPFT, in partnership with other leaders in this field, have improved
significantly, producing world class studies to national and international acclaim.

During the year, we embarked upon a comprehensive consultation exercise to review
and develop a new Research and Development Strategy with the aim of strengthening
the culture of research in CPFT across all professional groups to nurture an inquiring
and research-focused workforce. This will be launched in 2016-17.

As of March 2016, there were 153 active studies in CPFT, compared to 156 in 2014-15
and 123 in 2013-14. A total of 36 were approved in 2015-16, of which 16 were adopted
on the National Institute for Health Research (NIHR) portfolio, and there are a further 53
studies currently seeking Trust approval.
The number of patients receiving relevant health services provided or sub-contracted by CPFT in 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 840 (1,028 in 2014-15, 1,509 in 2013-14 and 1,029 in 2012-13).

The high number of patients recruited to take part in research in the previous years is largely due to the ‘Uchange’ longitudinal research project which commenced in 2011-12. This involved a large number of research subjects recruited in the following years, and moved to the next stage of the project in 2014-15. We have not had a project of this scale since 2011-12.

Examples of research in the CPFT R&D portfolio which are focused towards quality improvement actions include:

**Title: BIOmarkers in DEpression (BIODEP)**
**Sponsor: CPFT and University of Cambridge.**
**Aim:** This is a study to characterise the role of inflammatory processes in depression. There is compelling evidence that inflammation is often associated with, and can cause, depression. It is currently less clear that anti-inflammatory drugs have meaningful antidepressant effect. One goal is to identify the subset of depressed patients that is most likely to respond better to an anti-inflammatory drug than to a conventional antidepressant. The study involves 200 patients with a diagnosis of major depressive disorder (MDD) and 50 controls.

It includes four groups
1. incompletely responsive patients who have demonstrated failure to respond consistently or completely to standard treatment
2. those who have responded well to treatment and are not currently depressed
3. untreated patients who are currently depressed
4. healthy volunteers with no history of depression

Participants are identified in GP clinics, NHS clinics via posters in clinics and advertising. Participants undergo a clinical assessment, an interview and complete self-rated questionnaires. Blood is collected and saliva samples to measure certain immune markers.

Secondary cohort - a subsample of patients will be invited back to undergo an MRI to look for MRI markers in the brain and investigate brain inflammation using PET and CSF sampling (lumbar puncture).

**Title: A randomized, 18 week, Placebo Controlled, Double Blind Parallel Group Study of the Safety and Efficacy of PF05212377 (SAM760) in Subjects with Mild to Moderate Alzheimer’s Disease with Existing Neuropsychiatric Symptoms on a Stable Daily Dose of Donepezil.**
**Sponsor: CPFT and Pfizer**

**Background:** Alzheimer’s disease (AD) is the most common cause of dementia in elderly people and accounts for 60-70% of cases. AD is characterised by progressive deterioration in memory and other thinking processes such as language, judgement, planning, organising and reasoning. Current drug treatments are only symptomatic and do not affect the underlying disease process in the brain. Four drugs are currently available. Three of these (donepezil, rivastigmine and galantamine) increase the levels of a chemical in the brain called acetylcholine which is important in memory and thinking processes and they are used in mild to moderate AD. A fourth, memantine, acts on another chemical (glutamate) that is also important as a transmitter between nerve cells in the brain and is for moderate to severe AD.

In the absence of curative treatments, the goals of drug treatment are to improve or slow down loss in memory and thinking processes so as to maintain independent function. PF05212377 (SAM760) is a new drug which blocks another important chemical in the brain (serotonin or 5hydroxytryptamine (5HT)) at the type 6 receptors in the brain where this chemical acts. It has been developed for the symptomatic treatment of people with mild to moderate AD and is especially likely to be of benefit to patients who are already receiving a drug such as donepezil. There is also some preliminary evidence that it will be of particular value in people with AD who are also showing some disturbances in behaviour.

**Aim:** This is an 18 week, placebo controlled study to evaluate the safety and effectiveness of PF05212377 in patients with mild to moderate AD who also have some changes in behaviour and are taking stable doses of donepezil. Patient identification and all study activities were at the Windsor Unit, participants were randomised to receive either the new drug or placebo. Participants were also identified through outpatient and memory clinics, community mental health teams and day services within CPFT.
CLAHRC EoE
CPFT is the host NHS Trust for the NIHR (National Institute for health Research) Collaboration for Leadership in Applied Health Research and Care East of England (CLAHRC EoE), a five year programme and centre for mental health research that will accelerate health research into patient care.

CLAHRC EoE officially launched on 1 January 2014 as a result of a competitive application process set by NIHR. CLAHRC EoE currently has 29 projects on its portfolio and has six themes:

- Dementia, frailty and end-of-life care
- Enduring disabilities and/or disadvantage
- Health economics research
- Patient and public involvement research
- Patient safety
- Innovation and evaluation (core) theme

Eleven more projects are due to start in April 2016.

Examples of CLAHRC studies that have led to improved outcomes of care include:

Dementia Prison Projects
Research into the aging prison population around dementia friendly champions in prisons and buddying services for prisoners has led to the CLAHRC research team working closely with the National Offender Management Service (NOMS) for the Government to change policy. New research into transitions for patients with dementia once released from prison is now being undertaken collaboratively with NOMS.

CAMHS Transition Preparation Project
CLAHRC EoE has been involved in the development of work that centres on developing a transition from care preparation programme. Both CPFT and Hertfordshire Partnership NHS Foundation Trust are now reviewing transition procedures and protocols and have set up cross-directorate committees which are keen for all decisions to be informed by research findings and evidence. This work is also being considered outside the East of England region alongside work being undertaken by. Prof Sarwan Singh, Warwick University, who is involved in NICE guidance on CAMHS transitions. A cross-CLAHRC network on youth mental health is being developed to move this work forward and Valerie Dunn, Lead researcher on the transitions project is looking at future collaborations with the Rees Centre in Oxford.

Learning Disability Research
Research into the decision making capacity of people with learning difficulties continues post Winterbourne View, led by a CPFT researcher. The work has led locally to CPFT management and Cambridgeshire County Council, working on a partnership agreement between CPFT (as a health provider) and the County Council since the experience of both the research and the researcher’s clinical practice has suggested that such an agreement is crucial to effective partnership working in the provision of support from specialist locality-based community LD teams. Findings from the research have also been discussed with representatives of the Cabinet Office and NHS England.

NIHR CLAHRC EoE has continued to produce the successful Fellowship Scheme for health and social care professionals. Over the past five years this has included six cohorts, 69 professionals and 33 partner organisations. Projects from the scheme have included a qualitative investigation into mental health peer support workers professional development journey and role from their own perspective as well as their non-peer support colleagues, and the identification of a clinical diagnostic tool for the assessment of cognitive impairment in patients with chronic kidney disease.

CLAHRC also funds PhDs (Doctor of Philosophy) in each of its theme and is the lead CLAHRC nationally for the pilot NIHR Research Capacity in Dementia Care Programme 2014. This is a three year scheme to increase research capacity in Dementia Care by funding PhDs for nurses and Allied Health Professionals.
B. Service User and Carer Engagement in Research

Service user and carer involvement is a key priority area within CPFT’s R&D activities. CPFT’s R&D has 10 years of experience and expertise in this area. Our aim is to support, enable and empower service users, carers, researchers and clinicians to work together to develop high quality research which is relevant to people’s needs. The CPFT Service User and Carer Research Group (SUCRG) is a virtual group which has expanded throughout the years. People with lived experience of mental health issues or dementia are supported to be involved in the development, undertaking and dissemination of research and to facilitate learning.

During 2015/2016 we supported 54 people (30 in 2014-15) to be involved in 31 research or research related activities and we provided advice and support to 17 researchers. 28 of the people involved are members of the service user and carer research group. 33 people were involved for the first time. Involvement ranged from contributing to potential grant applications to reviewing research proposals, carrying out and promoting research as well as training researchers.

Key achievements during the year are outlined below.

Patient and Public Involvement (PPI)

- Increased number and diversity of people involved in CPFT research activities (ie, young people, people with experience of dementia, parents of children with non-communicative speech). In the majority of cases people were involved at early protocol development and grant application stage and provided feedback on proposals, ethical approval and participant information.
- An increase in the opportunities for people to be involved as peer trainers in learning and development. A PPI training programme was developed to raise awareness of service user involvement in research as well as service users’ and carers’ experiences in general. 18 members of the SUCRG delivered eight training events with attendance from 145 researchers.
- £2,000 received from the Royal College of Psychiatrists to part fund the user-led teaching programme for non-clinical researchers called Conversations with Experts by Experience. Five training events were held to inspire, motivate and help non-clinical researchers understand the symptoms and conditions they study from the service user perspective. Places for the training sessions were equally distributed among service users (educators/peer trainers) and researchers (students). The sessions focused on people’s experience of psychosis, depression and anxiety, and were developed and facilitated by a service user, a clinical researcher and the R&D PPI lead. These sessions have received excellent feedback and places have usually been taken within 12 hours of the email announcement. Eight more sessions are planned for 2016-2017.
- Evaluation of Service User and Carer Involvement in Research: In collaboration with University of Hertfordshire, RDS East of England and other PPI colleagues from East of England. We received a small development grant from CLAHRC to explore the impact of Patient and Public Involvement in research.
Patient and Public Experience (PPE)

- Two Patient Research Ambassadors were appointed to promote patient participation and involvement in research.
- In collaboration with CRN Eastern: Division 4, CPFT produced three short videos featuring people talking about their experience of taking part in CPFT research. The videos have been used in public engagement events and can be found along other stories at [www.cpft.nhs.uk/research.htm](http://www.cpft.nhs.uk/research.htm)
- A public event was organised as part of the World Mental Health Day, held on 7 October 2015 with attendance from around 100 people, to share the results of our research work and improve awareness of research opportunities within CPFT. One of the Patient Research Ambassadors opened the talks with a very insightful speech about her experience of taking part in research and the impact it had in her recovery journey. An “Images of Research” exhibition was also organised to showcase the amazing work of our researchers.
- Lay summaries of portfolio research studies are accessible on our webpages. This page is updated on a monthly basis. ([http://www.cpft.nhs.uk/professionals/Research%20we%20are%20doing.htm](http://www.cpft.nhs.uk/professionals/Research%20we%20are%20doing.htm))

2.2.4. Commissioning for Quality And Innovation (CQUIN) Payment Framework

A proportion of CPFT’s income in 2015-16 was conditional on achieving quality improvement and innovation goals agreed between CPFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.


**Note:** At the time of writing this report, the Trust has not received the outcome of the Quarter 4 submission from our commissioners. Therefore we are unable to present the total value of the payment for completion of our quality goals in 2015-16. In 2014/15 we received £809,410 for payment received from Cambridgeshire and Peterborough Clinical Commissioning Group and NHS England Specialist Commissioning Group in relation to achievement of our CQUIN targets in the year.

2.2.5. Care Quality Commission (CQC) Registration

The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England. Its primary role is to ensure that the care people receive meets essential standards of quality and safety and to encourage on going improvements by those who provide or commission care.

CPFT is required to register with the Care Quality Commission and its current registration status is ‘Registered without Conditions’.

The Care Quality Commission has not taken enforcement action against CPFT during 2015-16.

CPFT has participated in special reviews or investigations by the Care Quality Commission during 2015-16:
- Safeguarding children thematic review
- Integrated care for older people thematic review
CPFT has taken/intends to take the following actions to address the conclusions or requirements reported by the CQC:

**Safeguarding children thematic review**
- Ensure CAMHS (Child and Adolescent Mental Health Services) practitioners are aware of the importance of
  - capturing information about key relationships as prompted by the RiO electronic patients records system
  - documenting a plan for handing over the responsibility for managing ongoing risks to individual clients when a staff member leaves the employ of the service.
- Implement a formal method for assessing risk of child sexual exploitation of CAMHS clients and provide practitioners with a screening tool within the RiO system to enable them to assess such risk effectively.
- CPFT will work with Cambridgeshire and Peterborough CCG to
  - implement solutions to the problems of access and waiting times for core mental health services for children and young people and to bring the waiting times for those services down to acceptable levels.
  - urgently explore and implement ways to support the community and primary care services in delivering emotional support to children who are currently in need and until the improved access arrangements for core mental health services are implemented
- CPFT will work with Cambridgeshire Community Services NHS Trust and Hinchingbrooke Healthcare NHS Trust to define an appropriate, generic pathway for the CAMHS assessment of young people who attend the emergency department out-of-hours following incidents of self-harm or substance misuse.
- CPFT will work with Cambridgeshire and Peterborough CCG, Cambridge University Hospitals NHS Foundation Trust, and Hinchingbrooke Healthcare NHS Trust to ensure the paediatric emergency and urgent care need across the county complies with the ‘Standards for Children and Young People in Emergency Care Settings’ issued by the Royal College of Paediatrics and Child Health (RCPCH).

**Integrated care for older people thematic review**
We have not received the final report for this review at the time of writing this report, but CPFT has developed interim actions based on the feedback from the CQC following the review.

These are focused on the following key areas:
- Care co-ordination
- Care plans
- Case management
- Information sharing, including discharge information
- Fractured Neck of Femur (FNoF) pathway
- Falls management
- Stroke treatment

**A. CQC Inspections**
The Care Quality Commission (CQC) inspected CPFT in May 2015. Around 80 inspectors visited our inpatient units and most of our community-based services. The new services recently transferred from Cambridgeshire Community Services (CCS) were not included in the inspection as they had been inspected in the previous year.
The final CQC reports were published on Tuesday 16 October. CPFT received a ‘Good’ rating overall, with an amber (requires improvement) in ‘Are services safe?’ category.


**The CQC highlighted a number of areas of good practice, specifically**

1. Effective, responsive and caring services, and in particular
2. The board and senior management had a vision with strategic objectives in place and staff engagement in the improvement agenda. Where concerns had arisen the board had taken urgent action to address areas of improvement.
3. Effective use of performance management tools and governance structures which had brought about improvement to practices.
4. Morale was found to be good in most areas and staff felt supported by local and senior management. There was effective team working and staff felt supported by this.
5. CPFT had undertaken positive engagement action with service users and carers.
6. A good range of information was available for people and CPFT was meeting the cultural, spiritual and individual needs of patients.
7. Information systems were in place to ensure effective information sharing across teams.
8. CPFT had an increasingly good track record on safety in the previous 12 months. Effective incident, safeguarding and whistleblowing procedures were in place. Staff felt confident to report issues of concern. Learning from events was noted across CPFT.
9. CPFT had met its targets required under the Department of Health’s ‘Positive and Proactive Care: reducing the need for restrictive interventions’ agenda. There had also been a decreasing level of restraint and seclusion in the previous 12 months.
10. There was a commitment to quality improvement and innovation.
In particular, the CQC noted that
- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people’s individual needs.
- Admission assessment processes and care plans, including those for physical healthcare, were good.
- The inpatient environments were conducive to mental health care and recovery.
- The bed management system within adult and older people’s services was effective.
- Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines.
- Medicines management was effective and pharmacy was embedded into ward practice.
- Arrangements were in place to ensure effective use of the Mental Health Act and Mental Capacity Act

The Trust developed a strategic action plan in close consultation with our commissioners, which includes actions for both CPFT and its commissioners.

**Part 1** contains Trust level actions from the over-arching Trust report and addresses the Requirement Notices (must do’s) in three areas:
- **Regulation 13:** MHA and MCA compliance around section 58 Consent to Treatment and Seclusion
- **Regulation 15:** Ligature risks and observations within inpatient services
- **Regulation 18:** Staffing

and Recommended Actions (should do’s) in two other areas:
- Availability of psychological therapies
- Mixed sex accommodation in Maple 1

**Part 2** contains Trust level actions for the ‘should do’s’ from the service-level reports.

**Part 1: Trust overarching actions**
- **Reviewing the systems and processes around Consent to Treatment (section 58)**
- **Reviewing the procedures and facilities on the use of seclusion across CPFT’s inpatient services and ensure compliance with the regulations of the MHA**
- **Ligature risks – improving lines of sight to address risks relating to observation through the installation of convex mirrors in corners**
- **Working with our commissioners to review staffing establishments and agree service models and resource requirements to ensure adequate provision of psychological therapies in line with national guidance**

**Part 2: Service-level actions**
- **Access to GPs (General Practitioners) for patients in George Mackenzie ward**
- **Access to electronic physical investigation request system and results (primary care and acute hospitals) for CPFT staff**
- **Bringing our early intervention service model of care in line with the NICE**
- **Improvements to our section 136 suite in line with national guidance**
- **Improving documentation relating to the Mental Capacity Act (MCA)**
- **Improvements in practice in relation to care planning and risk assessments**
- **Improvements in specified premises and care environments**
- **Continuing our work around the elimination of the use of restraint**
- **Improving patient feedback on ‘food’**
A CQC Oversight Group was established to monitor the implementation of the action plan. Progress is also monitored at Directorate level in the Directorate governance management meetings and the Performance Executive (PRE) review meetings; and at Trust level by the Quality, Safety and Governance (QSG) Committee and CPFT Board.

Quarterly updates are provided to our commissioners, Monitor and the CQC.

In March 2016, an internal audit review of our CQC Compliance Framework found that CPFT has a “robust CQC compliance assurance process in place which is generally well embedded within the organisations senior management” and that “the Board can take reasonable assurance that the controls in place to manage this risk are suitably designed and consistently applied.”

