NHS
Pennine Care
NHS Foundation Trust

Agenda

BOARD OF DIRECTORS PI

Wednesday 3 May 2023, commencing at 2.00 pm – 4.30 pm

Boardroom, Trust Headquarters, 225 Old Street, Ashton-under-Lyne, OL6 7SR

- There will be a 10-minute break at approximately 3.15 pm

		Doc Ref	Action required	Lead ED/ NED	Presented by
1.	**Apologies for Absence** Mo Brown - Staff Governor (Registered Health and Social Care Professionals) **Observers –** Michelle England - Partnership Officer Atta Hanfi - Public Governor (Bury)	Verbal	For noting	EA-M	EA-M
2.	**Declarations of Interest** Against any items contained within the agenda	Verbal	For noting	E-AM	E-AM
3.	**Questions** At the Chair's discretion, questions may be invited from public attendees				
4.	**Previous meeting of the Board of Directors** Minutes of a meeting of the Board of Directors held on 1 March 2023	004.1	For approval	EA-M	EA-M
5.	**Matters arising and action plan** Action plan arising from meetings of the Board	005.1	For approval	EA-M	EA-M

		Doc Ref	Action required	Lead ED/ NED	Presented by
Culture					
6.	6.1 Freedom to Speak Up Guardian – Annual Report 6.2 Chair's & Chief Executive's report: March and April 2023 6.3 Workforce Race Equality Standard and Workforce Disabled Equality Standard 2022/23 6.4 Immediate response to media reports	006.1 006.2 006.3 006.4	To receive For noting For approval For noting	CP AH/EA-M NL AH	PG AH/EA-M NL AH
Strategy					
7.	7.1 Annual Business Plan 7.2 Operational Plan 2023/24 7.3 Clinical Strategy	007.1 007.2 007.3	For approval For discussion For approval	GM GM/NT SSa	GM GM/NT SSa
Annual Accounts					
8.	8.1 Draft 2022/23 Annual Accounts	008.1	To receive	NT	NT
Performance					
9.	9.1 Integrated Performance Report	009.1	For noting	DK	DK
Accountability					
10.	10.1 Audit Committee • Chair's reports: 15 March & 26 April 2023	010.1	For noting	EV	EV
	10.2 Performance and Finance Committee • Chair's reports: 29 March & 26 April 2023	010.2	For noting	DB	DB
	10.3 People and Workforce Committee • Chair's report: 28 March 2023	010.3	For noting	LA	LA
	10.4 Quality Committee • Chair's reports: 28 March & 25 April 2023	010.4	For noting	CE	CE

		Doc Ref	Action required	Lead ED/ NED	Presented by
	10.5 GM CAMHS Lead Provider Sub-committee • Chair's report: 29 March 2023	010.5	For noting	EV	EV
	10.6 Terms of reference review • Board and sub-committees	010.6	For approval	CP	AChi
	10.7 Risk Management Policy CO129 • Business Continuity Plans	010.7	For noting	CP	ACha
	10.8 Well led recommendations and actions	010.8	For scrutiny	Execs	AChi
	10.9 Board Assurance Framework	010.9	For approval	Execs	AChi
11.	**Any other business** 11.1 Information circulated since the last meeting				
12.	**Reflections on the meeting** **The next meeting of the Board of Directors will take place on:** Wednesday 7 June 2023, commencing at 2.00 pm – Venue TBC				

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Minutes

Board of Directors Part I

Wednesday 1 March 2023, 2:00 pm – 4.30 pm
Boardroom, Trust Headquarters, 225 Old Street, Ashton-under-Lyne, OL6 7SR

Present:

Liz Allen	Non-Executive Director
Edward Vitalis	Non-Executive Director
Daniel Benjamin	Non-Executive Director / Deputy Chair (Meeting Chair)
Claudette Elliott	Non-Executive Director
Maqsood Ahmad	Non-Executive Director
Anthony Hassall	Chief Executive Officer
Clare Parker	Executive Director of Nursing, Healthcare Professionals and Quality Governance / Deputy Chief Executive
Nicky Tamanis	Executive Director of Finance
Nicky Littler	Executive Director of Workforce
Gaynor Mullins	Director of Strategy
Simon Sandhu	Medical Director
Andy Chittenden	Director of Corporate Affairs

In attendance:

John Starkey	Assistant Trust Secretary (minutes)

Observing:

Michelle England	Partnership Officer
Mr. Eric Solomons	Public attendee
Mr. David Holden	Good Governance Institute - Director
Mr. Usman Khan	Good Governance Institute - Senior Advisor & Principal Consultant

1. Apologies for absence
The Chair welcomed everyone to the meeting, noting apologies had been received from; Evelyn Asante-Mensah – Chair, Clare Todd - Non-Executive Director and Donan Kelly - Chief Operating Officer

2. Declarations of interest
No interests were declared.

3. Questions
No questions were received prior to meeting or raised by observers.

4. Previous meeting of the Board of Directors

4.1 Minutes of a meeting of the Board of Directors held on 1 February 2023

The Chair presented minutes from a meeting of the Board of Directors held on 1 February 2023 to the Board for approval.

The Board approved the minutes subject to a minor typographical amendment identified in the meeting.

5. Matters arising and action tracker

5.1 Matters arising

No other matters arising were raised.

5.2 Actions arising from meetings of the Board of Directors

The Chair presented the action tracker arising from meetings of the Board of Directors to the Board for approval. All completed actions and items for future meetings were noted. The following updates were provided:

Delegation of authority to the Performance and Finance Committee to approve the financial elements of the Scheme of Delegation: The paper was presented to Performance and Finance Committee on 22 February and subsequently circulated to Board members.

6. Culture

6.1 Chair and Chief Executive's update: January 2023

The Chief Executive and Chair presented the Chair and Chief Executive report. Highlights were;

- National update on key issues, including industrial action, national financial position, recovery of the NHS and pressures on mental health services
- Greater Manchester update on the strategy for health and care and the independent review into Greater Manchester Mental Health NHS Foundation Trust
- Trust update, covering challenges and improvements, celebrating success, research and innovation, senior appointments, awareness events and Chair and Chief Executive meetings and visits over the month.

The Board discussed the update and noted the contents of the reports.

6.2 Gender Pay Gap report

Ms Littler presented the report, which included the statutory requirements of the Gender Pay Gap legislation and also provided further context, demonstrating the Trust's commitment to being fair and equal. Key points highlighted were:

- The mean gender pay gap had slightly increased from 11.32% to 11.55%.
- There was a lower proportion of female staff in the upper quartile pay band compared to the proportion of female staff in the other three pay bands.

- Across the staff employed by the Trust (not including consultants), there was a much lower proportion of male staff working in the organisation compared to female staff.

The Board noted and discussed the report and suggested it would be useful to benchmark the Trust's results against other providers within Greater Manchester.

Action: Ms Littler to compare results of neighbouring Trusts outside the Board meeting to provide a starting point for reporting in 2024 (not included on action tracker.)

7. Strategy

7.1 Neurodevelopment Pathway

The Deputy Chair sighted the Board on recent Governor concerns for any Trust patients impacted by the change of service provider away from LANCuk.
Dr Sandhu provided a commentary on the history of the service and the impact of the change on the Trust's patients – predominantly 170 patients returned to the Stockport CAMHS service from LANCuk, with additional patients on a waiting list awaiting treatment. There was GM-wide awareness of the position, with plans in hand for the triage of these patients.

Action: Mr Hassall to contact the Integrated Care Board to offer support, a written update should be provided to the Board in May 2023 and the risk register updated to reflect the position.

8. Resources

8.1 Annual Plan – planning update

Ms Mullins presented a report to provide Board with an update on the annual planning guidance and timelines for submission of the operational plan.

The ICB draft submission was made to NHSE 23rd February 2023. As with last year there was one overall submission made by the ICB, with contributions from providers being coordinated by GM.

The draft financial plan indicated a deficit of £19.3m. The overall draft workforce plan assumed no change to the overall establishment with an increase in WTE staff in post, reducing the current establishment gap.

PCFT activity trajectories assumed no / minimal increase in activity levels from actual during 2022/23.

Ms Tamanis provided an update on the financial plan. Final plans covering finance, activity and workforce were due to submitted by the ICB on 16th March 2023 with final plans due for submission by 30th March 2023. Draft plans covering finance, activity and workforce are due to submission by the Integrated Care Board on 23 February 2023 with final plans due for submission by 31 March 2023.

The Board noted the contents of the report and the financial challenge, particularly with the level of capital funding. The Board resolved to exercise extreme caution before accepting any dilution of the capital plan, should the system request one.

The Board agreed delegated authority of sign off for final submission to Anthony Hassall, Evelyn Asante-Mensah, Daniel Benjamin and Liz Allen.

The Board resolved to exercise extreme caution before accepting any dilution of the capital plan, should the system require one.

Action: Board approved delegated authority of sign off and submission of annual plan to Anthony Hassall, Evelyn Asante-Mensah, Daniel Benjamin and Liz Allen.