**B. Mental Health Act Inspections**

During the year, the CQC conducted 12 Mental Health Act visits to inpatient wards within CPFT. Four of the visits were announced, as part of the comprehensive Trust wide one week inspection in May 2016, and 8 of them were unannounced.

As in previous years, the CQC comments to CPFT following its inspections were very positive and highlighted many areas of good practice.

All detained patients were found to be sectioned lawfully under the appropriate legal authority.

The inspectors found our wards to be safe and clean and noted the good interaction between patients and their carers and our staff. The inspection also highlighted that patients were informed of their legal rights and had good access to the statutory Independent Mental Health Advocacy (IMHA) service.

Staff understood their duties under the Deprivation of Liberty Safeguards and were adequately following CPFT’s procedural guidance and protecting patients’ rights.

The CQC noted that actions which were highlighted in previous visits to CPFT were addressed in all wards. However, it noted that further improvement was required to further strengthen the following areas:

- Although CPFT was found to be compliant with the legal requirements of section 58 (consent to treatment) further improvements were needed to ensure consistent recording by clinicians of the outcome of capacity assessments to consent to treatment.
- The revised MHA Code of practice (CoP), which came into effect in April 2015, had introduced changes which seek to provide stronger protection for patients. One of the main changes outlined in the code was a clearer definition for seclusion and the requirement to minimise blanket restriction practices. The CQC recommended that CPFT review its seclusion practices and facilities in order to comply with the changes to the CoP.

**Areas of good practice noted:**

- Good interaction and engagement between nursing staff and patients we noted and patients reported that staff respect their privacy and dignity
- Patients were involved in individualised activities and informed the inspector that they got on well with staff
- Patients were informed of their rights under the Act on a regular basis.
- Care plans were found to be comprehensive, demonstrated evidence of the patient’s involvement and were regularly reviewed and updated.
- Risk assessments prior to granting section 17 leave were completed in line with the requirements of the Act and Trust’s procedures.
- Good evidence of patient’s awareness of their right to see an IMHA (Independent Mental Health Act Advocate) and good visibility of the advocates on the wards.
We have implemented the required actions in response to the recommendations. This includes carrying out a comprehensive internal audit looking at the compliance with Section 58 requirements across all Trust’s inpatient wards, scheduling a Trustwide mental capacity audit in collaboration with the local health authorities, as well as scheduling a Trust wide S17 leave audit. A Task and Finish Group was formed to review CPFT’s seclusion policy and practice, develop training for staff and review the current seclusion facilities in order to ensure that they meet the standards outlined in the revised Code of Practice. This work is on going.

2.2.6. Data Quality and Information Governance
The Trust continues to operate within a robust information governance (IG) framework, incorporating training, communication and effective monitoring of IG issues. During 2015-16, there were two incidents classed as level 2 on the Information Governance Incident Reporting Tool. Both of these incidents were reported to the Information Commissioners Office and notifications of no action were received. Both incidents were thoroughly investigated and measures were put in place in order to learn the lessons, prevent and minimise recurrence.

CPFT submitted records during 2015-16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in published data:
- which included the patient’s valid NHS number was: 98.25% for admitted patient care
- which included the patient’s valid General Practitioner Registration Code 97.16% for admitted patient care

CPFT’s Information Governance Assessment Report overall score for 2015-16 was 82%, from 80% in 2014-15, and was graded GREEN

CPFT was not subject to the Payment by Results (PbR) clinical coding audit during the reporting period by the Audit Commission.

The Trust understands the importance of data completeness and data quality, and works continuously to assist in maintaining and improving our data asset. As outlined in our ICT (Information and Communication Technology) Strategy 2015-18, we have undertaken an extensive range of business intelligence projects, all aimed at supporting effective and efficient data management. The aim of this development is to ensure that data is managed, assured and delivered to the relevant user at the required time. Such projects cover a range of initiatives including personalised clinical dashboards, unified reporting reference data and consolidation of key data sources into a single data repository. On the other hand, the BI (Business Information) Strategy ensures that the quality and richness of information available to our clinicians, managers and commissioners will improve, and as such data completeness and quality will continue to grow. Benefits of this strategy are already materialising, and will continue to do so as the strategy matures.

CPFT will be taking the following actions to improve data quality:
- Continue to monitor lower impact incidents through the Information Governance Steering Group. Each incident is investigated, assessed, reported (where appropriate) and appropriate learning outcomes are taken forward.
- The Information Governance function will continue to proactively review, revise and reissue guidance where necessary.
2.2.7. Mandatory National Core Quality indicators

From 2012/13, all Trusts are required to report against a core set of quality indicators using data for the last two reporting periods provided by the Health and Social Care Information Centre (HSCIC). The indicators that are relevant to CPFT are listed below.

Table 4: Mandatory core quality indicators for 2015-16

<table>
<thead>
<tr>
<th>Quality Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care.</td>
</tr>
<tr>
<td>2. The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.</td>
</tr>
<tr>
<td>3. The percentage of staff employed by, or under contract to, CPFT who would recommend CPFT as a provider of care to their family or friends.</td>
</tr>
<tr>
<td>4. CPFT’s “Patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker.</td>
</tr>
<tr>
<td>5. The number and, where available, rate of patient safety incidents reported within CPFT, and the number and percentage of such patient safety incidents that resulted in severe harm or death.</td>
</tr>
</tbody>
</table>

We have made excellent progress on our performance on these five national quality indicators during the year, with improved scores on four of the five indicators compared to previous years.

Of particular note is the significant improvement in our National NHS Staff Survey 2015 score, which showed a 17% increase from the previous year at 62% compared with 45% in 2014 and a mere 4% gap between the CPFT score and the national average score for all combined mental health and learning disability hospitals of 66%.

Another point worth noting is the significant improvement in our rate of Patient Safety Incidents (PSIs) resulting in severe harm or death. This has gone down from 0.80% in the six-month period April 2014 – September 2014 to 0.40% in the period October 2014 – March 2015 and April 2015 to September 2015 compared to the national average of 1.06%. This is an excellent achievement for CPFT and demonstrates the results of all the hard work and commitment that our staff has put into improving the quality and safety of our services and interventions, and their resilience in the face of the challenges during the year. It is worth noting, however, that our data from 1 April 2015 is no longer comparable with national data which is reported under specific service type groupings whereas CPFT is now an integrated mental health, learning disability and community service.

We have also improved upon our compliance with CPA 7-day follow up and CRHT gatekeeping from the previous year, and have exceeded our targets.

On the other hand, our scores on the National Community Mental Health Survey on the questions relating to the patient experience of community mental health services indicator has gone down by 1-2% based on the raw scores, and 3-5% based on the standardised scores. We are disappointed with these results and are working with our clinical directorates to develop improvement actions to improve our performance in these areas.
1. Patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.

Follow up within 7 days of discharge has been demonstrated as an effective way of reducing the rate of suicide in the UK, and enables us to ensure that our patient’s needs are met and that they remain safe following discharge from hospital to community care.

<table>
<thead>
<tr>
<th>Table 5: CPA 7-day follow up 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>2015-16</td>
</tr>
<tr>
<td>CPFT figures</td>
</tr>
<tr>
<td>CPFT (HSCIC figures)</td>
</tr>
<tr>
<td>National average</td>
</tr>
<tr>
<td>Highest nationally</td>
</tr>
<tr>
<td>Lowest nationally</td>
</tr>
<tr>
<td>CPFT annual average</td>
</tr>
<tr>
<td>Target</td>
</tr>
</tbody>
</table>

*Based on CPFT quarterly figures.

Our performance during the year and in the previous year shows that our compliance rates are generally in line with the national average.

CPFT considers that this data is as described for the following reason: We have checked the HSCIC figures and can confirm that they correlate with the data submitted by CPFT during the reporting periods.

During the year, we have strengthened our reporting and monitoring processes and as a result, our compliance rates have remained consistently higher than the national target. This is a clear improvement on our performance from the previous year.

Actions we have taken include:
- Data cleansing of our patient caseloads resulting in more accurate reporting
- Improved data quality procedures, ensuring close collaboration between the clinical directorates and the Business Information and Performance team on the production of monthly figures
- Improved practice in relation to documentation of clinical activities
- Regular performance monitoring of key performance indicators, holding clinical directorates to account

These actions apply to both CPA 7-day follow up and CRHT gatekeeping indicators.
2. Admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

The Crisis Resolution and Home Treatment (CRHT) teams support patients and carers at home to prevent unnecessary admissions to psychiatric inpatient wards and facilitate early discharge. By assessing the patients before admission, CRHT teams help to ensure that the patient’s best interest is considered and determine whether inpatient care is the best option.

| Table 6: CRHT Gatekeeping 2015-16 |
|-------------------------------|-----------------|-----------------|-----------------|-----------------|
|                               | 2015-16         | 2014-15         |
|                               | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| CPFT figures                  | 95%| 97%| 99%| 99%| 95%| 95%| 98%| 98%|
| CPFT (HSCIC figures)          | 95%| 97%| 99%| 99%| 95%| 95%| 92%| 98%|
| National average              | 96%| 97%| 97%| 97%| 98%| 99%| 98%| 98%|
| Highest nationally            | 100%|100%|100%|100%|100%|100%|100%|100%|
| Lowest nationally             | 88%| 49%| 62%| 84%| 82%| 93%| 73%| 60%|
| CPFT annual average           | 98%*|96%*|
| Target                        | 95%| 95%|

* based on CPFT quarterly figures.

We have improved upon our performance during the year, particularly in the second half of the year where our compliance rates are higher than the national average at 99%.

CPFT considers that this data is as described for the following reason:
We have checked the HSCIC figures and can confirm that they correlate with the data submitted by CPFT during the reporting periods.

In addition to the actions taken to improve our compliance rates as outlined in the narrative to the CPA 7-day follow-up in the previous page, we increased the number of the night Duty Nursing Officers in relation to our section 136 suite to ensure that people who are assessed as needing admission into our adult inpatient units are gate kept by our CRHT team.

CPFT intends to take the following actions to improve the quality of its services by continuing with the following actions:
- regular monitoring of key performance indicators, holding clinical directorates to account and supporting them to achieve their targets and objectives
- close collaboration between the clinical directorates and the Business Information and Performance team on the production of monthly figures to improve data quality and timely reporting
- working with our commissioners to provide safe staffing levels

Note: These actions relate to both CPA 7-day follow-up and CRHT gatekeeping indicators.
3. **Staff employed by, or under contract to, CPFT during the reporting period who would recommend CPFT as a provider of care to their family or friends.**

This is taken from the National NHS Staff Survey which is intended to help NHS organisations review and improve staff experience so that they can provide better patient care. The results from the survey are also used by the Care Quality Commission (CQC) to monitor ongoing compliance with quality and safety standards.

Data for this indicator is taken from the question “*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*”.

**Table 7: Staff who would recommend CPFT as a provider of care to their family or friends**

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>CPFT</th>
<th>Average rates</th>
<th>Highest rates</th>
<th>Lowest rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mental Health and LD</td>
<td>Mental Health and LD</td>
<td>Mental Health and LD</td>
</tr>
<tr>
<td>2015</td>
<td>62%</td>
<td>66%</td>
<td>69%</td>
<td>75%</td>
</tr>
<tr>
<td>2014</td>
<td>45%</td>
<td>59%</td>
<td>66%</td>
<td>85%</td>
</tr>
<tr>
<td>2013</td>
<td>41%</td>
<td>59%</td>
<td>65%</td>
<td>85%</td>
</tr>
<tr>
<td>2012</td>
<td>39%</td>
<td>58%</td>
<td>63%</td>
<td>80%</td>
</tr>
<tr>
<td>2011</td>
<td>50%</td>
<td>58%</td>
<td>60%</td>
<td>83%</td>
</tr>
</tbody>
</table>

Our staff survey scores have steadily improved from 39% in 2012 to 62% in 2015, with a significant increase of 17% on the previous year's score.

Key initiatives, some of which have continued from the previous year include, among others:

- New Trust values
- Raising the profile of nurses through the Nursing Strategy and Nursing Forums
- Accessible senior leadership team, through ‘back to the floor, induction and ‘Aidan Answers’
- Ongoing cultural change being delivered through the Organisational Development Strategy
- Leadership and Management Development programmes
- Staff recognition - Staff Awards, Quality Heroes and Long-Service Awards
- Stop the Line, which is a mechanism for staff to raise an objection and literally stop something that is happening that impacts on patient safety
- Whistleblowing Line, which allows staff to report concerns confidentially
- ‘Wider Leadership Team meetings, Team Brief system and regular email updates from the Chief Executive to inform staff in current Trust developments
Outcomes speak for themselves, and while we can speculate which actions made the most impact on improving our staff survey scores this year, perhaps the best way to illustrate this is through the progress we have made on the following areas:

**KEY FINDING 4. Staff motivation at work**
((the higher the score the better) Scale summary score)
- Trust score 2015: 3.95
- Trust score 2014: 3.73

**KEY FINDING 17. Percentage of staff suffering work related stress in last 12 months**
((the lower the score the better) Percentage score)
- Trust score 2015: 44%
- Trust score 2014: 50%

**KEY FINDING 8. Staff satisfaction with level of responsibility and involvement**
((the higher the score the better) Scale summary score)
- Trust score 2015: 3.83
- Trust score 2014: 3.72

**KEY FINDING 10. Support from immediate managers**
((the higher the score the better) Scale summary score)
- Trust score 2015: 3.80
- Trust score 2014: 3.72

**KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff**
((the higher the score the better) Percentage score)
- Trust score 2015: 36%
- Trust score 2014: 28%

**KEY FINDING 7. Percentage of staff able to contribute towards improvements at work**
((the higher the score the better) Percentage score)
- Trust score 2015: 72%
- Trust score 2014: 67%

**KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month**
((the lower the score the better) Percentage score)
- Trust score 2015: 21%
- Trust score 2014: 28%

**KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice**
((the higher the score the better) Scale summary score)
- Trust score 2015: 3.74
- Trust score 2014: 3.48

**KEY FINDING 32. Effective use of patient / service user feedback**
((the higher the score the better) Scale summary score)
- Trust score 2015: 3.72
- Trust score 2014: 3.56

This said, we are not complacent and see the improvement in our results as part of an ongoing journey.

We know that there are areas we need to continue to improve upon, particularly when compared to other similar Trusts. These are presented overleaf.
We recognise that there are no quick fixes for these issues and as such, these are the areas that our over-arching strategy on quality improvement will focus upon (see section 2.1.1). During the year, we have worked with our staff and Trust Leads to develop strategies and improvement plans to address these areas, among other things.

We intend to take the following actions to improve the quality of our services:

- develop a Clinical Effectiveness Strategy that will focus on improving evidence and outcomes-based practice, as well as developing effective teams
- refresh our Research and Development Strategy to strengthen the culture of research across all professional groups to nurture an inquiring and research-focused workforce, and improve the processes for embedding knowledge into practice

These are nearing completion and will be launched in the summer of 2016/17.

In addition, we have developed a Trust Physical Health action plan to improve arrangements for physical health monitoring, treatment and support, which include actions for both patients and staff.

We have also updated our Workforce Strategy to further improve staff training, development opportunities, engagement and the health and wellbeing of staff; and continue to deliver on our Organisational Development Strategy. Please see section 3.3.6 (High Quality Workforce) for more information about the Staff Survey.
For 2015/16, there is a new requirement for Trusts to present their most recent NHS Staff Survey results for the indicators on:
- the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
- percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

The results below show that, whilst the national average and best 2015 scores for combined mental health/learning disability and community Trusts have gone down, we have seen small improvements in our performance in these areas.

**KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**

*The lower the score the better*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>21%</td>
</tr>
<tr>
<td>Trust score 2014</td>
<td>24%</td>
</tr>
<tr>
<td>National 2015 average for combined MH/LD and community trusts</td>
<td>21%</td>
</tr>
<tr>
<td>Best 2015 score for combined MH/LD and community trusts</td>
<td>16%</td>
</tr>
</tbody>
</table>

**KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion**

*The higher the score the better*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>85%</td>
</tr>
<tr>
<td>Trust score 2014</td>
<td>84%</td>
</tr>
<tr>
<td>National 2015 average for combined MH/LD and community trusts</td>
<td>89%</td>
</tr>
<tr>
<td>Best 2015 score for combined MH/LD and community trusts</td>
<td>92%</td>
</tr>
</tbody>
</table>

We are pleased with these results and will continue to build upon the good work we have done in the previous year to make further improvements in these areas in the coming year.
4. “Patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.

Between 2011 and 2013, this indicator used the weighted average for the following questions in the CQC survey of community mental health services:

*Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition…*
- …did the person listen carefully to you?
- …did this person take your views into account?
- …did you have trust and confidence in this person?
- …did this person treat you with respect and dignity?

National comparative data is presented below which shows CPFT scores being in line with the national average from 2011 to 2013.

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>CPFT</th>
<th>England average</th>
<th>Highest</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>84%</td>
<td>86%</td>
<td>92%</td>
<td>81%</td>
</tr>
<tr>
<td>2012</td>
<td>89%</td>
<td>87%</td>
<td>92%</td>
<td>83%</td>
</tr>
<tr>
<td>2011</td>
<td>87%</td>
<td>87%</td>
<td>91%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Due to the change in survey questions from the 2014 Community Mental Health Survey, HSCIC can no longer use the questions used in previous years to calculate an overall measure of mental health patient experience.

For the 2014 and 2015 surveys, we have presented two sets of data, taken from the national report produced by Quality Health Ltd., for the questions that are similar to those used in the previous years. These are the
- raw, unweighted scores which is designed to provide CPFT with an unadjusted view of how our service users have responded to the questions; and
- standardised, weighted scores that are used for comparative benchmarking designed to provide CPFT with an indication of how our scores rank when directly compared with the average scores

**Raw unweighted scores**

<table>
<thead>
<tr>
<th>Questions</th>
<th>2015</th>
<th>England average</th>
<th>2014</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely or to some extent felt that they were listened to carefully.</td>
<td>94%</td>
<td>93%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Definitely or to some extent involved as much as wanted to be in agreeing what care will be received</td>
<td>92%</td>
<td>73%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Always or sometimes treated with respect and dignity</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>94%</td>
</tr>
</tbody>
</table>

The scores above show a very small drop on two of the questions from the 2014 survey scores. However, these scores are still high and are higher or equal to the national average scores particularly in relation to involvement in planning their care.
## Standardised, weighted scores

<table>
<thead>
<tr>
<th>Questions</th>
<th>2015</th>
<th></th>
<th></th>
<th>2014</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CPFT</td>
<td>Lowest</td>
<td>Highest</td>
<td>CPFT</td>
<td>Lowest</td>
<td>Highest</td>
</tr>
<tr>
<td>Definitely or to some extent felt that they were</td>
<td>80.6%</td>
<td>75.9%</td>
<td>87.0%</td>
<td>86%</td>
<td>81%</td>
<td>86%</td>
</tr>
<tr>
<td>listened to carefully</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely or to some extent felt involved as</td>
<td>73.3%</td>
<td>66.5%</td>
<td>81.9%</td>
<td>78%</td>
<td>72%</td>
<td>78%</td>
</tr>
<tr>
<td>much as wanted to be in agreeing what care will</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>be received</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always or sometimes treated with dignity and</td>
<td>80.6%</td>
<td>80.6%</td>
<td>88.2%</td>
<td>86%</td>
<td>81%</td>
<td>86%</td>
</tr>
<tr>
<td>respect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The standardised weighted scores above show a 3-5% drop in our scores from 2014.

CPFT is currently developing improvement actions to address the areas with low and/or declining scores.

**CPFT intends to take the following actions to improve the quality of its services:**

- We will continue to work with our Clinical Directorates to develop actions for improvement, to focus on:
  - Out of hours contact (knowing how to access)
  - Support/advice on physical needs/accommodation/employment/finance
  - Formal meeting to review care in the last 12 months

Refer to 3.1.3 for more details about the results of the 2015 National Community Mental Health Survey.
5. **The number, and where available, rate of patient safety incidents reported within CPFT during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.**

The data reported in the HSCIC (Health and Social Care Information Centre) indicator portal, which is derived from the NRLS (National Reporting and Learning System), are presented in six month periods up to September 2015. The national data for October 2015 – March 2016 is not yet available.

For the purpose of this report,
- we have only taken figures reported by mental health (MH) providers that have submitted six months’ worth of data per 1000 bed days in the relevant reporting periods for consistency purposes.
- Calculations of national averages are based on a simple average method,
- Organisational data presented for the highest and lowest scores are based on the total number of Patient Safety Incidents (PSIs) that resulted in severe harm or death.

CPFT considers that the data presented in this section is as described for the following reasons:
- The data is taken from the NRLS and has been verified by them up to period September 2014.
- Agreement of the figures for severe harm and death reported by NRLS against CPFT figures submitted into the NRLS system via Datix, our electronic incident reporting system.

CPFT has taken the following actions to improve this **0.40%** (rate of patient safety incidents that resulted in severe harm or death in April – September 2015), and so the quality of its services, by:
- Improving the processes involved in the development of improvement actions from Serious Incidents (SIs) and embedding change to improve the quality of services provided
- Continuing with the programme of training for Root Cause Analysis (RCA) for SI investigators to ensure the quality of the investigation process
- Ensuring the correct membership in the newly established Suicide Prevention Strategy Group to ensure our services are providing interventions that are in line with evidence-based practice
- Continuing to work with our local partners in suicide prevention to ensure actions are aimed towards a common goal and obtain maximum impact in our local health economy
**Number and rate of patient safety incidents (PSIs)**

**Table 11: Number and rate of PSIs, HSCIC data**

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Number of PSIs</th>
<th>Rate of PSIs per 1000 bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr15-Sep15</td>
<td>3837</td>
<td>2563</td>
</tr>
<tr>
<td>Oct14-Mar15</td>
<td>3266</td>
<td>2894</td>
</tr>
<tr>
<td>Apr14-Sep14</td>
<td>3058</td>
<td>2544</td>
</tr>
<tr>
<td>Oct13-Mar14</td>
<td>2723</td>
<td>2344</td>
</tr>
<tr>
<td>Apr13-Sep13</td>
<td>2396</td>
<td>2306</td>
</tr>
</tbody>
</table>

Figures 4 and 5 above show an increasing number and rate of reported incidents for CPFT. The significant increase in the number of incidents reported in the period April to September 2015 is due to the additional incidents reported by the new services that transferred to CPFT on 1 April 2015.

It is worth noting that our data from April 2015 is no longer comparable with the national data reported by NRLS and HSCIC which is reported under specific service type groupings whereas CPFT is now an integrated mental health, learning disability and community service.

National data is reported under the following service type groupings:
- Acute and general
- Ambulance
- Mental health
- Learning disability
- Community nursing
- Community optometry
- Community dentistry

Despite this, our number and rate of PSIs are still below the highest figures reported by organisations under the mental health grouping. As of the latest report published by NRLS for the period April to September 2015, CPFT remains in the highest quartile of reporting mental health organisations in the country. NRLS considers this as being reflective of a mature patient safety culture in CPFT where staff are encouraged to report incidents in order to learn from them.
An analysis of our reported incidents shows that a significant proportion of our reported incidents for the period April to September 2015 consist of

- 'no harm' (62.2%, n=2387) which is the same as the average for all mental health organisations.
- 'low harm' (29.3%, n=1126) incidents, and
- 'moderate' (8%, n=309).

This is consistent with previous years' reports.
On the other hand, while the number of PSIs reported by CPFT has increased significantly, Table 12 below shows that the number of PSIs resulting in severe harm or death is well below the national average.

Moreover our rate of PSIs resulting in severe harm or death has been steadily going down since the 6-month period between April and September 2014, and is now less than half of the national average at 0.40%

This is an excellent achievement for CPFT and demonstrates the results of all the hard work and commitment that our staff has put into improving the quality and safety of our services and interventions, and their resilience in the face of a very challenging year.

Table 12: Patient Safety Incidents (PSIs) that resulted in severe harm or death per 1000 bed days (NRLS/HSCIC figures)

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Severe harm</th>
<th>Death</th>
<th>Total</th>
<th>SH and D %</th>
<th>Rate (SH and D)</th>
<th>Ave Total SH and D</th>
<th>Total SH and death</th>
<th>% Rate (SH and D)</th>
<th>Total SH</th>
<th>% Rate (SH and D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct15-Mar16*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr15-Sep15# (HSCIC)</td>
<td>14</td>
<td>1</td>
<td>15</td>
<td>0.40%</td>
<td>25</td>
<td>1.06%</td>
<td>97</td>
<td>3.00%</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Oct14-Mar15# (HSCIC)</td>
<td>10</td>
<td>3</td>
<td>13</td>
<td>0.40%</td>
<td>24</td>
<td>1.07%</td>
<td>93</td>
<td>1.80%</td>
<td>4</td>
<td>0.30%</td>
</tr>
<tr>
<td>Apr14-Sep14 (HSCIC)</td>
<td>20</td>
<td>4</td>
<td>24</td>
<td>0.80%</td>
<td>24</td>
<td>1.13%</td>
<td>87</td>
<td>1.50%</td>
<td>2</td>
<td>0.30%</td>
</tr>
<tr>
<td>Oct13-Mar14 (HSCIC)</td>
<td>9</td>
<td>12</td>
<td>21</td>
<td>0.78%</td>
<td>24</td>
<td>1.18%</td>
<td>88</td>
<td>1.50%</td>
<td>2</td>
<td>0.20%</td>
</tr>
<tr>
<td>Apr13-Sep13 (HSCIC)</td>
<td>13</td>
<td>15</td>
<td>28</td>
<td>1.20%</td>
<td>28</td>
<td>1.21%</td>
<td>94</td>
<td>1.42%</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

* Data not yet available as of the date of the report
# Data published by NRLS and HSCIC in 2015-16

The data in Table 12 above are represented in Figures 6 and 7 below.

Figures 6 and 7: PSIs resulting in severe harm or death

Learning from Serious Incidents (SIs)
We are committed to continually improving the safety of the services we provide to our patients, and we recognise that one way of doing that is to ensure that SIs are identified correctly, investigated thoroughly and most importantly, trigger actions that will prevent them from happening again. Examples of learning that have emerged from SI investigations are outlined overleaf.
Documentation
- The need to improve the quality, accuracy and timely documentation in records, including risk assessments as well as highlighting any previous and current risks.
- The need for clearer guidance for staff in relation to the implementation of the Care Programme Approach (CPA)
- Ensuring that all entries in the electronic patient records system (e.g. RiO, SystmOne), including care plans and assessments, are updated in a timely manner.
- Ensuring that letters and all correspondence are uploaded in a timely manner.

Carer involvement - ensuring
- records are updated to reflect relevant family contact details.
- involvement of families and carer in the assessment and treatment of the patient
- carers are supported, appropriately signposted and referred to services in a timely manner.

Communication - ensuring
- clear, accurate and timely communication between CPFT teams and other healthcare professionals, and between CPFT and GPs (General Practitioners).
- engagement of relevant external agencies to support patients (e.g. Drug & Alcohol services, MIND, YMCA)

Administration
- The need for adequate administrative support for clinicians to enable them to focus on clinical work

Examples of some of the actions taken include:
- Changes made in RiO to show CPA reviews due for renewal within the next month (5-month report)
- Development of standard operating procedures (SOPs) to ensure consistency in booking CPA reviews and a clear system is in place to indicate non compliance, postponed CPA reviews and rescheduling.
- Delivery of falls training to all ward staff focusing on what to do when finding someone has fallen (Falls Protocol)
- Development of staff guidance for staff regarding the safe use of text messaging within the team

We have also implemented the Triangle of Care in the Trust (see section 2.1.2). Key principles required to achieve better collaboration and partnership with carers in the journey through health services are:
- Identification of carers and the essential role they play at first contact or as soon as possible thereafter
- Staff are ‘carer aware’ and trained in carer engagement strategies
- Ensuring that policy and practice protocols on confidentiality and information sharing are in place
- Provision of a carer introduction to the service, with a relevant range of information across the care pathway

CPFT has launched the Carers Charter to ensure its services meet the needs of carers. The charter formally recognises the important role carers play in supporting patients, while ensuring that their own needs are met.
3. CPFT Quality Performance Indicators

In this section, we present our performance on key areas that provides a snapshot of the quality of our services. These form part of our quality and safety dashboard, reported and monitored monthly at Directorate and Board level, and serves as an early warning system to enable us to act in a timely manner to ensure we continually safeguard the safety and wellbeing of the people who use our services.

It is worth noting that the number of patients we provided services to increased significantly in 2015-16 following the transfer of services on 1 April 2015, from around 30,000 in 2014/15 to around 52,000 in the mental health services which include the increase in the number of patients seen by our Psychological Wellbeing Service (IAPT), and around 106,000 from the services transferred to CPFT. This accounts for the increase in the number of activities presented in this section.

3.1 Patient Experience

3.1.1 PALS (Patients Advice and Liaison Service)
PALS provide impartial and confidential advice, support and information on health-related matters and provide a point of contact for patients, their families and their carers. PALS will also receive feedback about CPFT and help to resolve concerns locally where this is possible. If necessary, concerns that cannot be resolved quickly and informally will be escalated to the complaints team. It is worth noting that while the PALS and complaints functions in CPFT are separate, the two services are co-located in the same office which enables close joint working across the two services.

PALS provide us with the opportunity to use the information gained from comments and feedback from our patients and their carers to make improvements to our service.

The number of PALS contacts in 2015-16 was 582 compared to 449 in 2014-15 which represents a 30% (n=133) increase from the previous year. This is largely due to those received from the new services acquired by CPFT in April 2015.

Some of the improvements we have made from learning from PALS include:

- Harmonising the PALS systems and processes between CPFT and Adult and Older people’s service that was transferred to CPFT in April 2015
- Introducing an electronic link to the PALS service on the public facing website to provide an additional route for patients, family and the public to provide feedback
- Improving staff communication by introducing training to administrative staff in the Personality Disorder Pathway

3.1.2 Compliments

We value positive feedback from the people who use our services as this helps us to see our services through their eyes and in doing so validates everything that we do to improve the lives of our patients and their carers and tells us what we are doing right. Whether these are in the form of letters, cards or verbal expressions of thanks and gratitude,
During 2015/16, a total of **2,565** compliments and positive feedback were recorded compared with 124 in the previous year. The significant increase is due to the change in recording and collecting this data.

From October 2015, compliments and positive feedback received through the patient experience surveys for the question “*What has been good about the service you have received?*” have been routinely included in our compliments data to provide a more accurate picture of positive feedback. Prior to this, only compliments reported to and recorded by the PALS team were included.

*Figure 9 Compliments & Positive Feedback 2015-16*

During 2015/16, a total of 2,565 compliments and positive feedback were recorded compared with 124 in the previous year. The significant increase is due to the change in recording and collecting this data.

From October 2015, compliments and positive feedback received through the patient experience surveys for the question “*What has been good about the service you have received?*” have been routinely included in our compliments data to provide a more accurate picture of positive feedback. Prior to this, only compliments reported to and recorded by the PALS team were included.

*Figure 9 Compliments & Positive Feedback 2015-16*

During the year, we developed a patient survey questionnaire for the Integrated Care services, and this has been in use from January 2016. This explains the further increase in the number of compliments recorded in the period January to March 2016 above.

“To all you lovely people at Willow Ward, Thank you for looking after my husband. You have all been so very kind and helpful not only to him but to all of our family. Willow Ward is not only friendly but it is also very clean and tidy.”

*Figure 10 Compliments by Directorate Q4 2015-16*

During the year, we developed a patient survey questionnaire for the Integrated Care services, and this has been in use from January 2016. This explains the further increase in the number of compliments recorded in the period January to March 2016 above.

“To all you lovely people at Willow Ward, Thank you for looking after my husband. You have all been so very kind and helpful not only to him but to all of our family. Willow Ward is not only friendly but it is also very clean and tidy.”

*Figure 10 Compliments by Directorate Q4 2015-16*

Figure 10 shows that 59% (n=1031) of the compliments recorded in Q4 came from the Integrated Care services, with Adults coming second at 19% (n=341), Children at 16% (n=101) and Specialist services at 6% (101).

It must be noted that our Specialist services include the learning disability, eating disorder, complex cases, prison and forensic services.
3.1.3 Mental Health Community Survey (national)

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used their local health services for feedback about their experiences.

The comparative data for the 2015 Mental Health Community Survey presented in this report is from 48 Mental Health Trusts (MHTs) and Community Healthcare Providers with mental health functions surveyed by Quality Health (83% of the total number of MHTs). More than 13,500 responses were received, a response rate of 29% nationally. CPFT had a response rate of 32% (261 usable responses from a sample of 850).

Table 13 below show the questions where our scores were in the highest scoring 20% of the participating Trusts.

Table 13: Areas with highest scoring 20% of Trusts, Community MH Patient Survey 2015

<table>
<thead>
<tr>
<th>Highest 20% scoring questions of MH Trusts</th>
<th>2015</th>
<th>2014</th>
<th>Highest Trust score</th>
<th>Change from 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crisis care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q22. Definitely or to some extent got the help from out of hours team</td>
<td>70%</td>
<td>57%</td>
<td>78%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Treatments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q26. Definitely or to some extent given understandable information about prescribed medicines</td>
<td>76%</td>
<td>69%</td>
<td>80%</td>
<td>↑</td>
</tr>
</tbody>
</table>

We are committed to the principles of recovery and person-centred care, and this shows that our patients feel they are involved in their care and are working collaboratively with our teams and clinicians who are responsible for their care.

We are very happy and proud of these results and would like to thank our staff for all the work they have done in bringing our values to life by constantly seeking to improve the service and support that we provide to the people who use our services.

On the other hand, there are several areas where our scores were in the lowest scoring 20% of participating Trusts, as shown in Table 14 below.

Table 14: Areas with lowest scoring 20% of Trusts, Community MH Patient Survey 2015

<table>
<thead>
<tr>
<th>Lowest 20% scoring questions of MH Trusts</th>
<th>2015</th>
<th>2014</th>
<th>Highest Trust score</th>
<th>Change from 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Health and Social Care Workers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q5. Definitely or to some extent given enough time to discuss needs or treatment</td>
<td>72%</td>
<td>80%</td>
<td>80%</td>
<td>↓</td>
</tr>
<tr>
<td><strong>Organising Your Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9. Know how to contact the person in charge of organising your care</td>
<td>94%</td>
<td>96%</td>
<td>99%</td>
<td>↓</td>
</tr>
<tr>
<td><strong>Reviewing Your Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q14. In the last 12 months had formal meeting to discuss care</td>
<td>60%</td>
<td>75%</td>
<td>87%</td>
<td>↓</td>
</tr>
</tbody>
</table>
In addition, our scores on the questions around medication information and management were comparable with the mid 60% range of Trusts, with the exception of the question on medication review which is in the highest scoring 20% of the participating Trusts (see above).