9. Performance

9.1 Strategic Performance Assurance report

Ms Mullins presented the Quarter 3 report that provided Board with assurance that strategic objectives were being delivered in line with agreed plans. The report included the January 2023 integrated performance dashboards, providing an update on performance against key operating standards, in line with published data and identified key issues, risks and achievements.

Key standards that remained a risk included;

- Out of Area Placements,
- Talking Therapies (formerly IAPT) Access, recovery and waiting times,
- Data Quality Maturity Index
- Flu Vaccination
- Staff Attendance.
- My Yearly Conversation
- Core and Essential Training compliance
- Turnover
- Eating Disorders 4-week routine access

Some progress had been made during Quarter 3, but several plans were behind where they originally planned to be by the end of the quarter. Delays were mainly attributed to capacity, confirmation of investment and/or decision regarding funding and changes in leadership across key programmes. Progress was still being made with overall in-year deliverables expected to be achieved by the end of quarter 4 or, where appropriate, a revised timeline agreed.

Ms Tamanis presented the finance dashboard including updates on financial performance, cash balances, capital expenditure and efficiency.

Board discussed the report in depth and questioned performance around core and essential training and my yearly conversation. A deep-dive was suggested in respect of compliance with fire safety training and Ms Parker agreed to provide a verbal update on fire safety training at next Board meeting.

Action: Ms Parker to provide a verbal update on fire safety training compliance at next Board meeting.

9.2 Business continuity plans - Evacuation plans for inpatients

Mr Chittenden provided a narrative on the report, which provided a lower level of assurance than the Board's appetite and further work was being undertaken to meet the Board's requirements. A replacement EPRR Manager was due to start employment with the Trust to assist progress in this area.

The Board considered and noted the contents of the report and that progress updates would be reported to the Performance & Finance Committee.

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10. Accountability

10.1 Quality Committee Chair's report: 21 February 2023

Ms Elliott presented the report and the highlighted work done around learning and assurance from national reports such as the Ockenden Independent Review and the learning from the recent Panorama programme.

The Board received and noted the report.

10.2 Performance and Finance Committee Chair's report: 22 February 2023

Mr Benjamin presented the Chair's report and the Board received and noted the report.

10.3 Board Appointment and Remuneration Committee Chair's report: 15 February 2023

Mr Benjamin presented the report and highlighted key areas discussed.

The Board received and noted the report.

10.4 Council of Governors Chair's report: 8 February 2023

Mr Benjamin presented the report and highlighted key areas discussed.

The Board discussed communications with Governors and noted the broad range of experience, skills and expertise brought by Governors.

The Board received and noted the report.

10.5 Well led recommendations and actions

Mr Chittenden provided an update on progress made in actioning the agreed recommendations of the autumn 2022 Well Led review by Deloitte LLP. The Board's Quality and Performance and Finance committees were provided with opportunities during 21-22 February to scrutinise the assurance provided.

The Board received and noted the report.

10.6 Board Assurance Framework

Mr Chittenden provided assurance as to the mitigation of the Trust's six strategic risks and set out how Board Committees had undertaken reviews of each of the risks. Information was provided on higher-scoring operational risks and examples of how these were being linked to the Trust's strategic risks.

The Board received and noted the report and reflected on the potential to move capital and financial sustainability once the final planning had been completed. Board discussed future plans to progress this work.

10.7 Information circulated since last meeting

The Board noted items shared for information since the last meeting.

11. Any other business

11.1 Delegated authority request

The Board authorised delegated authority to the April Audit Committee to approve submission of the draft accounts.

11.2 Observation by Board development partner

Initial feedback on the Board meeting was provided verbally and formal feedback would be provided by the Good Governance Institute in due course.

12. Reflections on the meeting

The Chair thanked members for their engagement in the discussions and debate on the agenda items.

Date and time of next meeting

The next meeting of the Board of Directors held in public will take place on Wednesday 3 May 2023, commencing at 2.00 pm, venue to be confirmed.

Action tracker

Schedule of actions arising from meetings of the PI Board of Directors

	MIN NO	TOPIC	DATE ADDED	ACTION REQUIRED	FOR ACTION BY (TITLE)	FOR ACTION BY (DATE)	STATUS/PROGRESS
1	8.1	Annual Plan	01/02/2023	Provision of the final version of the Annual Plan at the Board Development Session 05/04/2023	Executive Director of Strategy	05/04/2023 03/05/2023	Not yet due - due 05/04/2023 - no meeting in April so will be brought for formal approval to Board 03/05/2023
2	5.2	Single gender accommodation: older adults	02/11/2022	Follow up evaluation summary report be provided to Board in 6 months-time. Report to include lessons learned themes, any access issues, progress on developing staff skills training and feedback on benefits to patients.	Executive Director of Nursing, Healthcare Professionals & Quality Governance / Deputy Chief Executive	03/05/2023	Not yet due - due 03/05/2023
3	5.3	Patient Story: 6 July 2022	07/09/2022	Thematic learning outcomes from patient stories summary to be prepared and submitted to Quality Committee for discussion.	Executive Director of Nursing, Healthcare Professionals & Quality Governance / Deputy Chief Executive	03/05/2023	Action put in progress. Discussed Dec Board meeting – Agreed summary of themes, collated from patient stories, be provided.
4	7.1	Neurodevelopment pathway	01/03/2023	CEO to contact the Integrated Care Board to offer support, a written update should be provided to the Board in May 2023 and the risk register updated to reflect the position.	Chief Executive Officer	03/05/2023	In the ICB, Manisha Kumar, Medical Director, has now taken over as mental health lead with Mandy Philbin, Chief Nurse, as lead for learning disability and autism. Mr Hassall has met with Manisha and has agreed to jointly Chair the GM Mental Health, Learning Disability and Autism Board. As part of these revised leadership arrangements the priorities, plan and resourcing of GM MHLDA priorities for 23/24 is being defined. It is expected that this will include review neurodevelopmental pathways. In addition, for children, we have agreed to report CAMHS waiting times through our Board governance and ensure we have strong sight on the impact of demand for neurodevelopmental assessment. This work is ongoing.
5	9.1	Strategic Performance Assurance report	01/03/2023	Ms Parker to provide a verbal update on fire safety training compliance at next Board meeting.	Executive Director of Nursing, Healthcare Professionals & Quality Governance / Deputy Chief Executive	03/05/2023	

Pennine Care
NHS Foundation Trust

Report to the Board of Directors
Wednesday 3 May 2023

Freedom to Speak Up Annual Report	
Paper prepared by	Phil Gordon: Freedom to Speak Up Guardian
Executive sponsor	Clare Parker: Executive Director of Nursing, Healthcare Professionals, Quality Governance and Deputy Chief Executive
Date of report	17/04/23
Purpose of the report and action required	Provide an independent perspective on Trust progress in development of the Freedom to Speak Up (FTSU) agenda. Provide assurance on the approach and activities of the Freedom to Speak Up Guardian (FTSUG) and FTSU team. Assurance of learning opportunities being identified and applied in response to casework.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	• Executive responsibilities are under Executive ownership, with continued development of the supporting governance / monitoring arrangements • The FTSUG role is well resourced, allowing for all proactive and reactive aspects of the role to be carried out, responsive to variations in demand • Trust-wide, The NHS Staff Survey and FTSU casework indicate a continued improvement in the culture of speaking up • Where staff groups may face particular challenges to speaking up, the FTSUG team is collaborating with those in roles that are key to facilitating continued learning and improvement
Recommendation	The Board of Directors is recommended to note the contents of the report.
Where else has this report been considered and when?	Quality Committee 25/04/23

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	**X**
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	

1. INTRODUCTION / PURPOSE

1.1 The purpose of this report is to provide the Board of Directors with:

- An independent perspective on Trust progress in development of the Freedom to Speak Up (FTSU) agenda
- Assurance on the approach and activities of the Freedom to Speak Up Guardian (FTSUG) and FTSU team
- Analysis of the themes and trends from the NHS Staff Survey 2022 and FTSU casework over the last 12 months, with recommendations as appropriate

2. EXECUTIVE RESPONSIBILITIES IN CONTEXT OF NATIONAL UPDATES (prepared in partnership with Executive Lead)

2.1 Trusts are required to consider the recommendations from National Guardian Office (NGO) case reviews. The NGO published a Speak Up Review of ambulance trusts in England in February 2023 with four recommendations, specific to the ambulance sector. On review, themes from FTSU casework or soft intelligence did not indicate any need for these recommendations to be applied at this Trust.