The three key areas that we need to improve upon are identified below, and we have taken/will take the following actions:

- **Out-of-hours/crisis contact**
  - We have increased staffing levels in our Crisis Resolution and Home Treatment (CRHT) teams.
  - We are also reviewing our out-of-hours service and will aim to work collaboratively with the third sector and local agencies. As the current service has not been formally commissioned, any plans for future development and funding requirements for this service will be taken forward with our commissioners.

- **Involvement and engagement of family and carers**
  - We developed a training programme for patient and carer involvement in conjunction with the Recovery College East and this will be delivered quarterly. The first session took place on 21 March 2015 with very positive feedback.
  - We have established a transformations project to develop better support for carers. We are also working towards achieving the Triangle of Care ‘Quality Mark’ for CPFT.

- **Medication information and management**
  - We have reviewed and updated our policies and procedures on medicines management, particularly in the community, and have expanded our annual audit on medicines management to the community teams to identify areas for improvement.
  - We have developed and are implementing a shared decision making policy following the completion of a research project about shared decision making in medicines management. General medicines information folders have been developed for wards and community team bases and teams have been given awareness training about the importance of shared decision making, giving information and regular reviews.

---

### Treatments

<table>
<thead>
<tr>
<th>Question</th>
<th>72%</th>
<th>82%</th>
<th>86%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q28. Medicines have been reviewed in last year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Areas of Life

<table>
<thead>
<tr>
<th>Question</th>
<th>36%</th>
<th>45%</th>
<th>58%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q32. Definitely or to some extent given advice about finances or benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. Definitely or to some extent given advice about finding or keeping work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q34. Definitely or to some extent given advice about finding or keeping accommodation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

3.1.4 **Meridian Patient Experience Survey (CPFT)**

We conduct our own internal monthly patient survey (Meridian) which in addition to having core questions across CPFT, building on the principles of the national patient surveys is also reflects the specific characteristics of our different service types to give our services the opportunity to ask questions in the areas that are important to them. This provides us with important feedback to help us identify the areas where we can improve our services.
The highest and lowest ranking questions for the patient surveys are shown below. The scores are based on the responses to all the questions within these surveys and therefore do not take into account any survey question variances.

**Inpatient survey**

Table 15 Highest scoring questions 2015-16 (Meridian patient survey)

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1*</th>
<th>Q2*</th>
<th>Q3*</th>
<th>Q4**</th>
<th>Total (April 15 Mar 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff polite and friendly?</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>Do you feel you are treated with respect and dignity by our staff?</td>
<td>95%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>When you arrived on the ward, did staff make you feel welcome?</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Do you know what your medication and or treatment, prescribed by this ward is for?</td>
<td>95%</td>
<td>96%</td>
<td>92%</td>
<td>89%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Table 16 Lowest scoring questions 2015-16 (Meridian patient survey)

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1*</th>
<th>Q2*</th>
<th>Q3*</th>
<th>Q4**</th>
<th>Total (April 15 – Mar 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you rate the food on the ward?</td>
<td>67%</td>
<td>64%</td>
<td>65%</td>
<td>72%</td>
<td>67%</td>
</tr>
<tr>
<td>Were you told about possible side effects of medication prescribed by this ward?</td>
<td>77%</td>
<td>75%</td>
<td>70%</td>
<td>64%</td>
<td>71%</td>
</tr>
<tr>
<td>Are there activities, groups or things to do during the evening and weekend?</td>
<td>74%</td>
<td>75%</td>
<td>75%</td>
<td>63%</td>
<td>72%</td>
</tr>
<tr>
<td>Has a member of staff talked to you about keeping healthy (diet, exercise, drinking, smoking, taking drugs?)</td>
<td>81%</td>
<td>79%</td>
<td>76%</td>
<td>69%</td>
<td>76%</td>
</tr>
</tbody>
</table>

* Q1 - Q3 excludes AOP services/Integrated Care Directorate as no there are no comparable questions.  
** Q4 includes Integrated Care Directorate data

**Community survey**

Following the transfer of the adults’ and older people’s services from Cambridgeshire Community Trust (CCC) to CPFT on 1 April 2016, the internal surveys for these teams were aligned with the rest of CPFT teams from January 2016. In some instances Q4 figures indicate lower scores that would ordinarily be expected for these particular questions. These areas have been identified and work will be undertaken in the coming year to improve satisfaction.

Common themes in the highest ranking questions in both inpatient and community survey results for 2015-16 shows that our patients feel our staff are polite and friendly and that they are treated with dignity and respect, and we would like to thank and commend our staff for these outstanding results.

On the other hand, there are clearly areas that we need to focus on in order to improve the experience of our patients. It is worth noting, however, that the lowest ranking questions in the community patient survey are still relatively high scores.
<table>
<thead>
<tr>
<th>Table 17 Highest scoring questions 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
</tr>
<tr>
<td>Are staff are polite and friendly?</td>
</tr>
<tr>
<td>Do you feel you are treated with respect and dignity by our staff?</td>
</tr>
<tr>
<td>Are you helped to make choices about your care/treatment/therapy?</td>
</tr>
<tr>
<td>Rate care received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 18 Lowest scoring questions 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
</tr>
<tr>
<td>Do you have a plan of care/treatment/therapy?</td>
</tr>
<tr>
<td>Were you told about the possible side effects of medication prescribed by this team?</td>
</tr>
<tr>
<td>Have you been provided with an out of hours contact number/know who to contact?</td>
</tr>
<tr>
<td>Have you had a meeting to review your care/treatment/therapy?</td>
</tr>
</tbody>
</table>

*Q1 - Q3 excludes AOP services/Integrated are Directorate as there are no comparable questions.

**Q4 includes Integrated Care Directorate

Below are examples of actions our teams have taken in response to feedback from our patients.

**Ward activities**
- In response to feedback that there are insufficient activities available on some wards, especially in evenings and weekends, wards have purchased extra resources such as table tennis, board games and are planning introduction of Tai Chi sessions. CPFT’s volunteer service has commenced focused recruitment of volunteers to cover evenings and weekends for these wards.
- Wards on Springbank ward spending more time engaged in meaningful activities with patients
- Extended visitor times for families and visitors for Mulberry 3
- Mulberry 2 ward has introduced film nights for its patients.

**Patient food**
- In response to food experience feedback, food menu rotations have been improved to reduce repetitiveness of meal items and local cooking groups have introduced to allow better choice of food.
- Maple ward has made available to its patients a substantial range of supper snack food in the evening in addition to the routine meals.
Environment Improvements

- Environments in some of the outpatient areas have been improved to include the provision of more information on medication and their side effects and pocket sized cards for patients to take with them on how to access information on medication. Some areas have been re-decorated and environments enhanced by new pictures and TV screen installed to provide useful information.
- In response to feedback about lack of Wi-fi and reading material in waiting areas for children’s services, Wi-fi and more reading materials have been introduced.
- A radio, photo board, leaflets and posters are now in situ in the reception area of Personality Disorder Community Service in response to comments that it was somewhat dull.
- Care co-ordinators / discharge planning:
- In response to feedback that service users do not always know who their care coordinator or doctor is, welcome letters now include this information
- Two new workshops were co-produced with peer support workers and Recovery College East, focussing on moving on from PDCS (Personality Disorder Community Service). These will run in both localities in the fortnight prior to person’s discharge.

Staffing

- Staffing establishments have increased for wards
- Additional administrative staff are now in post for the PDCS. In addition, training for administrative staff has been delivered that focused on improving understanding of the needs and difficulties faced by those diagnosed with a personality disorder
- Additional day of Consultant time was introduced in the PDCS to help reduce the waiting times for medication reviews.

3.1.5 Mental Health Act (MHA) Reading of Rights

All patients, irrespective of their status must be informed of their rights. The information should be given in a language and manner that best enables the patient to understand it.

Detained patients in particular have a legal right under the MHA 1983 to be informed of their legal situation and rights. There is also a legal duty under Article 5(2) of the Human Rights Act 1988 to inform a patient of the reasons for their detention.

Compliance with Reading of Rights is reported and monitored monthly through our quality dashboard.

The Trust continues to achieve a high level of compliance with the process of reading and reminding patients of their rights. This year, we achieved 97% compliance overall.

Ensuring patients are aware and understand their rights under the Mental Health Act remains a priority of the Trust and we will continue to work with our teams to improve the Reading of Rights process and ensure that information is available to patients in easy-read version, as well as different languages.
3.2 Patient safety

3.2.1 Complaints

‘A health service that does not listen to complaints is unlikely to reflect its patients’ needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment.’ Francis report, 2013

We are committed to ensuring that formal complaints are used as an opportunity to learn and improve the services provided to patients, relatives and carers.

The number of complaints received in 2015-16 increased by 15% (n=24) as compared to the previous year. This can be attributed to complaints relating to the new services acquired by CPFT in the year.

The adults’ and older people’s services from CCS were integrated into CPFT’s older people’s directorate on 1 April 2015 to form the new Integrated Care Directorate (ICD). Complaints relating to these services have been managed in line with CPFT’s policy since that date. Figure 13 below shows that the Integrated Care Directorate received 30 more complaints in 2015-16 compared to the previous year, while the number of complaints received by the other Clinical Directorates has largely remained the same.

A total of 188 complaints were closed in 2015-16. Of these, 34 were upheld and 46 were partially upheld, representing 43%; while 10 were undetermined, 24 were withdrawn and 74 were not upheld, representing 57%.

The top five subjects of complaints are:

- quality of care
- access to service
- issues specific to mental health services
- communication
- staff attitude
3.2.2 Prevention of suicide and self-harm
Suicide is preventable and we believe that good care can make a vital difference in the outcome for people with suicidal intent.

The number of suicide and possible suicide incidents in CPFT increased during 2015-16 with a total of 47 compared with 32 in the previous year, representing a 47% increase from the previous year.

It is worth noting that only nine of these have been confirmed as a suicide by the coroner as of 31 March 2016.

There has been no specific cause identified for the increase in the year.

As part of our commitment to improve the quality and safety of our services, we developed a Trust Suicide Prevention Strategy, and worked in partnership with a number of agencies to implement a joint Cambridgeshire and Peterborough Suicide Prevention Strategy in 2013. We also undertake an annual Suicide Prevention audit in line with the recommendations of the National Suicide Prevention Strategy.

The results of the most recent audit completed in 2015, based on examination of records of 100% of the confirmed and probable suicides during 2013/14 and 2014/15, showed that our suicide rates and characteristics are generally in line with national trends (National Confidential Inquiry into Suicide and Homicide annual report 2015). Moreover, an audit undertaken by NHS England in late 2015 showed that CPFT is not an outlier in terms of suicide rates in the region.

Table 19: Number of suicides in CPFT by gender, 2014 and 2015

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</thead>
<tbody>
<tr>
<td>Male</td>
<td>20</td>
<td>20</td>
<td>21</td>
<td>21</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>74%</td>
<td>74%</td>
<td>58%</td>
<td>72%</td>
<td>50%</td>
<td>64%</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>7</td>
<td>15</td>
<td>8</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>26%</td>
<td>26%</td>
<td>42%</td>
<td>28%</td>
<td>50%</td>
<td>36%</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>27</td>
<td>36</td>
<td>29</td>
<td>32</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 20: Number of suicides in the general population (UK) by gender, NCSIPH annual report 2014 and 2015

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3443</td>
<td>3430</td>
<td>3428</td>
<td>3312</td>
<td>3202</td>
<td>3232</td>
<td>3474</td>
<td>3304</td>
<td>3292</td>
<td>3442</td>
<td>3728</td>
<td>3371</td>
</tr>
<tr>
<td></td>
<td>74%</td>
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* Indicates the final estimated number based on delays recorded in previous years
Tables 19 and 20 show that the male to female ratio of deaths by suicide in CPFT patients is 3:1 in 2010/11, 2011/12 and 2013/14, which is generally in line with national trends (national data only available up to 2013, NCISH July 2015). CPFT data has deviated from the national trend in 2012-13 (3:2), 2014-15 (1:1) and 2015-16 (2:1).

While it remains to be seen whether national figures will mirror the deviation from the historical trend in 2014 and 2015, we will explore the possible reasons behind this internally in more detail as part of our annual audit of suicide prevention.

The audit completed in 2015 identified areas of good practice, which include:
- documentation relating to dependent children improved from 50% in 2013/14 to 100% in 2014/15
- clear improvements in documentation around risk assessments in 2014/15, particularly in nCPA patients. Documentation of planned interventions in relation to the management of risks also showed a significant improvement in 2014/15 particularly in relation to nCPA patients
- significant improvement in practice around sharing of information about the patient’s care with other agencies, particularly around doing this in a timely manner

The audit also identified areas that require improvement. Actions we have/are taking include
- review of the training on risk assessment
- establishing a Suicide Prevention Group that will have the primary responsibility for reviewing the results of the suicide prevention audit and other pieces of work related to self harm, as well as developing and overseeing the implementation of actions.
- ensuring proper implementation of the Care Programme Approach (CPA) principles as set out in the Care Planning Policy

We are currently in the data collection stage of the 2015/16 audit. The findings of this audit will inform the ongoing development of the Trust’s Suicide Prevention action plan.

Key recommendations from the second annual report on the cross-government suicide prevention strategy (DH February 2015) which are relevant to CPFT include:
- providing services that are more appropriate for men and ensuring information about depression and services are available in ‘male’ settings.
- ensuring health services know the options for someone at risk of suicide because of economic difficulties, from debt counselling to psychological therapy.
- working with parents and schools in keeping children and young people safe online, and ensuring there are appropriate supports for young people in crisis who are at risk of self harm.
- effective assessment and management of self-harm, particularly in Emergency Departments, to reduce repetition of self-harm and future suicide risk.

Actions specific to mental health services in the cross-government suicide prevention strategy which we already have in place include:
- providing specialist community mental health services such as crisis resolution home treatment teams, assertive outreach and services for people with dual diagnosis.
- ensuring implementation of the NICE guidance on depression which is linked with falling patient suicide rates.
- ensuring physical safety and reducing absconding on inpatient wards.
- creating a learning culture based on multidisciplinary review.
3.2.3 Physical assaults
The effective management of violence and aggression in our hospital settings is one of the factors that contribute to the provision of a safe environment for both our patients and staff.

Figures 16 shows a 25% (n=101) increase in the number of patient assaults in 2015-16 from the previous year, following a 3-year period of declining number of incidents.

The majority of the reported incidents are from the adult inpatient wards, including our psychiatric intensive Care Unit (PICU) and an inpatient dementia ward. This high incident rate resonates with the nature of the client group in these services.

Figures 17 shows that a majority of the reported physical assault incidents are ‘no/low/minimal harm’.

We recognise that this is an area that we need to focus upon as it has a significant impact on the patient’s experience of their stay in our inpatient units.

We have identified this as a quality priority for improvement for 2016-17 and we will work with our clinical teams on strategies to reduce the number of incidents relating to physical assaults in our inpatient units.

3.2.4 Physical Health Assessments
Research shows that people with mental health conditions suffer from high rates of physical illness, much of which often goes undetected. There are a number of lifestyle factors which make patients with mental health conditions more vulnerable to poor physical health – they tend to have poorer diets, smoke more and take less exercise. Moreover, certain antipsychotic medication can cause weight gain, which may result in type 2 diabetes. It is therefore unsurprising that morbidity among people with mental health problems is high.

The importance of good quality and timely physical health assessments in people with mental health conditions cannot therefore be overstated. It supports the prevention, detection and treatment of physical health problems in people with mental health conditions, and ensures the provision of safe, effective care.

In CPFT we set a target of 95% for the completion of physical health examination within 24 hours of admission into an inpatient unit.
In January 2015, we made some changes to the RiO electronic patient records system following an audit undertaken in the previous year to enable clinicians to document patient refusal of physical health examination and therefore present a more accurate picture of practice. This was publicised again in March 2015 to increase staff awareness of the change in the patient records system.

From a baseline of 86% in March 2015, compliance dipped in April 2015 but then increased steadily for the rest of the year, reaching 99.4% as of the end of March 2016.

This is testimony to the hard work and dedication of our staff in improving the quality of care to our patients.

One of the areas that we need to improve upon is in relation to practice and documentations of assessments of the cardio metabolic risk factors in patients with psychoses – see section 3.3.

- smoking status
- Lifestyle, including diet, exercise, alcohol and drugs
- Body mass index
- Blood pressure
- Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
- Blood lipids

We appointed a half time Trust Physical Health Lead in November 2015, and we have developed an action plan to improve physical health monitoring arrangements in our mental health services, particularly in our community services. We also established a Physical and Mental Health Strategic Group to lead on the implementation of the action plan. Improvement actions include:

- Updating the Physical Healthcare Policy and manual
- Developing health and wellbeing standards in order to provide staff with guidance, which includes developing a ward admission standard operating procedure.
- Developing Physical Health Champions in inpatient and community teams
- Improving training package for staff on physical health matters

We are also working closely with our commissioners and local primary care services to develop enhanced primary care mental health services in the community (See section 2.2.1, actions for CQUIN 4a and 4b audits.)
3.2.5 Reducing Healthcare Associated Infections (HCAI)

Infection Prevention and Control (IPaC) remain a priority for CPFT and we have robust systems in place to ensure that our patients are cared for with compassion and dignity in clean, safe environments.

We acquired two members of staff as part of the transfer of services from CCS on 1 April 2015, bringing the total members of staff in the IPaC team to three during 2015-16. This has made a significant difference to the level of service and support provided to our clinical services during the year to ensure compliance with infection control standards.

On the other hand, due to the changes in CPFT at the beginning of the year, 2015-16 data is not directly comparable with data from previous years; however a review of our IPaC data over the year shows that the incidence of health care associated infections remains low throughout CPFT.

HCAI incidents in a snapshot
- No ward closures during the year due to diarrhea and/or vomiting.

Compliance with IPaC training has steadily improved over the years as shown in Figure 19 above, at 91% in 2015-16. However, we recognise that this is still below the level from TNA (Training Needs Analysis) and this is being managed as part of the mandatory Training programme by Learning and Development. The IPaC Team provide both face-to-face training and e-learning programmes.

Key measures that we have in place for IPaC are:
- Merging of IPaC services and members of the Team transferred in from CCS
- Embedding IPaC in all areas of CPFT
- All in-patient areas have had an environmental audit and all audits have produced action plans
- The Essential Steps audit, which looks at compliance with standards around hand hygiene, personal protective equipment, aseptic techniques and sharps, is undertaken by all inpatient areas on a monthly basis.
- MRSA screening of all in-patients with swabbing taking place where indicated as per Trust policy
- Monitoring of MRSA positive patients, ensuring appropriate decolonisation and care
- Contacting all in-patient areas either via a visit or phone call on a minimum of a weekly basis to remain informed of any issues/concerns
- Maintenance of an IPaC database of telephone/visit information about areas and patients.
- Face-to Face training on IPaC is provided at induction and when requested by teams. This is supplemented by e-learning modules which have been updated during the year.
• All areas have an IPaC link worker and the link workers programme runs successful, informative training days. The link workers are a valuable resource aiding communication to and from the IPaCT
• Participation in PLACE (Patient Lead Assessments of the Care Environment)
• Working closely with the Estates Department in relation to water safety, especially in relation to legionella monitoring.

3.2.6 Flu Campaign
CPFT is required to vaccinate front line staff to protect them and our service users from influenza. This year our overall vaccination rate was 61.9% compared with 51% in 2014-15. The increase can be attributed to the increase in the IPaC team.

Priorities for improvement for 2016-17 are:
• To continue to embed infection prevention and control throughout CPFT
• Continue the provision of a high visibility and accessibility of Infection Control team
• To increase the number of staff vaccinated against seasonal Flu to meet the Government target of 75%
• Continue to monitor ‘alert organisms’ and advise clinical areas accordingly
• To support CPFT in ensuring all staff are appropriately trained to use safety devices to reduce the risk of contaminated sharps.
• To roll out the hand hygiene audit programme to augment the Essential steps audit process, this will ensure all staff working in clinical areas have a practical yearly assessment of their hand hygiene technique and to ensure they conform with ‘bare below the elbows’

3.2.7 MRSA Screening
MRSA (methicillin-resistant staphylococcus aureus), sometimes referred to as a ‘super bug’, is a type of bacterial infection that is resistant to a number of widely used antibiotics. MRSA infections are more common in people who are in hospital or nursing homes where many patients are older and weaker, which makes them more vulnerable to infection; and they are surrounded by a large number of people, which means bacteria can easily spread through direct contact with other patients or staff or contaminated surfaces

In recent years, rates of MRSA have fallen because of increased awareness of the infection and most NHS patients who are admitted to hospital are screened for MRSA. This helps reduce the chance of patients developing an MRSA infection or passing an infection on to other patients.

As of 2015-16, we have continued to achieve 100% returns from our inpatient units for MRSA screening of high risk patients in the last 3 years (as defined in the MRSA screening policy), resulting in 0 cases of MRSA Bacteraemia during the same period. This has been a significant improvement from compliance rates in 2011-12 and 2012-13 which we have maintained.
3.2.8  **Pressure Ulcers**

A pressure ulcer is an area of damage to the skin and underlying tissue. They are sometimes known as pressure sores or bed sores. Pressure Ulcers are caused by poor circulation to the tissues due to a combination of unrelieved pressure and sheer (sliding or slumping down the bed/chair).

Good nursing care and completing all aspects of SSKIN (Pressure Ulcer Prevention and Management Care Plan – Skin, Surface, Keep moving, Incontinence and Moisture, Nutrition and Hydration) is essential to the prevention and management of pressure ulcers.

Pressure ulcers are graded using the adapted European Pressure Ulcer Advisory panel grading tool, Grade 1 and 2 being superficial damage and Grade 3 and 4 being deep tissue damage. All grades are reported by clinical and medical members of staff working in CPFT who identify these when completing personal care, routine skin inspections and other general assessments.

Pressure ulcer coding in our Datix incident reporting system allows reporters to identify in whose care the pressure ulcer developed. The reporting options are:
- **Pressure ulcer acquired ‘no professional health/social care input’** – e.g. the pressure ulcer developed when the patient was not receiving treatment or help form any care provider
- **Pressure ulcer acquired elsewhere** e.g. pressure ulcer developed when the patient was in hospital or a hospice
- **Pressure ulcer acquired under CPFT Care** – e.g. pressure developed when the patient was on an active CPFT caseload

For all grade 3 and grade 4 pressure ulcers reported as developed in the care of CPFT, the Tissue Viability Specialist Nurse Team complete a joint visit to the patient with the incident reporter or their line manager within one working week of the incident being reported. Where a Grade 3 or Grade 4 pressure ulcer is identified to be ‘avoidable’ due to an act or omission of care directly related to CPFT services, this is reported to our commissioners as a serious incident (SI).

The number of PU incidents reported in CPFT has increased dramatically in the year due to the number of incidents from the new services transferred to CPFT on 1 April 2015, and this is in the top five highest reported incident in CPFT. It is worth noting that reporting of combined figures for our mental health and new services commenced in Q3.

**PU incidents in a snapshot**

Figure 21 shows that a significant majority of PUs developed in CPFT are Low Harm (Grade 1 or 2) – 75% in Q1, 83% in Q2, 80% in Q3 and 76% in Q4.

In comparison, we had 7 PUs reported in CPFT in 2014-15 that were developed under our care – 3 Grade 1 and 4 Grade 2.
Avoidability can be a result of one or a range of acts or omissions in care, and are assessed following the NHS [www.stopthepressure.com](http://www.stopthepressure.com) SSKIN programme:

**Surface:** Make sure your patients have the right support  
**Skin inspection:** Early inspection means early detection. Show patients and carers what to look for  
**Keep your patients moving**  
**Incontinence/moisture:** Your patients need to be clean and dry  
**Nutrition/hydration:** Help patients have the right diet and plenty of fluids

A **Pressure Ulcer Ambition Group** was formed in CPFT during the year, responsible for reviewing any learning identified from SI investigations of avoidable PUs. Improvements made from identified learning include:

- Improved information provided at induction training to facilitate selection and timely delivery of pressure relief equipment from the community equipment suppliers. Nurses applying to Nottingham Rehab Services (NRS) for a Personal Identification Number (PIN) to access the electronic ordering system are also provided with step-by-step instruction by NRS staff to get the most from the ordering options available.
- A simple and effective written care plan (based on national ‘Stop the Pressure’ SSKIN campaign recommendations) has been developed and disseminated to community nurses to complete and hand to carers to help them to remember verbal advice discussed with them at the visit to the patient. The simple, written plan will help to support a patient and their carer to optimise pressure relief and to promote a healing environment.

We recognise that this is an area that requires improvement and we have identified this as a quality priority for 2016-17.

### 3.2.9 Other information relevant to patient safety

**Duty of Candour**

The introduction of a statutory Duty of Candour is an important step towards ensuring the open, honest and transparent culture that was lacking at Mid Staffordshire Hospitals NHS Foundation Trust. The failures at Winterbourne View Hospital reveal that there were no levers in the system to hold the ‘controlling mind’ of organisations to account. It is essential that CQC uses this new power to encourage a culture of openness and to hold providers and directors to account.”

**Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities)**

*Regulations 2014* sets out what is required of all providers. The intention of the Regulation is to ensure that providers are open and transparent with people who use services and other "relevant persons" (people acting lawfully on behalf of patients) in general in relation to care and treatment.

It is a criminal offence not to notify a service user of a notifiable safety incident or fail to meet the requirements for such a notification. The CQC can prosecute without serving a warning notice first.

This means that when any patient is harmed by the provision of any of our services, and is deemed as moderate harm, severe harm or death, we will be obliged to investigate the incident and inform the patient or their next of kin and any other relevant person, as soon as possible. This then has to be followed up in writing, regardless of whether a
complaint has been made or a question asked. We have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.

We have undertaken the following actions to implement the Duty of Candour in CPFT:
- Standard operating procedures and templates for the written notification under the Duty of Candour have been developed and are available to all staff on the intranet. In addition the Patient Safety Team are available to address any questions.
- The Datix incident reporting system was amended and the IMR (Initial Management Report) updated to reflect mandatory Duty of Candour requirements. This is highlighted in the system with a link to the NMC and GMC document on openness and honesty when things go wrong.
- A standard operating process was developed to provide staff with guidance
- The Complaints Policy, Being Open and Duty of Candour Policy, and the Incident Management Policy Including Serious Incidents and Near Misses have all been updated.
- When sending Serious Incidents (SI) out for investigation, staff are reminded of the requirements of the Duty of Candour
- CPFT’s patient safety web page contains information that highlights the Duty of Candour requirements
- Families are involved in Serious Incident Investigation

**Sign up to Patient Safety**

*Sign up to Safety* is a national initiative, led by NHS England, to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. At the heart of *Sign up to Safety* is the philosophy of locally led, self-directed safety improvement.

The five *Sign up to Safety* pledges are:

1. **Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans
2. **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are
3. **Being honest.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. **Collaborating.** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. **Being supportive.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress

CPFT signed up in August 2015 and we are developing our safety improvement plan as part of the work in the development of our over-arching Quality Improvement Strategy. The patient safety aspect of the strategy focuses on three areas:
- Reducing avoidable harm and improving early detection of the deteriorating patient
- Strengthening the processes around the development of improvement actions from incidents and near misses and embedding change
- Providing safe staffing levels with the appropriate skill mix to deliver high quality care.

It is worth noting that the Trust strives to achieve all the pledges listed above on a daily basis and is something that we continue to embed in practice
### 3.3 Clinical Effectiveness

#### 3.3.1 Care planning

A care plan is a written document that describes the treatment and support being provided, and should be developed jointly between the healthcare provider and the person receiving that care. Good care planning is the foundation of safe, clinically effective care.

In CPFT we have continued to work hard in the past year to ensure that our patients have a care plan that is developed with them that meets their needs and aspirations.

Care planning is monitored monthly using iPad-based tools in the form of:
- patient surveys (Meridian)
- team-based assessments (Integrated Compliance Assessment tool)

The patient surveys enable us to obtain the views of our patients, while the team-based assessments provide the teams with a framework to assess their care plans against the national quality standards.

Figure 22 shows that our scores from the patient survey relating to care plans have remained consistently in the 90% and above range during the year, with the exception of Q4 in the community patient survey. We will explore the reason behind this and work with our community services to improve performance in this area.

The results of the National Community Mental Health Survey 2015 show that we are generally in line with the national average, with the exception of undertaking reviews where we are among the worst performing Trusts. This is an area we need to improve upon.

#### Planning care

- **Q11.** Have you agreed with someone from NHS mental health services what care you will receive?
- **Q12.** Were you involved as much as you wanted to be in agreeing what care you will receive?
- **Q13.** Does this agreement on what care you will receive take your personal circumstances into account?

#### Reviewing care

- **Q14.** In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?
- **Q15.** Were you involved as much as you wanted to be in discussing how your care is working?
- **Q16.** Did you feel that decisions were made together by you and the person you saw during this discussion?
3.3.2 Effectiveness of psychological therapy

The IAPT (Improving Access to Psychological Therapies) programme supports the implementation of NICE (National Institute for Health and Care Excellence) guidelines for people suffering from common mental health problems, most notably anxiety and depression.

Our IAPT service was originally established in 2008 and provides services for people aged 17 and over with no upper age limit, although cases over 65 years old with more age-related issues will be referred on the older peoples team for more specialised treatment. The service is the main provider of IAPT services commissioned by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), and covers the entire Cambridgeshire and Peterborough region with team bases established in Peterborough, Huntingdon, Fenland and Cambridge.

In August 2015, the service opened itself to self-referrals, and aims to see almost 12,000 patients per year as its contribution to the CCG’s 15% access target for patients with depression and anxiety. The service was rebranded as the Psychological Wellbeing Service (PWS) in September 2015 following a service expansion and the need to develop a service name that was more recognisable to the public.

At the end of 2015-16, PWS saw 11,867 people, of which 39% were self-referrals. Figure 23 shows that the number of GP referrals went down while the number of self-referrals significantly increased in the following months.

The service is highly monitored nationally. In 2015-16, those reporting feeling satisfied or very satisfied range between 94 to 97%, with the vast majority reporting feeling very satisfied. Including the neutral responses, satisfaction rates rise to over 99% on each quarter, with unsatisfied patients actually representing less than 1% of total responses. This is consistent with previous years’ satisfaction rates.

Figure 25 shows that, while the satisfaction rate has gone down to 97% in 2015-16 compared to 98% in the previous two years, this is still well above the target rate of 95%.
3.3.3 HoNOS (Health of the Nation Outcome Scales)
HoNOS was developed to measure the health and functioning of people with severe mental illness to provide a means of recording progress towards the Health of the Nation target ‘to improve significantly the health and social functioning of mentally ill people’. It is the most widely used routine clinical outcome measure used by English mental health services.

It consists of 12 items measuring behaviour, impairment, symptoms and social functioning, and completed as part of routine clinical assessments. The use of HoNOS is recommended by the English National Service Framework for Mental Health and by the working group to the Department of Health on outcome indicators for severe mental illness.

In CPFT HoNOS is used in our Adults, Specialist, and Integrated Care services. This had been a Quality Priority for CPFT, with a target of 95%, since 2010-11. We achieved this in 2014-15.

This remains a priority of CPFT and is monitored in our quality and safety dashboard.

During 2015-16, we have continued to meet our target with an overall compliance of 95.3% for the year.

3.3.4 Breastfeeding
NICE guidelines on Maternal and Child Nutrition (March 2008) promotes breast milk as the best form of nutrition for infants and recommends exclusive breastfeeding for the first six months (26 weeks) of an infant’s life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet.

Whilst there is currently no set national target for prevalence of breastfeeding at 6-8 weeks from birth, the latest figures for the national average stood at 45.2% as of Q1 2015/16 (NHS England Statistical Release Breastfeeding Initiation & Breastfeeding Prevalence 6-8 weeks Q1 2015/16).

Table 21 Breastfeeding

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<tr>
<td>Prevalence of breastfeeding (totally plus partially) at 6-8 weeks from birth (%)</td>
<td>38%</td>
<td>41%</td>
<td>42.1%</td>
<td>41.5%</td>
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<tr>
<td>Local target</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Percentage of infants for whom breastfeeding status is recorded at 6-8 weeks from birth (%)</td>
<td>93%</td>
<td>89%</td>
<td>98.0%</td>
<td>99%</td>
</tr>
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</table>

Table 21 above shows that the local target for breastfeeding prevalence was adjusted for 2015/16 to reflect the national average.
Meeting the local target for breastfeeding prevalence in the Peterborough area has always been challenging given the high rates of deprivation, the wide ethnic mix, and the numbers of families moving in and out of the city. On the other hand, we continue to improve upon our performance on recording breastfeeding status.

Despite the inherent challenges within which our Health Visiting service operates, it achieved Level 3 United Nations Children’s Emergency Fund (UNICEF) accreditation for the second time at the beginning of the year, which is the highest level that can be achieved and identified many areas of good practice. The team was commended for its work to maintain the standards established, and it was clear to the assessment team that pregnant women and new mothers in the Peterborough area receive a high standard of care. Of particular note was the high regard with which the mothers held their relationship with their health visitor.

The service is committed to building on the UNICEF accreditation to strive to increase the prevalence of breastfeeding in the Peterborough area.

A re-audit was completed at the end of the year and we are awaiting the results.

3.3.5 Participation in National Quality Improvement Programmes
The College Centre for Quality Improvement (CCQI), regulated by the Royal College of Psychiatry (RCPsych), aims to raise standards of care by providing a framework that enables providers and commissioners of services to assess the quality of its services against nationally recognised standards, and benchmarking performance with other similar organisations across the country. There are other accreditation schemes for specific services, such as UNICEF for children’s services.

CPFT takes part in these national quality accreditation schemes as it provides us with assurance that our services are meeting the highest standards set by the professional bodies, and also informs our quality improvement programme.