2.2 A research paper into the implementation of FTSU in NHS acute and mental health trusts concluded that optimal implementation of the role includes five components. These are mapped against the Trust position below:

Component	Trust Position
1. An early, collaborative and coherent strategy	Work in progress for Board reflection and planning tool, FTSU Action plan, and oversight groups (see section 2.3)
2. Robust yet supportive policies and practices	Up to date policy meeting best practice recommendations
3. Frequent, reflexive monitoring of FTSU implementation	As per component 1
4. Sufficient time and resource allocation [for FTSUG role]	Assurance provided in Board reports as standard
5. Positive implementation climate	Collaborative approach to FTSU including direct access to senior leaders, quarterly Board reports / strategic oversight group, and monthly casework oversight group

2.3 The table below summarises the position and plan for Executive responsibilities:

Executive-Led Responsibility	Position	Plan
Board reflection and planning tool	Under Executive Lead review	To be shared with and reviewed by the Board of Directors (national requirement)
FTSU Action plan	Summarises all opportunities to implement recommendations from internal and external documents / learning: now under Executive ownership	Establish supporting governance and reporting arrangements
Oversight groups	Quarterly strategic oversight group and monthly casework oversight group	

3. FTSUG CAPACITY AND ADDITIONAL ACTIVITIES

3.1 The FTSUG is contracted to work 0.7 WTE, with paid additional hours up to 1 WTE according to need. The FTSUG worked additional hours in 7 months, averaging at 9.9 additional hours per month across the year.

3.2 The national FTSUG Job Description requires FTSUGs to support and contribute to regional and national FTSUG networks. Ongoing external activities include:

- Chair of the North-West FTSUG Network
- Mentor conversations for new FTSUGs
- Buddying up with the FTSUGs at Greater Manchester Mental Health NHS Foundation Trust and NHS Greater Manchester Integrated Care

3.3 Internal additional activities help to increase awareness of the FTSUG role. These include:

- Deputy Chair of the Trust LGBT+ Staff Network
- Equality mentor
- Schwartz round facilitator
- Equality Impact Assessment assessor
- Participation in Trust coaching pool (postholder is completing a coaching apprenticeship)
- Regular Trust-led communications on all routes of speaking up

4. FTSU AMBASSADORS

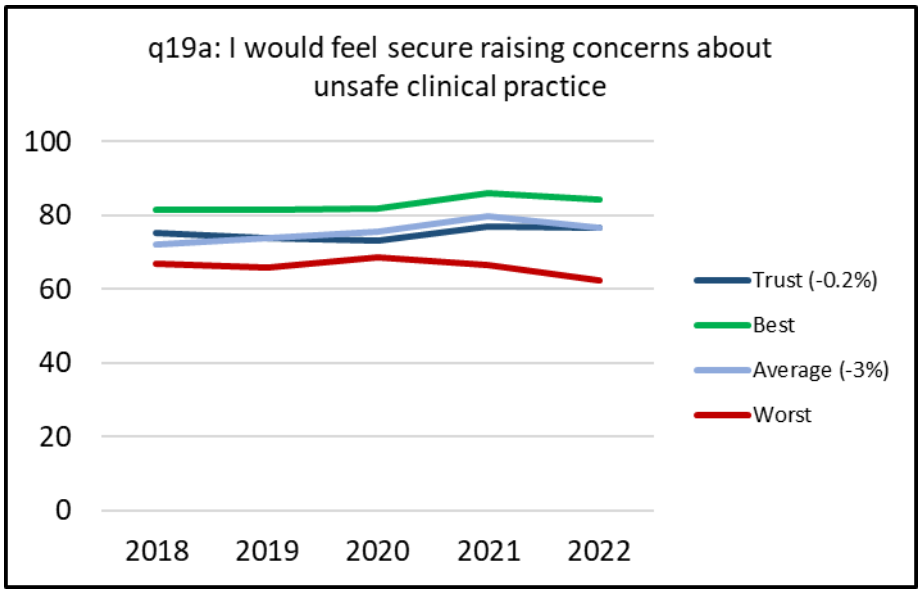
4.1 We currently have twelve FTSU ambassadors.

4.2 More could be done to recruit FTSU ambassadors from a range of backgrounds. This will be discussed with the newly expanded Equality, Diversity and Inclusion team. However, a high proportion of colleagues from minority backgrounds already engage with the FTSU route (see section 7.1).

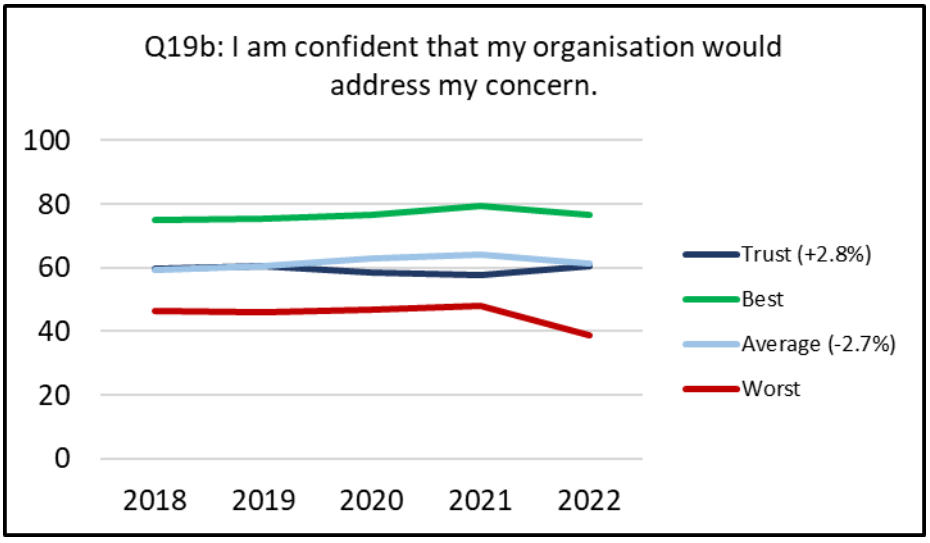
4.3 Our Chief Executive and Chair plan to meet with our FTSU ambassadors face to face on 26/04/23.

5. NHS STAFF SURVEY

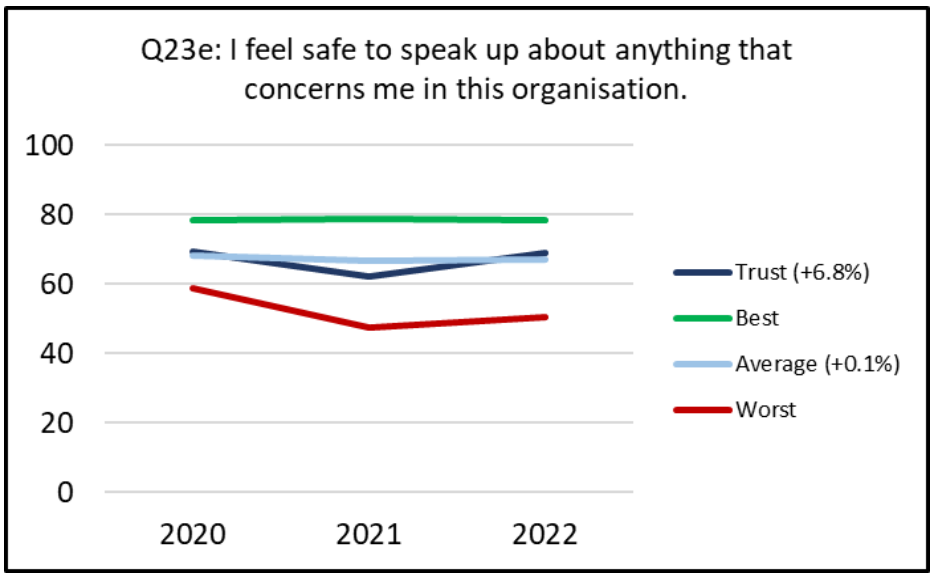
5.1 There was a national decline in staff feeling secure raising concerns about unsafe practice. However there was only a slight decline at this Trust:

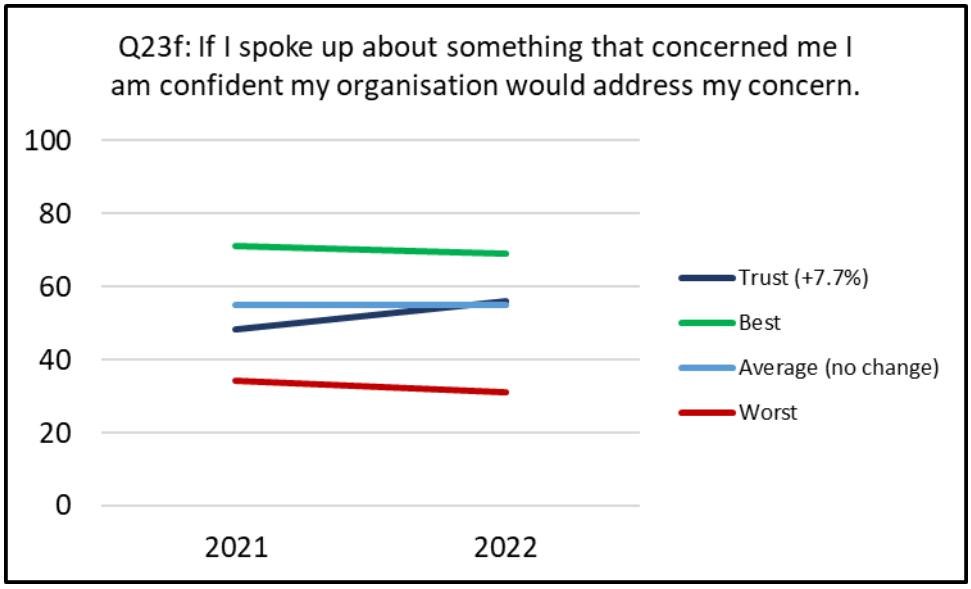


5.2 There was also a national decline in confidence that these [clinical] concerns would be addressed, however at this Trust we saw an improvement:



5.3 Nationally there was no change in staff feeling able to speak up about anything that concerned them and confidence that this would be addressed. However for both these questions, our Trust showed a marked improvement, bringing us above the national average:





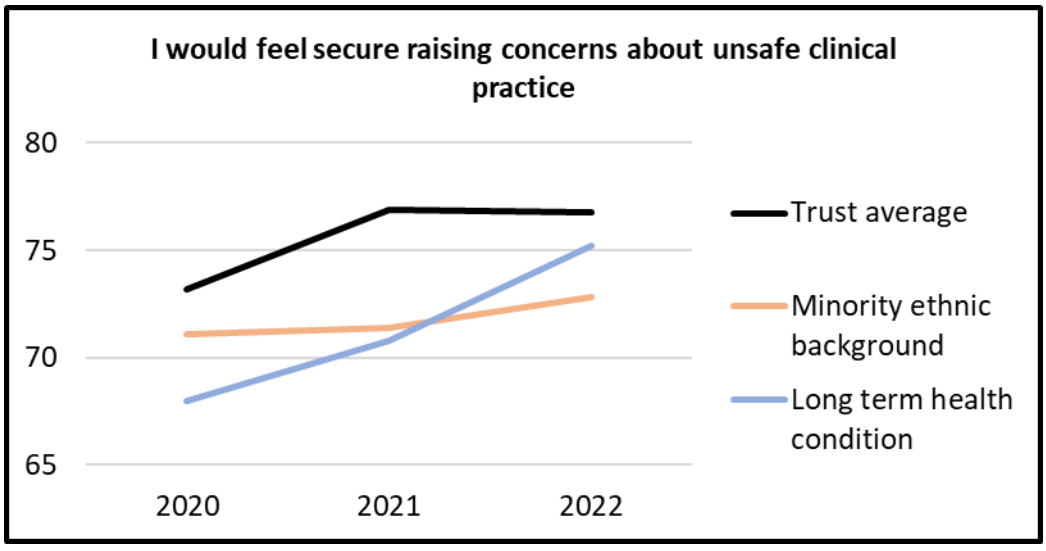
5.4 The data can be examined further to compare perceptions between particular groups of staff. The heat map below shows the greatest opportunities for targeted improvement for each question:

NHS Staff Survey Speaking Up Questions (Trust)	Additional Clinical Services	Nursing and Midwifery Registered	Add Prof Scientific and Technical	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Medical and Dental
I would feel secure raising concerns about unsafe clinical practice	79.3 %	84.0 %	77.5 %	69.5 %	79.0 %	61.1 %	71.9 %
I am confident that my organisation would address my concern	67.1 %	61.2 %	59.7 %	59.6 %	56.1 %	57.4 %	40.6 %
I feel safe to speak up about anything that concerns me in this organisation	73.7 %	70.0 %	71.2 %	66.7 %	63.2 %	67.9 %	68.8 %
If I spoke up about something that concerned me I am confident my organisation would address my concern	62.9 %	55.1 %	57.2 %	56.9 %	50.9 %	52.8 %	37.5 %
Average	**70.8%**	**67.6%**	**66.4%**	**63.2%**	**62.3%**	**59.8%**	**54.7%**

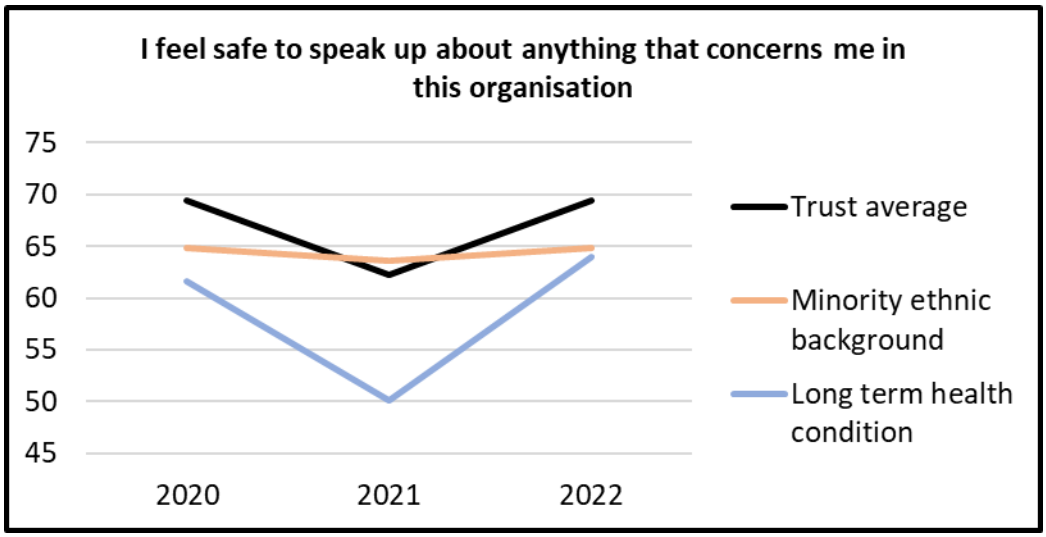
5.5 The table below summarises actions in relation to the greatest opportunities for improvement (with input from the relevant senior leaders):

Opportunity for Improvement	Actions
Estates and Facilities staff: Confidence in speaking up about clinical concerns	• FTSUG meets regularly with Director of Estates and Facilities • Bespoke FTSU session to be arranged with senior management team • EFM Group Bi-monthly meeting Agenda has specific Speak up item included - 'Non estates related site concerns'. This is for senior team discussion around any concerns noted from staff across the EFM team that are not estates related
Allied Health Professionals: Confidence in speaking up about non-clinical concerns	• Reported to Board of Directors November 2022: discussed issues around professional isolation, inclusion and involvement • Principal OT started 17/04/23: FTSUG to liaise • FTSU feature in AHP bulletin • Focus on recruitment of FTSU ambassadors from AHP background • FTSUG scheduled to attend Trust AHP event October 2023
Assuring that feedback to Medical colleagues ensures their concerns have been addressed	• Bespoke FTSU session doctors teaching programme 26/10/22 • FTSUG and Guardian of Safe Working Hours met January 2023 • Senior medical colleague interested in becoming FTSU ambassador

5.6 A richer picture is provided using data from the previous two years. For example, underneath the unchanged average response for security in raising clinical concerns, there has been improvement for some minority groups:



5.7 For speaking up about any concern, the significant improvement brings us back to where we were in 2020, and the Trust average correlates with the experiences of staff with long term health conditions:



5.8 The Trust *FTSU survey 2022* explored the average confidence around the expected response to concerns. While the questions themselves are not directly comparable to the *NHS Staff Survey*, the disparity in responses was greater for colleagues from minority ethnic backgrounds compared to those reporting a disability.

5.9 Comparisons for *NHS Staff Survey* questions for protected characteristics, both national and Trust-specific, are available via the dashboard and local heatmaps respectively. The table below combines these: for all speaking up questions, the disparity is greater than the national average for colleagues from minority ethnic backgrounds, and smaller than the average for colleagues with long term conditions:

NHS Staff Survey Question	Differences in percentage of positive responses for…			
	…staff from minority ethnic backgrounds (compared to white staff)		…staff with long-term conditions (compared to those without)	
	National*	Trust	National*	Trust
Q19a: feel secure raising concerns (clinical)	-2.2	-4.7 (↓)	-5	-2.3 (↑)
Q19b: confident organisation would address concern (clinical)	+1.7	0 (↓)	-8	-6.8 (↑)
Q23e: feel safe to speak up about anything	-4.9	-5.3 (↓)	-8.1	-7.8 (↑)
Q23f: confident organisation would address concern	+0.2	-3.7 (↓)	-9.4	-6.5 (↑)

**Mental health and learning disability (and community) Trusts*

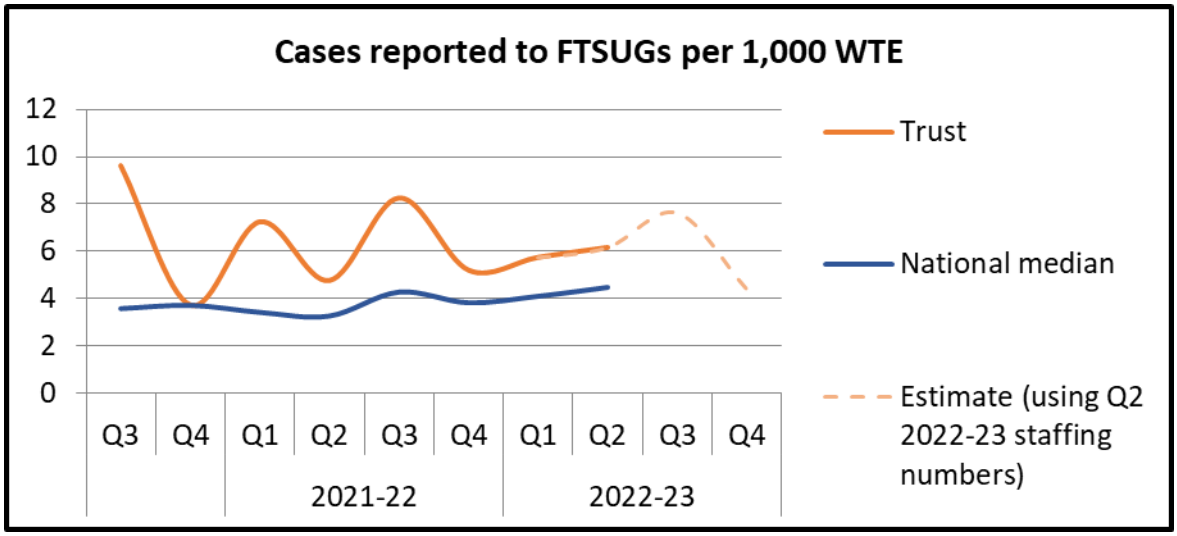
5.10 The NHS staff survey and FTSU survey data were also compared for colleagues who identify as LGBT+. In both sets of data:

- There was no significant disparity between different sexual orientations (except nationally for those who reported "other")
- Nationally, those who identified their sex as not being the same as that registered at birth reported lower confidence in speaking up, but the lowest results were in those who responded

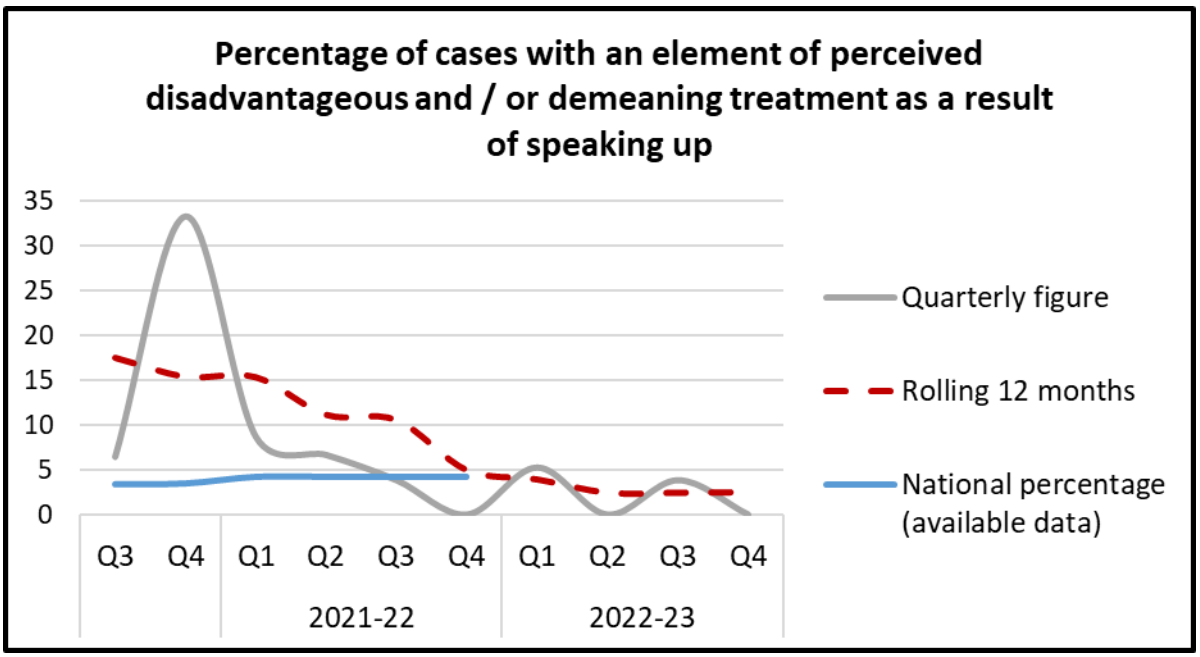
"prefer not to say"

6. CASEWORK THEMES AND TRENDS

6.1 The rate of FTSU cases is usually higher than the national average, but appears to be close to it for Q4:



6.2 The improvements in our rate of perceived detriment as a result of speaking up have been maintained:



6.3 The table below shows how we compare favourably against the national picture for other indicators of the health of our culture of speaking up. In particular, our rates of anonymous FTSU concerns are currently four times lower than average:

	National 2021-22	Trust 2021-22	Trust 2022-23
Cases raised anonymously	10.4%	6.2%	2.5%
Staff saying they would speak up again	86.7%	92%	87.5%

6.4 The table below summarises the number of concerns raised including various themes:

Theme	2022-23				
(**red**= individual assurance provided to Casework Management Group	Q1	Q2	Q3	Q4	TOTAL
Policy and procedure	6	6	11	2	25
Other inappropriate attitudes / behaviours	6	10	5	4	25
Worker safety / wellbeing	5	6	4	6	21
Bullying and harassment	3	5	2	5	15
Recruitment practices	3	4	4	3	14
Quality and safety	3	4	3	4	14
Patient experience	1	2	2	4	9
Service change	4	1	1	0	6
Staffing levels	2	1	1	0	4
Equipment and maintenance	0	0	1	2	3
Discrimination	1	2	0	0	3
Disadvantageous / demeaning treatment	1	0	1	0	2
Anonymous	1	0	1	0	2
Fraud / bribery / corruption	0	0	0	2	2
Person capability	0	0	0	1	1
Covid-19	0	0	0	0	0
Immediate safety concern	0	0	0	0	0

6.5 The themes collected have been reviewed for 2023-24:

- *Covid-19*, *Equipment and Maintenance* and *Person Capability* have been removed
- *Reasonable Adjustments* and *Fear of Repercussions* have been added

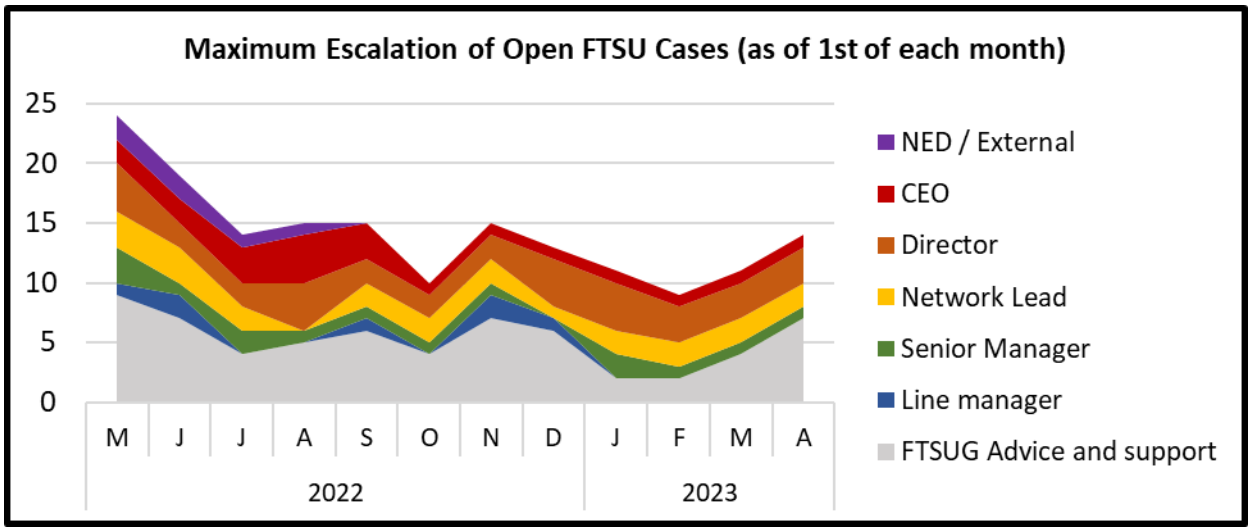
6.6 Exploring the top themes in more detail:

- *Policy and Procedure:* Cases explored and no sub-themes identified
- *Worker Safety / Wellbeing:* This theme is required by the NGO. Where this theme appears in casework, the heavy bias is towards the impact of the concern on the individual's wellbeing: there are no trends around concerns for worker safety
- *Attitudes / Behaviours / Bullying and Harassment / Quality / Safety:* Expected due to nature of FTSUG role, no sub-themes to escalate
- *Recruitment Practices:* See section 7.2