During 2015-16

- Our health visiting service was accredited for level 3 for the second time, which is the highest level of accreditation
- Mulberry 1 and 2, our adult acute wards, maintained its accreditation for AIMS (Accreditation for Inpatient Mental Health Services).
- Oak 1 and Oak 2, our adult acute wards, maintained their accreditation for AIMS. In particular, Oak 2 was accredited as "excellent"

Research based evidence
There is a correlation between higher rates of breastfeeding prevalence and lower rates of inpatient admissions among infants under one year old for the following ten conditions:
- lower respiratory tract infections
- wheezing
- non-infective gastroenteritis
- otitis media (ear infection)
- lactose intolerance
- asthma
- infant feeding difficulties
- gastroenteritis
- eczema
- infant feed intolerance

For mothers, breastfeeding is associated with a reduction in the risk of breast and ovarian cancer

Changes to the CCQI accreditation ratings in 2016
From 1 January 2016, CCQI will stop the award of "excellent". The main reason for this change is that patients, staff and the members of the public would expect that a team “accredited” by the Royal College of Psychiatrists is excellent. Also a general award of “excellent” is misleading if the team is not excellent in every area of the standards. The centre will continue to look at ways to commend very good practice in their work
- Mulberry 3, our adult inpatient recovery unit, also achieved its Accreditation for Inpatient Mental Health Services (AIMS) award
- Our Liaison Psychiatry Service, based at Addenbrooke's Hospital, Cambridge, was accredited as excellent
- Our ECT (Electro-Convulsive Therapy) Team at the Cavell Centre, Peterborough, was also accredited as excellent

**Table 22: Accreditation schemes 2015-16**

<table>
<thead>
<tr>
<th>Accreditation Scheme</th>
<th>Services</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ECTAS</strong> (ECT Accreditation Service)</td>
<td>Addenbrookes ECT Clinic, Cambridge</td>
<td>Accredited Cycle 4</td>
</tr>
<tr>
<td></td>
<td>Cavell Centre, Peterborough</td>
<td><strong>Accredited as excellent</strong></td>
</tr>
<tr>
<td><strong>AIMS</strong> (Accreditation for Inpatient Mental Health Services)</td>
<td>Oak 1 Ward, Cavell Centre, Peterborough (Adults unit)</td>
<td>Accredited Cycle 2</td>
</tr>
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<td></td>
<td>Oak 2 Ward, Cavell Centre, Peterborough (Adults unit)</td>
<td><strong>Accredited as excellent</strong></td>
</tr>
<tr>
<td></td>
<td>Oak 3 Ward, Cavell Centre, Peterborough (Adults unit)</td>
<td><strong>Accredited as excellent</strong></td>
</tr>
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<td>Mulberry 1 Ward, Fulbourn (Adults unit)</td>
<td>Accredited in May 2015</td>
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<td></td>
<td>Mulberry 2 Ward, Fulbourn (Adults unit)</td>
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<td></td>
<td>Mulberry 3 Ward, Fulbourn (Adults unit)</td>
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<tr>
<td><strong>AIMS contd.</strong></td>
<td>IASS, Ida Darwin, Cambridge (Learning Disability unit)</td>
<td>Accredited as excellent</td>
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<tr>
<td>(jointly accredited with QED (Quality Network for Eating Disorder))</td>
<td>The Hollies, Cavell Centre, Peterborough (Learning Disability unit)</td>
<td>Accredited as excellent</td>
</tr>
<tr>
<td></td>
<td>S3 Adults Eating Disorder unit, Addenbrookes *</td>
<td>Accredited</td>
</tr>
<tr>
<td><strong>Forensic CCQI</strong></td>
<td>George MacKenzie House, Fulbourn Hospital</td>
<td>Accredited</td>
</tr>
<tr>
<td><strong>HTAS</strong> (Home Treatment Accreditation Schemes)</td>
<td>CRHTT North (Huntingdon and Peterborough)</td>
<td>Accredited as excellent</td>
</tr>
<tr>
<td></td>
<td>CRHTT South (Mulberry 1, Fulbourn)</td>
<td>Accredited</td>
</tr>
<tr>
<td><strong>QNIC</strong> (Quality Network for Inpatient CAMH)</td>
<td>The Croft, Ida Darwin, Cambridge (Children's unit)</td>
<td>Accredited cycle 11</td>
</tr>
<tr>
<td></td>
<td>Darwin Centre, Ida Darwin, Cambridge (Children's unit)</td>
<td><strong>Accredited as excellent</strong></td>
</tr>
<tr>
<td><strong>PLAN</strong> (Psychiatric Liaison Accreditation Network)</td>
<td>Addenbrookes, Cambridge</td>
<td><strong>Accredited as excellent for the second time</strong></td>
</tr>
<tr>
<td><strong>SUSTAIN</strong> Health visiting accreditation (UNICEF)</td>
<td>Peterborough universal child health services</td>
<td>Accredited Level 3 for the second time</td>
</tr>
</tbody>
</table>
3.4 Performance against key national priorities

CPFT is required to achieve a number of key national priorities as outlined within the Department of Health NHS Outcomes Framework.

CPFT continues to perform well against the national targets in 2014-15 as shown in Table 23 below.

Table 23: Key national priorities 2015-16

<table>
<thead>
<tr>
<th>Target (%)</th>
<th>Target 2014-15</th>
<th>Target 2015-16</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPA 7-day follow up after discharge</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>96.2%</td>
</tr>
<tr>
<td>CPA patients having formal review within 12 months</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Minimising delayed transfers of care</td>
<td>&lt;= 7.5%</td>
<td>&lt;= 7.5%</td>
<td>4.92%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Admissions gate kept by CRHT</td>
<td>95%</td>
<td>95%</td>
<td>96.25%</td>
<td>97.85%</td>
</tr>
<tr>
<td>Meeting commitment to serve new psychosis cases by early intervention teams</td>
<td>95%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Data completeness: identifiers</td>
<td>97%</td>
<td>97%</td>
<td>98.70%</td>
<td>99.2%</td>
</tr>
<tr>
<td>Data completeness: outcomes</td>
<td>50%</td>
<td>50%</td>
<td>84.50%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Data completeness: Community services referral to treatment information</td>
<td>50%</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Referral information</td>
<td>50%</td>
<td>50%</td>
<td>99.35%</td>
<td>98.33%</td>
</tr>
<tr>
<td>• Treatment activity information</td>
<td>50%</td>
<td>50%</td>
<td>99.83%</td>
<td>99.8%</td>
</tr>
<tr>
<td>• Patient identifier information</td>
<td>50%</td>
<td>50%</td>
<td>97.65%</td>
<td>97.95%</td>
</tr>
<tr>
<td>Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>No threshold set</td>
<td>No threshold set</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

Notes:
1. Data presented in this section have not been rounded off to show the actual performance in the year. Where similar data is presented elsewhere in this report, these have been rounded off for presentation purposes.

2. Data for the following indicators are also presented in section 2.2.7 under the mandatory national core quality indicators for 2015-16:
   - Patients on Care Programme Approach who were followed up within seven days following discharge from psychiatric inpatient care during the reporting period (2.2.7, no. 1)
   - Admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period (2.2.7, no. 2)

3. Satisfaction with IAPT treatment is also presented in section 3.3.2.

Definitions for key core indicators are set out in Annex 1.
### 3.5 High-quality workforce

#### 3.5.1 Workforce factors

During 2015-16, we reviewed our workforce strategy in line with the implementation of CPFT action plan from the outcome of the staff surveys, both national and in-house. The CPFT Workforce Strategy 2016-2021 was developed following consultation with staff, our governors and staff side. The strategy identifies six key priorities which are shown below.

The over-arching aim of the workforce strategy is to ensure we have a workforce which is highly skilled and engaged to enable them to support the delivery of Trust’s Business Plans, Strategic Objectives and Trust Vision whilst maintaining financial stability. It brings together all workforce related strategies, identifying key priorities and actions for the next five years. Key priorities are:

<table>
<thead>
<tr>
<th>Integration</th>
<th>Resourcing and recruitment</th>
<th>Organisational development</th>
<th>Workforce planning, education, training and development</th>
<th>Supporting staff</th>
<th>Quality and safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>To develop the workforce to be fully integrated to support future Trust strategies and enhance the skills knowledge and experience across all staff groups and disciplines, developing new integrated roles.</td>
<td>To attract, recruit and retain high calibre, appropriately skilled and experienced staff who share our values and demonstrate supporting behaviours to ensure the provision of safe integrated care of high quality.</td>
<td>To strengthen the leadership and management development ensuring values are role modelled for all staff and appropriate plans are in place to support talent management and succession planning</td>
<td>To develop a robust workforce plan to support CPFT strategy. To support CPFT through the learning and development process, in achieving a competent and confident workforce able to deliver a responsive, equitable, safe and compassionate service that meets all required standards.</td>
<td>To strengthen staff engagement, reward and recognising achievements, and maximising the value of our workforce whilst supporting and improving our staff well-being</td>
<td>To improve patient experience by ensuring staff are appropriately trained, equipped, supported and can perform at their optimum level improving efficiency and productivity.</td>
</tr>
</tbody>
</table>
CPFT measures a range of key workforce performance indicators that are detailed in a monthly workforce dashboard. CPFT Board receives quarterly workforce reports which will include progress against the workforce strategy.

The following table details the Key Performance Indicators (KPIs) that will be used to measure the outcomes of the strategy along with the targets set.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>FY17</th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
<th>FY21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turnover</td>
<td>&lt;10.5%</td>
<td>&lt;10.5%</td>
<td>&lt;10%</td>
<td>&lt;10%</td>
<td>&lt;10%</td>
</tr>
<tr>
<td>Vacancy levels</td>
<td>&lt;5%</td>
<td>&lt;5%</td>
<td>&lt;5%</td>
<td>&lt;5%</td>
<td>&lt;5%</td>
</tr>
<tr>
<td>Stability</td>
<td>60%</td>
<td>65%</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Recruitment time to fill</td>
<td>10wks</td>
<td>9wks</td>
<td>9wks</td>
<td>9wks</td>
<td>9wks</td>
</tr>
<tr>
<td>Number of apprenticeships</td>
<td>60</td>
<td>60</td>
<td>65</td>
<td>70</td>
<td>80</td>
</tr>
<tr>
<td>National Staff Survey engagement Scores</td>
<td>3.81</td>
<td>3.85</td>
<td>4.00</td>
<td>4.25</td>
<td>4.5</td>
</tr>
<tr>
<td>Sickness absence rates</td>
<td>&lt;4.35%</td>
<td>&lt;4.35%</td>
<td>&lt;4.35%</td>
<td>&lt;4%</td>
<td>&lt;4%</td>
</tr>
<tr>
<td>% of staff to recommend CPFT to family and friends as a place to work</td>
<td>60%</td>
<td>65%</td>
<td>70%</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td>% of staff to recommend CPFT as a place to care for family and friends</td>
<td>60%</td>
<td>65%</td>
<td>70%</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td>Mandatory training compliance</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Appraisal compliance</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Appraisal quality as per Staff Survey scoring</td>
<td>3.05</td>
<td>3.15</td>
<td>3.25</td>
<td>3.30</td>
<td>3.45</td>
</tr>
<tr>
<td>Reporting of bullying and harassment as per Staff Survey</td>
<td>20%</td>
<td>18%</td>
<td>16%</td>
<td>12%</td>
<td>10%</td>
</tr>
</tbody>
</table>
3.5.2 Staff Survey

The 2015 National NHS Staff Survey was completed by 46% of our workforce (an increase from 43% in 2014) and is in line with the National average for combined community and mental health/learning disability Trusts in England.

The survey results indicate an ongoing trend of improvement in the trust. When comparing results from 2014 to this year’s survey 21 of the 22 comparable key findings were either improved or the same, reflecting the continuing positive cultural change within the Organisation that was highlighted from the 2014 survey results, even with all the unprecedented change and pressures over the last year.

Our top 5 strengths and weaknesses:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer staff feeling the pressure to come into work when unwell</td>
<td>Staff said they had suffered from work-related stress in the last 12 months</td>
</tr>
<tr>
<td>Fewer staff witnessing harmful errors, near misses or incidents</td>
<td>Staff are feeling dissatisfied with resourcing and support</td>
</tr>
<tr>
<td>Improved staff confidence and security in reporting unsafe clinical practice</td>
<td>Fewer staff had an annual appraisal in the past 12 months</td>
</tr>
<tr>
<td>Improved engagement felt by staff towards CPFT</td>
<td>Dissatisfaction felt by staff around the level of responsibility and involvement</td>
</tr>
<tr>
<td>Communication between senior management and staff is effective</td>
<td>Some staff feeling discriminated against, and have suffered from harassment, bullying and abuse by other staff</td>
</tr>
</tbody>
</table>

The survey results have been used to support the priorities of the Workforce Strategy and a specific action plan has been developed (currently awaiting Board sign off) to ensure that feedback is acted upon; these have been grouped into 4 aims:

- For staff at all levels to feel able to contribute to improvements
- To keep staff well and at work
- To ensure staff are safe, feel safe and are not discriminated against
- For staff to feel more valued and supported

Once endorsed by the Board, delivery of the action plan will be monitored closely by the Workforce Executive.

3.5.3 An effective healthcare organisation

CPFT has robust workforce policies in place to ensure staff are safely recruited, inducted, supervised and appraised and provide a high standard of practice. The policies are monitored to ensure managers and staff are compliant with these standards. In 2015 CPFT almost doubled in size following the transfer of staff from CCS to form the new Integrated Care Directorate. These individuals maintained a number of their previous organisation’s policies, procedures and systems. Over the last year a task of harmonising these with current CPFT policies has commenced and is still ongoing.

Mandatory training compliance is monitored on a monthly basis as well as being included on the monthly quality dashboard which is reported corporately to demonstrate compliance.
A new and integrated appraisal and supervision system, will be launched in July 2016 using the CPFT Academy system. This will integrate mandatory training with appraisals and supervision to ensure a cohesive system, it will also include competencies assessments based around CPFT’s values of ‘PRIDE’. The target of 95% of appraisals completed will stay the same.

To support the embedding of effective team working and all staff aligning to the key objectives for their area all teams will have access to team building and effective team performance coaching. This was piloted with the Integrated Care Directorate to support their development with new ways of working and culture change.

A new workshop, “Building a High Performance Team” has been designed and will be delivered for managers. To supplement the training, team-building tools will be made available on the organisational development pages of the CPFT intranet.

Building on the appraisal process, a talent and succession planning process is being developed which will ensure that staff are supported in their career aspirations and CPFT grows and develops its own staff in areas which are traditionally difficult to recruit to as well as ensuring there is a pipeline of talent in each area.

The Workforce Executive, which includes executive directors and directorate managers, continues to be held to account for the governance of all workforce factors. A quarterly workforce report is part of the agenda for the Quality, Safety and Governance Committee. Each month workforce Key Performance Indicators (KPIs) are reviewed at high level performance meetings for each directorate, alongside patient safety and experience KPIs, to enable triangulation and highlight areas of concern for action.

3.5.4 Planning and developing the workforce
To support the development of our workforce, the talent and succession plan will focus on developing and ensuring we have a pipeline of talent and suitably qualified staff. A recruitment and retention strategy has been developed to attract new recruits as well as retaining current staff. All vacancies are still managed centrally and CPFT continues a strategic approach in maintaining low recruitment timelines and managing vacancy levels. A new recruitment system ‘NHS Jobs 2’, was launched in autumn 2015 and has enabled a more stable and low average recruitment timeline, currently at 10.44 weeks (Feb16). The vacancy rate of 11.27% (Feb16), is above target, mainly due to the increased establishment in integrated care, which also has a high turnover (caused by the uncertainty around organisational change and competition locally). Other areas of high vacancy rates relate to an increased establishment in Children’s services, alongside some hard to recruit to positions. Recruitment supplements have also been introduced for difficult to recruit nursing roles ensuring that we can attract candidates into roles which have consistently been challenging to fill.

The Trust’s focus on growing our own staff continues, with the development of new apprenticeship positions across CPFT with over than 40 apprentices being developed over the last 12 months. The work experience programme is also being reviewed to ensure we attract interest and raise the profile of CPFT as an employer within the local area as well as the opportunities which are available.
3.5.5 Staff engagement
CPFT continues to deliver on the Organisational Development (OD) Strategy with the launching of CPFT’s new values in January 2016. These were developed by staff and service users and signed off by the Board. These are:

<table>
<thead>
<tr>
<th></th>
<th>Professionalism</th>
<th>Respect</th>
<th>Innovation</th>
<th>Dignity</th>
<th>Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professionalism</strong></td>
<td>We will maintain the highest standards and develop ourselves and others</td>
<td>...by demonstrating compassion and showing care, honesty and flexibility</td>
<td>...by being kind, open and collaborative</td>
<td>... by taking the time to hear, listen and understand</td>
<td>...by enabling you to make effective, informed decisions and to build your resilience and independence</td>
</tr>
<tr>
<td><strong>Respect</strong></td>
<td>We will create positive relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Innovation</strong></td>
<td>We are forward thinking, research focused and effective</td>
<td>...by using evidence to shape the way we work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dignity</strong></td>
<td>We will treat you as an individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Empowerment</strong></td>
<td>We will support you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the 2015 National Staff Survey the staff engagement score has again improved, as can be seen on the chart below:

![Figure 27 Staff engagement 2014 & 2015](chart)

This now brings CPFT’s staff engagement score in line with the national average for comparable Trusts. It is also worth noting that the survey was completed during the Neighbourhood Team consultation period, which affected around 20% of the total workforce, and just prior to the other consultations occurring in the Integrated Care Directorate at the time.

3.5.6 Health and wellbeing
A new Health and Wellbeing Strategy has been developed to support the over-arching Workforce Strategy.