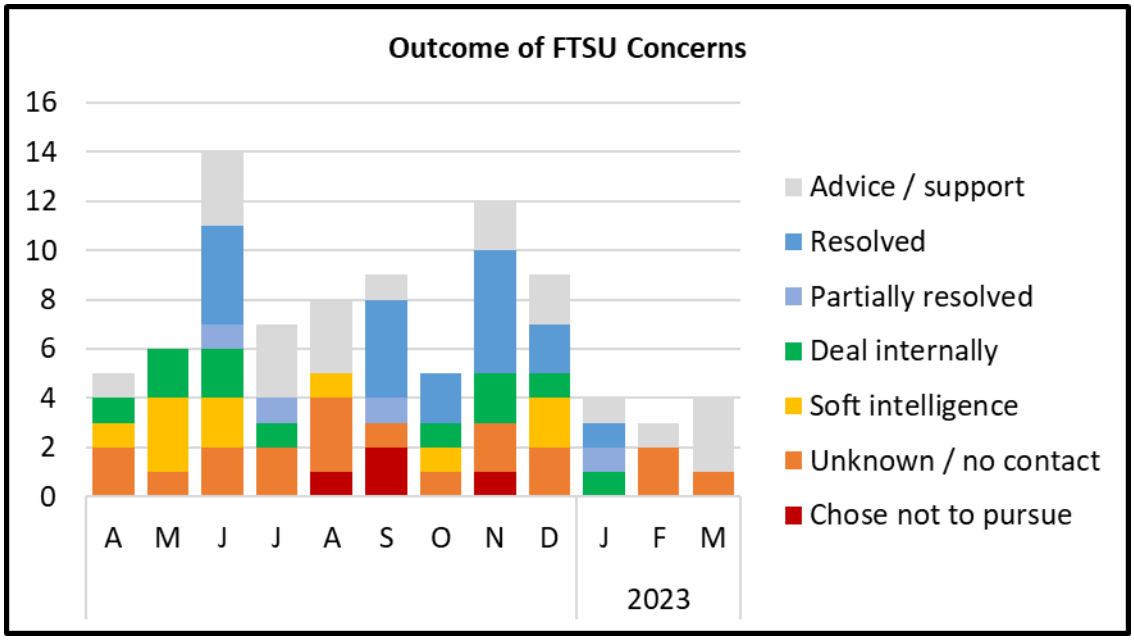
6.7 Referring to Q4 in particular:

- For five individuals who have spoken up to the FTSUG, their concerns fit within wider issues known internally. Several internal processes are underway, and awareness had previously been raised at the appropriate level of senior management.
- *Fraud / bribery / corruption:* These concerns are outside of the norm for FTSU casework. Both concerns refer to the same instance, with no indication of financial loss to the Trust. The nature of the issue has been shared with the Executive Lead, and the individuals advised it is being investigated via internal processes. (The FTSU signposts all concerns relating to fraud to the Local Counter Fraud Officer as per Trust policy.)

6.8 Case numbers and escalation levels remain steady, with a recent increase in advice and support provided.



6.9 When compared to the previous year, the only noticeable change in outcomes is a reduction in cases where the individual chose not to pursue their concern (four this year compared to seven in the previous year). This outcome is sometimes attributed to personal reasons: there are no sub-themes to report. Outcomes are summarised below:



6.10 Colleagues who proactively provided qualitative feedback were very positive about their experience of speaking up via the FTSU route (Appendix 1).

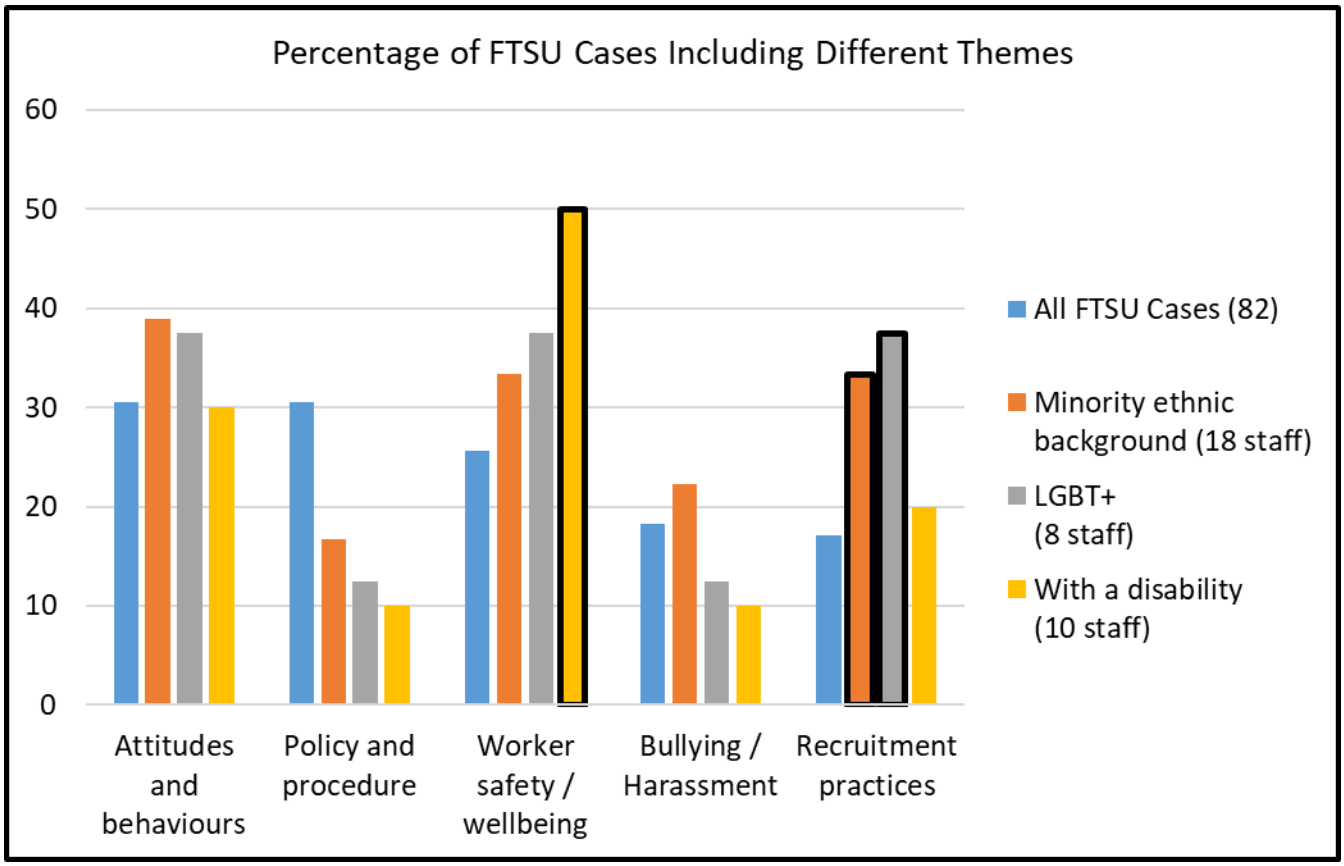
7. EQUALITY, DIVERSITY AND INCLUSION

7.1 The 2021-22 FTSU annual report indicated that the diversity of colleagues approaching the FTSUG was broadly representative of the workforce. This year, the proportion of staff from minority ethnic backgrounds and identifying as LGBT+ has increased significantly.[1]

Colleagues speaking up via FTSU identifying as…	**2021-22**	**2022-23**
Minority ethnic background	18%	34%
LGBTQ+	9%	15%
Disabled / long term health condition	19%	19%

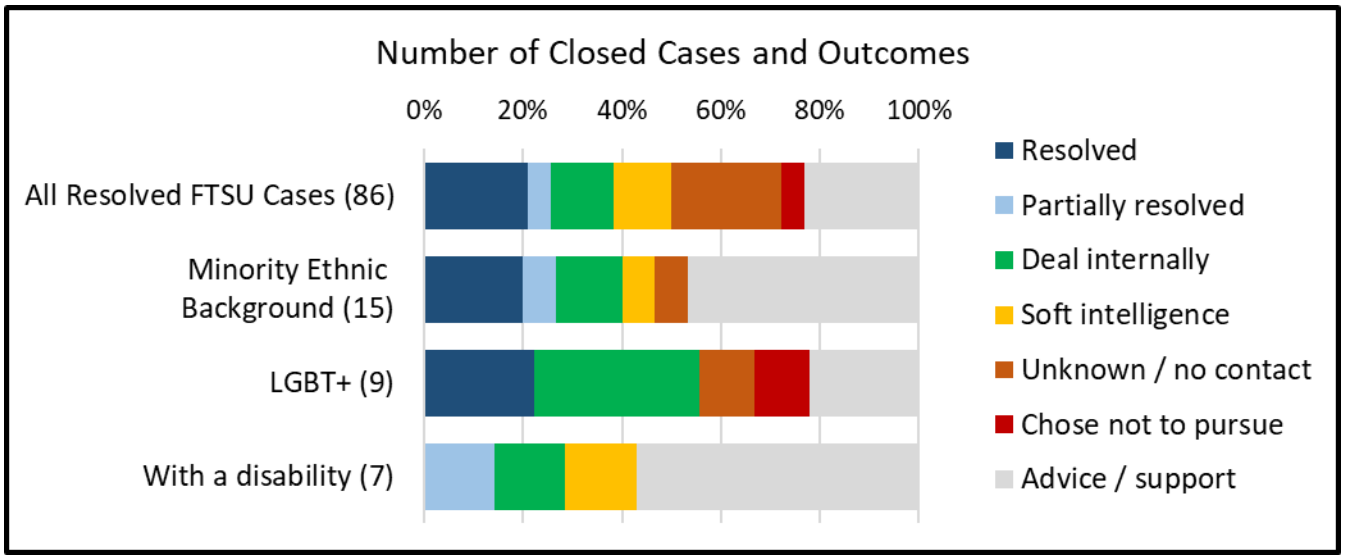
7.2 The graph below shows the proportion of FTSU cases with different themes for different minority groups, with the greatest disparity for each minority group outlined in black. Of particular note:

- Colleagues with a disability were twice as likely to have a concern that impacted on their wellbeing
- Colleagues from minority ethnic backgrounds / from the LGBT+ community were twice as likely to speak up about recruitment practices,



[1] Research indicates that staff with a minority ethnic background are six times more likely to approach a FTSUG who also has a minority ethnic background. https://nationalguardian.org.uk/wp-content/uploads/2021/09/Difference_Matters.pdf

7.3 Outcomes of FTSU cases are broadly consistent for staff from minority groups, for example the percentage of resolved concerns is about the same. This is consistent with 2021-22 casework:



7.4 For colleagues with a disability, the absence of cases confirmed to the FTSUG as resolved is considered alongside the low sample size and equal absence of negative outcomes. Therefore no sub-themes have been identified.

Commentary

7.5 Colleagues from minority groups speaking up via FTSU experienced equitable outcomes. The overrepresentation of some minority groups / themes may be indicative of the level of confidence in the internal routes for root issues related to inclusion. This information may inform related ongoing work within the Trust.

7.6 The Trust is in the process of establishing a newly expanded Equality, Diversity and Inclusion team. The FTSUG will collaborate fully with this new team to provide information to support organisational challenge and progress around EDI issues.

8. SUMMARY, KEY MESSAGES AND FORWARD VIEW

8.1 In summary:

- Executive responsibilities are under Executive ownership, with continued development of the supporting governance / monitoring arrangements
- The FTSUG role is well resourced, allowing for all proactive and reactive aspects of the role to be carried out, responsive to variations in demand
- Trust-wide, The NHS Staff Survey and FTSU casework indicate a continued improvement in the culture of speaking up
- Where staff groups may face particular challenges to speaking up, the FTSUG team is collaborating with those in roles that are key to facilitating continued learning and improvement

9. RECOMMENDATIONS

9.1 The Board of Directors is recommended to note the contents of this report.

APPENDIX 1: QUALITATIVE FEEDBACK

Qualitative feedback is not proactively sought: below are instances where colleagues took the time to share their experiences of speaking up via the FTSU route.

Admin & Clerical

- *"…felt very supported by the FTSU guardian…been amazing at keeping [me] informed and supporting us to separate our personal grievances from our FTSU issues, ensuring none of it is lost in translation"*
- *"Helpful / supportive safe space to discuss concerns"*
- *"…so helpful and even if I do not get what I wanted (and I understand why) at least I know it has been raised and is 'on record'"*

Allied Health Professions

- "I am very grateful for your professional support, it was so helpful and actually made me feel a lot better about what options I had…it felt safe and confidential, and I felt very much listened to with objective and informed advice."
- "It gave me confidence to speak out...I think having a sounding board to help organise my thoughts was really invaluable."

Corporate Services

- *"I didn't really have faith in the process...but having spoken up I now feel very differently...it has been a very positive process for me."*

Estates & Facilities

- "…very helpful. Thank you for all your help and advice."

Medical

- *"Brilliant in listening to me and advising me."*

Nursing

- *"Thanks for all your support…I think FTSU is a brilliant service. The fact you are impartial allows you to see both sides and that is something I needed as it was very emotional stuff."*

Psychological Therapies

- *"I would definitely speak up again and found having someone independent from my team a really helpful resource."*
- *"It's helpful both to have impartial advice and having the external wider knowledge of the system. It just adds confidence of knowing what to say and who to say it to. I would use the speak up service again if needed as it shares the problem and takes some of the anxiety away of having to deal with it alone."*

Team Manager

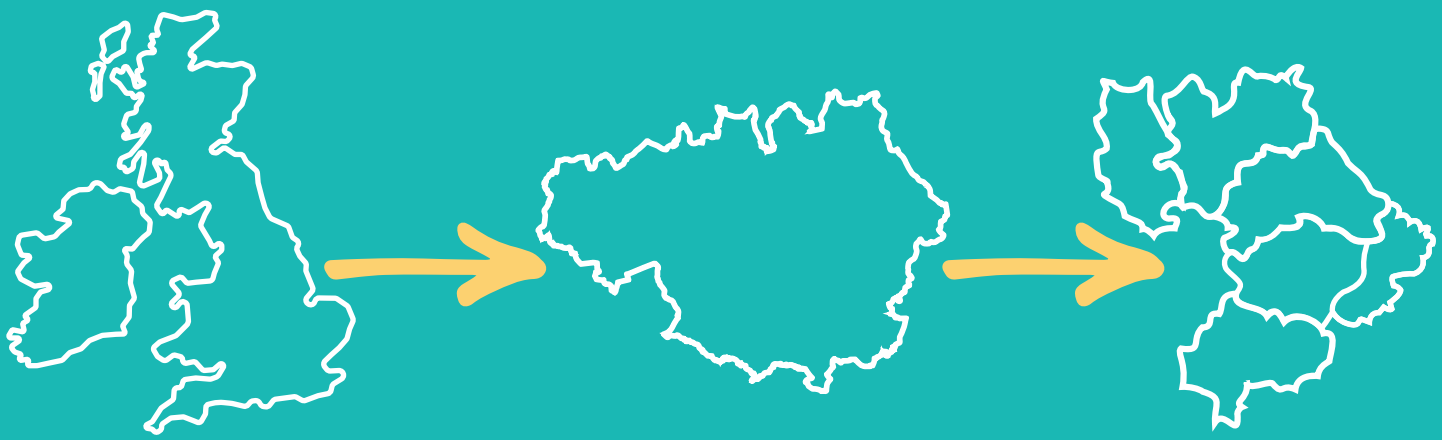
- *"I would definitely ring you again if I need to speak up. I felt you listened to me and took my concerns seriously."*

NHS
Pennine Care
NHS Foundation Trust

Chair and CEO Board report

March and April 2023

The Chair and Chief Executive report outlines key strategic and operational issues relevant to the Trust, not covered elsewhere on the Board agenda and set in a national, regional, and local context.



Maximising potential

Report to the Board of Directors March and April 2023 Part I

Chair and Chief Executive Report	
Paper prepared by	Karen Hamer, Senior Exec PA to the Chief Executive and Chair / Olivia Donnelly, Graphic Designer
Executive sponsor	Evelyn Asante-Mensah, Chair Anthony Hassall, Chief Executive
Date of report	March/April 2023
Purpose of the report and action required	The attached report sets out strategic and operational updates from a national, regional, and local perspective.
Trust Goals	
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The report includes updates on: • Industrial action • Workforce • Spring budget changes • Workforce Race Equality Standard Report • Patient Safety • Mental Health, Learning Disabilities and Autism transformation programme • Services under pressure • Integrated Care Boards • NHS Estates • Covid Inquiry • Digital improvements in the NHS • Greater Manchester Mental health stakeholder briefing • GM Integrated Care Partnership Strategy 2023 – 28 • Trust updates including: • Trust HQ redesign • Improvements to services • New services • Digital improvements • Trust challenges and improvement • Operational Plan • Staff Survey
Recommendation	The Board of Directors is asked to note the report.
Where else has this report been considered and when?	N/A

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	**X**
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	

National update

Industrial action

Members of the Royal College of Nursing (RCN) union have rejected the government's pay offer in England and will now go on strike from 30 April to 1 May (24 hour walkout).

Members of the RCN in Pennine Care did not vote to participate in this round of industrial action. However, as with previous strike action, we are reviewing business continuity and risk issues associated with action within neighbouring organisations and will keep these plans updated.

Junior doctors took strike action for 72 hours in March, ahead of the budget, and for four days in April following the Easter Bank Holiday weekend.

Junior Doctors deployed within Pennine Care took action on both of these dates. We had strong contingency planning arrangements across the medical and clinical workforce and thanks to our medical directorate team and clinical directors, all shifts were covered, maintaining medical workforce cover during a very pressured period. We will review and update our contingency planning arrangements for any future strike action based on lessons learnt from these two instances of strike action.

Workforce

Health leaders have warned at risk NHS staff will be left in "dangerous" situations without support when national funding for mental health hubs ends next month. The hubs are being forced to close or reduce services as neither the Department of Health and Social Care nor the NHS has confirmed ongoing funding for 2023-24. This is at a time when record levels of NHS staff are seeking mental health help as clinicians warn the "crisis" facing workers is "worse than the pandemic".