This focuses on four key themes:
- Physical health
- Mental health
- Health promotion
- Management development

This is represented in the diagram overleaf.
The strategy aims to support employees in maintaining good physical and mental health in order to enjoy healthier lives; act as role models for the community we serve and provide high standards of care to our patients. The anticipated benefits will be appreciated by staff, patients and the organisation as a whole. An action plan is currently being developed to support the delivery of the Health and Wellbeing Strategy.

CPFT is signed up to two pledges of the National Responsibility Deal for Health and Wellbeing in the workplace.

3.5.7 Management and leadership
The Leadership and Management Development programmes are underway to support the development of CPFT’s managers and leaders. The programmes aim to enhance the skills of those who manage others thereby enhancing employee satisfaction and engagement.

In 2016, two cohorts of each programme have been commissioned to meet the demand for places and evaluation of previous programmes has been outstanding.

An additional suite of “Management Skills Toolkit” sessions have also been commissioned, which will be available to all managers.

2016 heralds the start of a revised New Managers’ Induction Programme aimed at supporting new managers during their first 100 days in post.
As CPFT’s Learning and Education Academy is developed, further leadership development opportunities will continue to be made available.

The Wider Leadership Team (WLT) meets regularly; this includes the organisational leadership group and reflects the multi-disciplinary approach of CPFT. The format has been reviewed following staff feedback. On a quarterly basis all line managers from band 7 upwards are brought together to network and to ensure that all our line managers are part of the development of the organisation’s strategic objectives and are developed in the skills and behaviours which will support the culture change.

3.5.8 Empowering staff
The formal mechanism for consulting, liaising and negotiating with staff side colleagues and trade unions is through the Staff Consultative Forum. All consultations, staff developments and employment policy development and changes are consulted on with staff side.

Over the last year there have been a number of initiatives to support this direction of travel:

More empowering, supportive management style
- Introducing a ‘Managers’ Charter’ which is being tested with line managers and developing a new Managers’ Handbook
- Providing training opportunities for managers which encourage an more supportive leadership style - Management Development Programme (MDP) and Leadership Development Programme (LDP)
- Management and Leadership Development Programmes have an active improvement project built in as part of the programme, providing the opportunity for staff to implement improvements.
- Improving the ‘New Managers’ Induction Programme’
- Introducing a suite of management skills workshops that supplement managers’ knowledge and skills.
- Extending the invitation to the “Wider Leadership Team” meetings to a wider number of line managers promoting an inclusive approach to development of CPFT strategy and vision
- Ensuring all line managers are involved and driving the business plans for their Clinical Directorates and departments
- One-to-one coaching offered to line managers and exploring whether team coaching will also support the change in culture
- Team development and support being implemented to support teams to be achieve their full potential

Ensuring communication processes are two way and staff are empowered to give feedback and make suggestions:
- Piloting an engagement approach with a section of staff to test out whether regular staff engagement gives an opportunity for giving feedback and suggesting areas which require improvement.
- Implementing a ‘Team Brief’ system to engage staff in current Trust developments and introduce a direct method of feedback to the senior team
- Holding twice-yearly informal meetings for the CEO to meet with all staff, giving opportunity for direct feedback
Ongoing ‘back-to-the-floor’ programme whereby executives spend one day a month working alongside a team, with a built in process for giving feedback to executives.

‘Aidan Answers’ e-mail system which gives staff direct access to the CEO

Launching the “Wider Leadership Team” which now includes all middle managers in October 2014

**Recognition and rewards which encourage staff to innovative and improve services**

- Annual awards recognise the innovation of staff as individuals and teams
- Quality Hero and Team Awards recognise on a monthly basis the actions taken by staff and teams to improve the services provided by CPFT.
ANNEX 1
DEFINITIONS OF KEY NATIONAL QUALITY INDICATORS

1. The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days.

Data definition
‘Patients discharged’ includes all patients discharged to their place of residence, care home, residential accommodation, or to non psychiatric care or to prison. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

CPFT adapted definition
The indicator excludes patients who
- die within seven days of discharge
- patients removed from the country as a result of legal precedence
- transferred to other wards (patients transferred to NHS psychiatric inpatient ward when discharged from inpatient care)
- CAMHS (children and adolescent mental health services), i.e. patients aged under 18
- readmitted within seven days
- discharged to other hospitals
- discharged to Alcohol Service/Bridge Alcohol Team/Drink Sense
- discharged to out of area
- discharged to Community Alcohol Team CAT/Community Drug Team/Add Action
- are of no fixed abode
- discharged to the prison service
- discharged having been admitted under the Ministry of Defense (MoD) contract or as a planned admission to a detox bed

Those that are recorded as followed up receive face to face contact or a telephone conversation (not text or phone messages). The 7-day period is measured in days not hours and starts on the day after discharge

Accountability
Achieving at least 95% rate of patients followed up after discharge each quarter

2. The proportion of inpatient admissions gate kept by the crisis resolution home treatment teams.

Data definition
Gatekeeping: In order to prevent hospital admission and give support to informal carers CRHT are required to gate keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate kept by a crisis resolution team if they have assessed the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.
CPFT adapted definition
The indicator is expressed as proportion of inpatient admissions gate kept by the crisis resolution home treatment teams in the year ended 31 March 2016. The indicator is expressed as a percentage of all admissions to psychiatric inpatient wards.

The following patients are excluded from the indicator:
- patients recalled on Community Treatment Order (CTO),
- patients transferred from another NHS hospital for psychiatric treatment,
- Internal transfers of patients between wards in CPFT for psychiatric treatment,
- patients on leave under Section 17, patients who are sections under s.2 or s.3 or patients who are brought in under section 136 (police custody) of the Mental Health Act (MHA)
- planned admission for psychiatric care from specialist units such as eating disorder unit.
- planned admissions to detox beds, and
- Ministry of Defence (MoD) patients,

An admission is reported as gate kept by a crisis resolution team where they have assessed* the service user before admission and if the crisis resolution team were involved** in the decision-making process which resulted in an admission.

Notes:
1. An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient.
2. Involvement is the assessment of all patients thought to be requiring admission other than those detained under the Mental Health Act, although seen out of hours between 10pm -8am
3. Where the admission is from out of CPFT's area and where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local areas, the admission is recorded as gate kept if the crisis resolution team assure themselves that gatekeeping was carried out.
4. Where an assessment has been carried out by another Trust service (ie, Liaison team or another community team) immediately prior to the referral, the crisis resolution team will review the assessment with the referrer prior to making the decision whether or not to admit the patient into a ward.

3. The number of delayed transfers of care per number of occupied beds (all adults – aged 18 plus).

Data definition
A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.

A patient is ready for transfer when:
- a clinical decision has been made that the patient is ready for transfer AND
- a multi-disciplinary team decision has been made that the patient is ready for transfer AND
- the patient is safe to discharge/transfer.
To be effective, the measure must apply to acute beds, and to non-acute and mental health beds. If one category of beds is excluded, the risk is that patients will be relocated to one of the ‘excluded’ beds rather than be discharged.

**Indicator construction**

Provider numerator 03: Number of patients (acute and non-acute aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly sitrep figures is used as the numerator.

Provider denominator 04: Average number of occupied beds.

**Accountability**

The ambition is to maintain the lowest possible rate of delayed transfers of care. Good performance is demonstrated by a consistently low rate over time, and/or by a decreasing rate. Poor performance is characterised by a high rate, and/or by an increase in rate.

4. **Patient safety incidents reported**

**Indicator description**

Patient safety incidents (PSI), reported to the National Reporting and Learning Service (NRLS), is defined as ‘any unintended or unexpected incident(s) that could or did lead to harm for one of more person(s) receiving NHS funded healthcare’.

**CPFT adapted definition**

CPFT also uses the criteria of 'suffered long term harm' to classify an incident as severe, as well as 'permanently harmed'.

**Indicator construction**

The number of incidents as described above.

**Indicator format**

Whole number

5. **Safety incidents involving severe harm or death**

**Indicator description:**

Patient safety incidents reported to the National Reporting and Learning Service (NRLS), where degree of harm is recorded as ‘severe harm’ or ‘death’, as a percentage of all patient safety incidents reported.

**Indicator construction**

**Numerator:** The number of patient safety incidents recorded as causing severe harm/death as described above.

The ‘degree of harm’ for PSIs is defined as follows;

‘severe’ – the patient has been permanently harmed as a result of the PSI, and
‘death’ – the PSI has resulted in the death of the patient.

**Denominator:** The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS).

**Indicator format:** Standard percentage.

(Monitor 2013-14 Detailed Guidance for External Assurance for External Reports)
ANNEX 2

GLOSSARY

Adults’ and Older People’s (AOP) Community services
These are the services that have transferred to CPFT from Cambridgeshire Community Services NHS Trust (CCS) on 1 April 2015. The breakdown of the specific services are detailed in page 29 of this report.

Appraisal
Performance appraisal is an opportunity for individual employees and those involved with their performance, typically line managers, to engage in a dialogue about their performance and development, as well as agreeing the support required from the manager and CPFT. This will include a review of the past year’s objectives and the employee’s performance against these, setting new objectives for the coming year and reviewing the employee against their competency framework.

ARC (Analysis of Root Cause)
Also known as RCA (Root Cause Analysis) is a well recognised way of offering a framework for reviewing patient safety incidents. This method is recommended by the National Patient Safety Agency (NPSA) to all NHS organisations and staff. This process can identify what, how and why patient safety incidents have happened. Analysis can then be used to identify areas for change, develop recommendations, and look for new solutions. Ultimately they should help prevent incidents from happening again.

Audit Commission
An independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high quality local and national services for the public.

C Difficile
Clostridium Difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics.

Caldicott Guardian
A senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing.

Cardio Metabolic Assessment
An assessment of key cardio metabolic parameters (as per the 'Lester tool'): Smoking status, Lifestyle (including exercise, diet alcohol and drugs), Body Mass Index, Blood pressure, Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate) and Blood lipids.

Care Act 2014
The Care Act was first published as a Bill in the House of Lords on 9 May 2013, following legislative scrutiny. The legislation, which aims to modernise adult social care law, received Royal Assent on the 14 May 2014, becoming the Care Act (the Act).
Care plan
A written document that describes the treatment and support being provided, and should be developed jointly between the healthcare provider and the person receiving that care.

Carer
Paid practitioner carers refers to people employed to support people with mental health problems, often in their own homes, with everyday tasks such as cleaning, shopping, getting dressed and cooking according to an agreed plan of care. This group is also commonly referred to as 'care workers' or 'care assistants'. Informal carers refers to family or close friends who provide a variety of emotional and practical supports. This caring is generally unpaid and carried out on a voluntary basis. However some carers will receive statutory benefits such as a carer allowance, direct payment or personal budget.

Care Programme Approach (CPA)
Describes the framework that was introduced in 1990 to support and co-ordinate effective mental health care for people using secondary mental health services. Although the policy has been revised over time, the CPA remains the central approach for co-ordinating the care for people in contact with these services who have more complex mental health needs and who need the support of a multidisciplinary team.

Care Quality Commission (CQC)
This is the independent regulator of health and adult social care in England. Its purpose is to make sure hospitals, care homes, dental and GP surgeries, and other care services in England provide people with safe, effective, compassionate and high-quality care, and encourage them to make improvements. Its role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish findings, including performance ratings to help people choose care.

CCQI
The College Centre for Quality Improvement (CCQI) aims to raise the standard of care that people with mental health needs receive by helping providers, users and commissioners of services assess and increase the quality of care they provide. It does this by collecting information from patients, carers and staff about standards of care using national clinical audits, surveys and peer-review visits.

CEARG
Clinical Effectiveness, Audit and Research Group is a working group in CPFT reporting to the Clinical Governance and Patient Safety Group, and has over-arching responsibility for monitoring of implementation of clinical guidance via regular update reports from identified lead.

CGI
The Clinical Global Impression rating scales are commonly used measures of symptom severity, treatment response and the efficacy of treatments in treatment studies of patients with mental disorders.

CGPSG
Clinical Governance and Patient Safety Group is a working group in CPFT reporting to the Quality, Safety and Governance Committee, and is responsible for providing
leadership in all matters relating to risk and patient safety to ensure the provision of safe, effective and high quality clinical services.

**CLAHRC**
The NIHR CLAHRC EoE (National Institute for Health Research, Collaborations for Leadership in Applied Health Research and Care East of England) is a five year research programme hosted by CPFT which started on 1st January 2015. The programme is a collaboration between the Universities of Cambridge, East Anglia and Hertfordshire along with health and social care, industry and third sector organisations within the East of England.

**Clinical audit**
Is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

**Commissioner**
An NHS commissioner, known as a 'Clinical Commissioning Group' (CCG), is responsible for planning and purchasing healthcare services for its local population.

**Competency frameworks**
A framework that works as a portfolio of an individual's knowledge, skills and clinical competency, which helps to highlight their strengths and identify areas for improvement.

**Complaints**
Within the NHS, the term 'concern' or 'complaint' refers to 'any expression of dissatisfaction that requires a response'. A person's right to complain about the care or treatment they have received is embedded in the NHS Constitution and are subject to strict set of process and procedures.

**Community mental health services**
Provide care and treatment for people who require care over and above what can be provided in primary care. Services are provided through a wide range of service models, and through a broad range of interventions. People using these services may receive support over a long period of time or for short-term interventions.

**Council of governors**
The 'voice' of local people and helps set the direction for the future of the hospital and community services, based on Members’ views

**CPFT Academy**
A Trust wide resource, providing support to current and future employees around leadership, learning and development, training and medical education.

**CQUIN**
The CQUIN (Commissioning for Quality and Innovation) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

**CRHTT**
Crisis Resolution and Home Treatment Teams support patients and carers at home to prevent unnecessary admissions to psychiatric inpatient wards and facilitate early discharge.
Data Quality
A perception or an assessment of data's fitness to serve its purpose in a given context.

Datix
A web-based software that helps organisations manage their risks, incidents, service user experience and CQC Standards compliance.

ECT (Electroconvulsive therapy)
This is a standard psychiatric treatment in which seizures are electrically induced in patients to provide relief from psychiatric illnesses.

E-learning
The use of electronic technology in teaching and learning.

Electronic Staff Records system (ESR)
A Department of Health (England) led initiative, providing an integrated Human Resources and Payroll system across the whole of the NHS in England and Wales

Essential Steps audit
An audit completed monthly for all in-patient units. It looks at key points in the spread of infection such as hand hygiene, aseptic techniques, personal protective equipment and sharps.

Formal patients
Patients detained under the Mental Health Act

Francis report
Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6 February 2013. The 1,782 page report had 290 recommendations with major implications for all levels of the health service across England, and called for a whole service, patient centred focus.

Friends and Family Test (FFT)
This is a national feedback tool that asks people if they would recommend the services they have used and offers a range of responses.

Fundamental Standards of Quality and Safety
The fundamental standards were introduced as part of the government’s response to the Francis Inquiry’s recommendations and define the basic standards of safety and quality that should always be met, and introduce criminal penalties for failing to meet some of them. The standards are used as part of the Care Quality Commission’s (CQC’s) regulation and inspection of care providers, and are enshrined in the Health and Social Care Act 2012 (amended 2014).

GP (General Practitioner)
A medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients.

HCAI (Healthcare Associated Infections)
Infections that are acquired as a result of health care.

Health Visiting service
A workforce of specialist community public health nurses who provide expert advice, support and interventions to families with children in the first years of life, and help
empower parents to make decisions that affect their family’s future health and wellbeing.

HSCIC (Health and Social Care Information Centre)
The national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

IG (Information Governance) Toolkit
An online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments.

Informal patients
Voluntary patients who are not detained under the MHA

Information Governance
Ensures necessary safeguards for, and appropriate use of, patient and personal information

Learning disability
This is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life.

Mandatory training
Training identified by CPFT as an essential requirement for the safe conduct of CPFT’s activities

Medicines Reconciliation
The process of obtaining an up to date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes deletions and additions.

Mental Health
A person’s condition with regard to their psychological and emotional well-being.

MRSA Bacteraemia
A blood stream infection caused by the presence of methicillin resistant staphylococcus aureus.

National Community Mental Health Survey
This is a mandatory annual survey run by the Care Quality Commission (CQC). Service users aged 18 and over are eligible for the survey if they were receiving specialist care or treatment for a mental health condition.

National NHS Staff Survey 2014
This is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution.
NCISH (National Confidential Inquiry into Suicide and Homicide)
The Inquiry examines suicide, and homicide committed by people who had been in contact with secondary and specialist mental health services in the previous 12 months. It also examines the deaths of psychiatric inpatients which were sudden and unexplained. Previous findings of the Inquiry have informed national mental health strategies, and continue to provide definitive figures for suicide and homicide related to mental health services in the UK.

NHS (National Health Service)
This is a publicly funded healthcare system, primarily funded through central taxation, in the United Kingdom. It provides a comprehensive range of health services, the vast majority of which are free at the point of use for people legally resident in the United Kingdom.

NHS Outcomes Framework
Provides a national overview of how well the NHS is the primary accountability mechanism, in conjunction with the mandate, between the Secretary of State for Health and NHS England and improves quality throughout the NHS.

NICE (National Institute for Health and Care Excellence)
NICE provides national guidance and advice to improve health and social care.

NIHR
National Institute for Health Research aims to improve the health and wealth of the nation through research.

NRLS (National Reporting and Learning System)
The world’s most comprehensive database of patient safety information.

PALS (Patients Advice and Liaison Service)
A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient Safety Incidents (PSIs)
Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

PbR (Payment by Results)
This is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient’s healthcare needs.

PhD
Doctor of Philosophy, abbreviated as PhD, Ph.D., D.Phil., or DPhil in English-speaking countries and originally as Dr.Philos. or Dr.Phil., is in many countries a postgraduate academic degree awarded by universities. The academic level known as a doctorate of philosophy varies considerably according to the country, institution, and time period, from entry-level research degrees to higher doctorates. A person who attains a doctorate of philosophy is automatically awarded the academic title of doctor.

PLACE (Patient Led Assessment of Care Environments)
This was introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) programme. The programme is voluntary and is open to all NHS and independent sector hospitals, hospices and treatment centres. Through this programme, hospitals, in collaboration with patient assessors, undertake an annual
assessment to a standard format of their non-clinical services including, but not limited to, cleanliness, condition and appearance.

**POMH**
The national Prescribing Observatory for Mental Health (POMH) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice. It identifies specific topics within mental health prescribing and develops audit-based Quality Improvement Programmes (QIPs).

**PPI (Patient and Public Involvement)**
The creation of a partnership between patients and the public and researchers, to try to make the research process more effective.

**Pressure ulcer (PU)**
An area of skin that breaks down when something keeps rubbing or pressing against the skin. Good nursing care and pressure area management are essential to the prevention and management of pressure ulcers.

**Primary care**
Primary care is the day-to-day health care given by a health care provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a health care system, and co-ordinates other specialist care that the patient may need.

**Psychosis**
A severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality.

**QSGC**
Quality, Safety and Governance Committee is a standing committee of CPFT Board. Its over-arching responsibility is to provide the Board with assurance that high standards of care are provided by the Foundation Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout CPFT.

**Quality Account**
A report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.

**Quality Dashboard**
Enables a straight forward graphical view of the performance of CPFT against certain Outcomes. These Outcomes have been identified as those requiring improvement throughout CPFT based on Care Quality Commission (CQC) requirements.

**Recovery**
This is about being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual’s recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.

**Recovery College**
The Recovery College was set up by CPFT in October 2013 to empower people with mental health problems to become experts in their own recovery. It provides a range of
courses and workshops to service users, carers and members of staff to develop their skills, understand mental health, identify goals and support their access to opportunities.

**Safeguarding Adults**
Aims to support adults at risk to retain independence, well-being and choice and to be able to live a life that is free from abuse and neglect

**Safeguarding Children**
The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.

**Schizophrenia**
This is a long-term mental health condition that causes a range of different psychological symptoms, including hallucinations, delusions, muddled thoughts based on hallucinations or delusions and changes in behaviour.

**Senior Information Risk Owner (SIRO)**
An Executive Director or Senior Management Board Member who will take overall ownership of the Organisation’s Information Risk Policy, act as champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Organisation’s Statement of Internal Control in regard to information risk.

**SI (Serious Incidents)**
The definition of a Serious Incident (SI) extends beyond those incidents which impact directly on patients and includes incidents which may indirectly impact on patient safety or an organisation’s ability to deliver ongoing healthcare services in line with acceptable standards. CPFT adopts the definition of SI as set out by the NPSA in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and as adopted by the Cambridgeshire and Peterborough Clinical Commissioning Group. In brief, an SI is an incident that occurred in relation to NHS-funded services and care resulting in: unexpected or avoidable death, serious harm, a provider organisation’s inability to continue to deliver healthcare services, allegations of abuse, adverse media coverage and/or one of the core set of Never Events.

**Social care**
The provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.

**Third sector**
The range of organisations that are neither public sector nor private sector including voluntary and community organisations.

**Triangle of Care**
This is a scheme set up by the Carers’ Trust and the National Mental Health Development Unit to improve the involvement of carers and families in the care planning and treatment. The approach, developed by carers and staff, aims to improve carer engagement throughout services and to improve partnership working between people using services, their carers, and organisations.

**ZERO Tolerance**
Non-acceptance of antisocial behaviour, typically by strict and uncompromising application of the law.
ANNEX 3

STATEMENTS FROM CLINICAL COMMISSIONING GROUP, LOCAL HEALTHWATCH and OVERVIEW AND SCRUTINY COMMITTEES

23 May 2016

Statement from Cambridgeshire and Peterborough Clinical Commissioning Group

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) has reviewed the Quality Account produced by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) for 2015/16.

The CCG and CPFT work closely together to review performance against quality indicators and ensure any concerns are addressed. There is a structure of regular meetings in place between the CCG, CPFT and other appropriate stakeholders to ensure the quality of CPFT services is reviewed continuously with the commissioner throughout the year. In addition, the CCG has carried out announced and unannounced visits to CPFT to observe practice and talk to staff and patients about quality of care, feeding back any concerns so the Trust can take action where required.

At the start of 2015/16 CPFT experienced a period of significant change, having joined in partnership with Cambridge University Hospitals NHS FT to form UnitingCare, an organisation responsible for commissioning the provision of Adult and Older Peoples’ services for the CCG. This resulted in a substantial increase in the number of staff working for CPFT, bringing a new directorate, Integrated Care, and a new range of skills and challenges as the provider of community services in Cambridgeshire and Peterborough. CPFT rose to the challenge and for staff and patients there was reportedly an easy transition. It is also widely recognised that the delivery model has brought positive change for patients and the local system, and CPFT are now building on this. In October 2015, the commissioning of the community services passed back from UnitingCare to the CCG, which led to further change for staff. CPFT has managed this addition transition well and ensured staff were supported, motivated and felt well led.

In October 2015 CPFT Mental Health Services also had a positive Good rated CQC rating, from an inspection carried out in May 2015. For the Trust this was a real achievement with positive comments including an organisation focussed on caring and compassionate services, good staff morale and a board with a clear vision.

However concerns were identified regarding potential clinical risk in the Children and Adolescence Mental Health service (CAMHS) due to capacity and increased demand. This reflects high profile national concerns. Following close working with the LA and CCG joint commissioning team additional investment was identified, the waiting lists re-opened in December with the aim of delivery of 18 week waits by the end of March 2016. This has been achieved and the Trust are to be commended on their approach to partnership working and already recognised improvements for children and families.
There was also a mismatch identified between capacity and demand in the Personality Disorder (PD) service which resulted in a waiting list for both assessment and then treatment and concerns about the safety of patients with unmet need following initial triage. A new consultant was recruited to work in the PD service from February 2016 to address the backlog of cases and already a positive impact has been felt.

Other areas of concern raised by the CCG with CPFT in 2015/16 included training levels for staff for Safeguarding Children. This improved during the year and the Trust was complaint at all levels by October 2015.

There have been many examples of good practice highlighted by the Trust during 2015/16 including the Triangle of Care programme which supports carers in their role working with patients and CPFT staff and the leadership role they have taken in delivering the Urgent and Emergency Care Mental Health work stream.

12 May 2016

CAMBRIDGESHIRE & PETERBOROUGH FOUNDATION TRUST (CPFT)
QUALITY ACCOUNT 2015/16
STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL
HEALTH COMMITTEE

The Health Committee within its scrutiny capacity has examined the following issues with CPFT over the past year:

- CPFT Adult & Child Mental Health Service Pressures (16th July 2015)
- Older People & Adult Services – Termination of the Uniting Care Contract (21st January 2016)
- CPFT & CCG Update on Mental Health Service Pressures (21st January 2016)
- Older People & Adult Services – Learning from Internal reviews (12th May 2016)

Minutes of these discussions can be found following the link below.
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/Committee.aspx?committeeID=76

The Health committee welcomed the update on progress made against quality priorities 2015/16 as outlined in the draft report that has been shared for comment with the committee. The Health Committee also wanted to note the “good” rating CPFT received from the CQC inspection last year. The committee has continued to meet with the Chief Executive from CPFT through liaison meetings which has provided enhanced communication and resulted in some formal scrutiny and understanding of the pressures faced specifically around the Child & Adolescent Mental Health Services. The committee was concerned with the closure of ADHD clinics and examined this further in their scrutiny meeting in July 2015 and January 2016. The committee noted the current pressures and the measures put in place locally to mitigate these.

Whilst there is a recognition in the Quality Account, of the services that CPFT acquired in April 2015 as part of the Uniting Care Partnership contract, the health committee is concerned over the future direction of the new Integrated Care Directorate and the ability for CPFT to manage the integrated care needs of the local population. The health committee welcomes continual open and honest dialogue with CPFT as these services are developed to meet the needs of the local population.
Detailed Scrutiny

CPFT Adult & Child Mental Health Service Pressures – 16th July 2015
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=11850

Older People and Adult Services - Termination of the Uniting Care Contract – 21st January 2016
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12696

CPFT & CCG Mental Health Service Pressures – 21st January 2015

Minutes of the discussion can be located here
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12973
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12694
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12695

Peterborough Overview & Scrutiny Committee

We have not received a formal commentary from the Peterborough Overview & Scrutiny Committee this year.

15 May 2016

Healthwatch Peterborough comment on Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Quality Account 2015-16

Healthwatch Peterborough welcomes the Trust’s commitment to engage with the public through the appointment of two Patient Research Ambassadors. We also commend the Trust’s use of public engagement events such as the Vanguard Mental Health Project engagement events, which Healthwatch Peterborough supported and promoted. We also welcome the Trust’s decision to attend and contribute to our local monthly community meetings held in Peterborough, providing regular updates on their activities and responding to public feedback raised in those meetings.

There appears limited information in regards the termination of the Uniting Care contract in December 2015, only eight months after commencement. The Trust was the major contract holder and continues to work to deliver many of the services in that contract, so it may be useful to provide an overview regarding these services and how the Trust is moving forward.

Targets met by the Trust and those not met are clearly displayed in the performance on quality priorities for 2015/16 table, along with a detailed breakdown. This demonstrates an encouraging level of transparency on areas for improvement.

Healthwatch Peterborough supports the inclusion of patient safety in the Trust’s strategic priorities; particularly as this reflects the findings following the CQC inspection that the Trust requires improvement in the ‘Are services safe’ category.
Healthwatch Peterborough were delighted to support the Trust by providing its own staff and trained volunteers as ‘patient-volunteers’ required to take part in the Patient-Led Assessment of the Care Environment (PLACE) for the Trust. Further, we welcome the Trust’s response to the findings from these patient-led reviews, in highlighting improvements needed.

Healthwatch Peterborough wished to commend CPFT for hosting the **Collaboration for Leadership in Applied Health Research and Care East of England (CLAHRC EoE)** and facilitating its research into dementia in prisoners. Over the past two years Healthwatch Peterborough has been working to improve engagement between prisoners and health services. CLAHRC EoE’s research into prisoners with dementia, and on the effects of dementia champions and buddyng services upon those prisoners, is a sign that positive change is indeed occurring.

Healthwatch Peterborough wishes to commend CPFT for publishing the results of the various patient surveys in an open and transparent manner. The results of the Mental Health Community Survey seem to indicate a lack of adequate interaction and information for many mental health patients. We recommend the Trust use this valuable evidence to allocate adequate time to ensuring that each patient or carer has an opportunity discuss their care and has access to information necessary to navigate other areas of life which impact on mental health, such as housing and employment.

The new Health and Wellbeing Strategy diagram is rather simplistic and fails to demonstrate the relationship between the four key themes. There is also little, if any, detail in the resources and information available to staff, and feedback from these schemes and/or any outcomes.

Overall Healthwatch Peterborough recognises many of the achievements by the Trust, and the dedication and commitment of the staff who provide the services, often in challenging circumstances. Our relationship with the Trust is very positive, especially with the attendance at our monthly meetings to reach out to the Peterborough community. We also commend the Trust on the provision of transparency in its information and where improvements are required. We look forward to our continued commitment to raising the patient and carer voice and being the critical friend to the Trust.

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**18 May 2016**

**Healthwatch Cambridgeshire comment on Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Quality Account 2015-16**

2015/16 has been a time of great change for CPFT NHS Foundation Trust. Healthwatch Cambridgeshire recognises the significant challenge experienced by the Trust as a result of being the major partner in the Uniting Care consortia; the preferred bidder for the Older People’s and Adult Services contract. The transition of a large number of staff, whilst at the same time establishing a new organisation, Uniting Care, and developing and starting to deliver new integrated models of care was a hugely significant undertaking. Furthermore, the collapse of that contract in December 2015 has had a major impact upon the Trust, both financially and developmentally. However, the Trust’s
staff are to be commended in ensuring that at no time any patient care was compromised by the collapse of the contract and for their commitment to patient care and maintaining services through a period of extensive change.

Healthwatch Cambridgeshire welcomes the ‘Good’ CQC rating received by the Trust during 2015. The CQC report did however highlight low staffing levels in some areas. This is consistent with feedback received by Healthwatch Cambridgeshire which indicates that people have difficulties accessing mental health support services, particularly post-discharge. Healthwatch Cambridgeshire has experienced difficulties referring patients to the Crisis Resolution Service, which has a narrow remit. Extra resources in these areas are needed and welcomed.

Healthwatch Cambridgeshire has received feedback regarding the delays in accessing Personality Disorder Services. It is understood that a new service model has been developed for this vital service and look forward to seeing improvements, particularly decreases in waiting times.

Healthwatch Cambridgeshire was one of the local Healthwatch that escalated nationally concerns around Children and Adolescents’ Mental Health Service. These concerns were collected from a number of local partner organisations and centred around waiting times and lack of information. This feedback was directly fed to the national Task Force and informed ‘Future in Mind’. Healthwatch Cambridgeshire very much welcomes the current redesign of CAMH Service and has been able to support this by feeding in the views of children and young people.

Paragraph 3.2.1 solely sets out numbers of complaints; there is no demonstration of resulting learning. In future Quality Accounts Healthwatch Cambridgeshire would look to see how learning from complaints is embedded throughout the organisation.

Healthwatch Cambridgeshire welcome Patient Experience as a Trust Priority area for 2016/17. The work of the Recovery College is an excellent example of how the Trust places people at the heart of their care and recovery. Demonstrable extension of this ethos throughout the whole of the Trust would represent a significant step forward. With the Trust now responsible for providing integrated mental health services, learning disability and community services the scale of this task should not be underestimated.

Healthwatch Cambridgeshire looks forward to working constructively with the Trust in the coming year as it consolidates and integrates these newly acquired services.
ANNEX 4

STATEMENT OF DIRECTOR’S RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations 2010 to prepare quality accounts for each financial year.

Monitor 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 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 2015-16 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period 1 April 2015 to 25 May 2016;
  - papers relating to Quality reported to the Board over the period 1 April 2015 to 25 May 2016;
  - feedback from commissioners, Cambridgeshire and Peterborough Clinical Commissioning Group dated 23 May 2016;
  - feedback from Governors, dated 17 May 2016;
  - feedback from Cambridgeshire Overview & Scrutiny Committee dated 12 May 2016;
  - feedback from Healthwatch Peterborough dated 15 May 2016;
  - feedback from Healthwatch Cambridgeshire dated 18 May 2016;
  - The national staff survey “2015 National NHS Staff Survey - Cambridgeshire and Peterborough NHS Foundation Trust”;
  - The Head of Internal Audit opinion on the effectiveness of the system of internal control for the year ended 31 March 2016 dated 20 May 2016;
- 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 Monitor’s annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the Quality Report (available at [www.monitor.gov.uk/annualreportingmanual](http://www.monitor.gov.uk/annualreportingmanual)).

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

NB: sign and date in any colour ink except black

25 May 16 Date .................................................. Chairman

25 May 16 Date .................................................. Chief Executive
ANNEX 5

EXTERNAL AUDIT REPORT

Independent auditor’s limited assurance report to the Council of Governors and Board of Directors of Cambridgeshire and Peterborough NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Directors and Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust to perform an independent limited assurance engagement in respect of Cambridgeshire and Peterborough NHS Foundation Trust’s Quality Report for the year ended 31 March 2016 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital;
- admissions to inpatient services had access to crisis resolution home treatment teams.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditor
The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual’ issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance
- the Quality Report is not consistent in all material respects with the sources specified in Monitor’s ‘Detailed guidance for external assurance on quality reports 2015/16’, and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the ‘NHS Foundation Trust Annual Reporting Manual’ and the six dimensions of data quality set out in the ‘Detailed guidance for external assurance on quality reports 2015/16’.

We read the Quality Report and consider whether it addresses the content requirements of the ‘NHS Foundation Trust Annual Reporting Manual’, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2015 to 25 May 2016;
papers relating to quality reported to the Board over the period 1 April 2015 to 25 May 2016;
feedback from Commissioners, dated 23 May 2016;
feedback from Governors, dated 17 May 2016;
feedback from local Healthwatch organisations, dated 15 May 2016 and 18 May 2016;
feedback from Overview and Scrutiny Committee dated 12 May 2016;
the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 18 April 2016;
the 2015 national staff survey;
the CQC Intelligent Monitoring Report dated February 2016;
the Head of Internal Audit’s annual opinion over the Trust’s control environment, dated May 2016.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust as a body and the Board of Directors of the Trust as a body, to assist the Board of Directors and Council of Governors in reporting Cambridgeshire and Peterborough 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 2016, to enable the Board of Directors and 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 Board of Directors as a body, the Council of Governors as a body and Cambridgeshire and Peterborough NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:
- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual’.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Cambridgeshire and Peterborough NHS Foundation Trust.

**Conclusion**
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance.

Grant Thornton UK LLP
London
25 May 2016