As Board members will know, Pennine Care runs the Greater Manchester Resilience Hub on behalf of Greater Manchester NHS (and social care) organisations. The Hub has been noted nationally for its work on developing 'trauma informed' care models and is increasingly supporting organisations outside of the NHS and social care system. Whilst the national decision to stop elements of funding for the mental health hubs is disappointing, the Greater Manchester Integrated Care Board has indicated a willingness to discuss and continue at least many elements of the current Resilience Hub offer and we are discussing with them how the model can be both improved and modified to meet a new funding environment.

New data has revealed registered nurse vacancies across the NHS in England are up 10% in a year (43,619 nurse vacancies). According to NHS Providers, the total mental health nursing workforce has declined by 10% since May 2010 – a reduction of more than 4,000 mental health nurses. However, the organisation said it is important to note that the reduction has been in inpatient

settings, and 'encouragingly the numbers of community mental health nurses has increased in recent years'.

In Pennine Care, workforce remains our biggest risk and, whilst we have seen some progress in the past 12 months in reducing our overall vacancy rates, these still remain high and pose risks to our organisation and wider system. There is a particular risk around Band 5 inpatient nurse vacancies and variation across our Trust in attracting candidates to these roles. Our ongoing work on culture and retention, as well as 'growing our own' through our trainee nurse associate, apprenticeship and other programmes are having an impact, but there is more to do in this area. We will bring an update on our workforce strategy through our governance in 2023.

Rule changes designed to encourage NHS pension scheme members to work for longer have been confirmed by government and may lead to a rise in staff opting for partial retirement. The changes for staff who have retired and returned came into force from April, although the rules for staff who wish to partially retire will not come in until October 2023.

We welcome these changes as conversations with medics and other senior professionals across our Trust have indicated that the previous pension scheme rules were acting as a disincentive to take on additional duties or activities.

Health Education England (HEE) has published its new strategy to ensure the NHS has enough educators supporting the next generation of health professionals.

The seven priorities include:

- Ensuring educators are a key consideration in integrated workforce and service planning;
- Protecting educators' time and resources to help Integrated Care Board workforce plans;
- Implementing career frameworks for all educators;
- Supporting the development and wellbeing of educators;
- Catalysing improvement via defined standards and principles;
- Boosting equality, diversity and inclusion by promoting the NHS aspirations;
- Harnessing the potential of new education models.

Pennine Care has a strong reputation as an educator across a range of health professionals and, whilst it is challenging in the face of operational constraints, we recognise the value of continuing to develop our education role and welcome this strategy. We will review this in line with our current workforce and education priorities to ensure we are able to take advantage of any opportunities this may offer.

The British Medical Association is appealing to organisations across the healthcare sector to stamp out sexism in the medical profession. Among the 10 goal pledge is a call for senior doctors to 'Call out sexism' and be responsible and accountable for tackling their own bias. The 'Ending sexism in medicine' declaration has already been signed by NHS Employers, NHS Providers, the Medical Women's Federation, and numerous royal medical colleges and other representative organisations.

In Pennine Care we will discuss the pledge and commitment through our Women's Staff Network and are planning to sign this pledge as part of our wider work on equality, diversity and inclusion.

Spring budget

On 15th March, the Chancellor delivered his Spring Budget setting out measures which will help grow the economy and improve labour market activity. The measures announced include an expansion of childcare provision, reforms to support disabled people and those with long term health conditions back into work, an extension to the government's Energy Price Guarantee and changes to the pension tax system.

This NHS Providers' briefing outlines the key policy announcements, as well as their analysis of the implications for the health and care sector.

Workforce Race Equality Standard Report

NHS England have published the annual Workforce Race Equality Standard (WRES) data report. This is a link to a briefing provided by NHS Providers on the report, On the day briefing: Workforce Race Equality Standard (WRES) - NHS Providers. NHS Providers have welcomed the development of targeted initiatives to tackle race inequality. Their foreword also makes the moral case for tackling race inequality, highlighting that there is still much work to be done there. It also talks about the link between improved staff experience and better patient outcomes.

We will report the Pennine Care position at the May Board and are already working on refreshing and revising our action plans in this area, in line with our staff survey results and areas for improvement.

NHS England have circulated a statement to all North West regional Chairs and Chief Executives regarding the Black, Asian and Minority Ethnic Assembly, highlighting the importance and the need for all senior leaders to tackle racism within the NHS.

Pennine Care fully endorses and supports the work of the Assembly and, as we review our approach and plan around engagement, EDI and our work on the patient, carer race equality framework, we will ensure strong connectivity to the work of the Assembly and our part in its leadership and development.

Patient Safety

Mental health trusts are exploring wider use of CCTV to review incidents of seclusion or restraint in response to high-profile abuse scandals. All providers of mental health, learning disability and autism services were asked to review safety and feedback to NHS England's national team. The request was made in a letter from national director Claire Murdoch sent in response to abuse allegations aired by BBC Panorama and Channel 4's Dispatches.

As part of our 'Learning and Assurance' response to the safety and quality issues identified at Greater Manchester Mental Health and other Trusts, we have included all recommendations from those reports into a single action and response plan. This includes reviewing our approach to seclusion and restraint amongst other issues. This is being reviewed and updated through our quality governance structure and reported to Board directly and through our quality committee.

Charities have said that too many patients, mostly elderly, were being left "to become a shadow of their former themselves" and stripped of mobility and independence as delays, due to problems with paperwork and assessments, rise. NHS data, revealed under Freedom of Information disclosures, shows the numbers of patients stuck in hospitals in England for at least three weeks has doubled in the last year to 19,308.

The Greater Manchester Integrated Care Board has distributed additional delayed discharge monies through localities.

Pennine Care has been in discussion with all five of our localities to ensure issues associated with delays for mental health, learning disability and autism patients receive parity of attention and funding. Delayed discharges continue to impact on our services with approximately 12% of our beds occupied by patients who could be more suitably managed in alternative settings. The drivers of these delays are complex and sometimes long standing (lack of supported housing provision for example), however this additional recurrent funding is welcome – although allocations have varied across all of our localities, meaning that in some instances the existing variation we see in service provision across our boroughs will worsen rather than get better. The Chief Executive has raised this with the Integrated Care Board.

Mental health, learning disability and autism transformation programme

A new national quality transformation programme supports expanding and improving the quality of community care for people with mental health problems, including people with a learning disability and autistic people. It has four core themes:

- Localising and realigning inpatient services
- Improving culture and supporting staff
- Supporting systems and providers facing immediate challenges
- Making oversight and support arrangements fit for the sector.

We have now received the information associated with the quality improvement 'offer' from this national programme and are reviewing this to ensure we can both align our existing approach to quality improvement and ensure maximum gain and impact from the national offer. This will link to our wider 'Learning and Assurance' plan and wider quality strategy.

The National Institute for Health and Care Excellence (NICE) has recommended eight online therapies for anxiety and depression. NICE says the therapies have the potential to help more than 40,000 people in the UK. Each therapy must come with a formal assessment from an NHS therapist in order for it to be recommended.

As with all NICE recommendations, these therapeutic offers will be reviewed and incorporated as appropriate into our wider service and clinical offer.

Services under pressure

The Royal College of Psychiatrists (RCP) warn children's lives are at risk because eating disorder services are overstretched and unable to deal with a surge in demand. The RCP said the NHS is "facing an eating disorders crisis", with referrals to specialist services for under-19s up 51% compared with 2019. Every region of England is failing to meet waiting time targets for conditions such as anorexia and bulimia.

Services delivered across the Pennine Care footprint in this area are operated by a number of different service providers, including ourselves, Greater Manchester Mental Health and the private sector. We have seen an increase in referrals for service operated by Pennine Care and, whilst we have maintained performance on a number of metrics (as reported through our integrated performance report), it is true that the mix of service provision, the lack of service provision (for some specialist areas) and increases in demand are putting pressure on services.

The lead provider for specialist eating disorder services across the North West is Cheshire and Wirral Partnership NHS Foundation Trust, whilst service commissioning in Greater Manchester is overseen by the Integrated Care Board. The Chief Executive has raised the issue of shortfalls in eating disorder provision with the Integrated Care Board and is in ongoing dialogue with them and other system partners about the action we could take to address the risks these issues pose.

A Freedom of Information investigation has uncovered a postcode lottery in child and adolescent mental health care, with some young people waiting up to four years for help. In 2022, NHS Providers surveyed all mental health trusts and asked them how they would describe their ability to meet current demand. More than 80% of community CAMHS services said they were not able to meet current demand, 30% more than adult community mental health services, the next most burdened. The government has designed the new integrated care systems to help address inequalities in mental health funding, ensuring any budget increases for medical and physical health services are matched in mental health services.

Demand for CAMHS services remains high and waiting times are increasing across all of our localities and is noted on our risk register. This demand has worsened by the failure of a number of local independent sector providers, as well as increases in awareness of mental health conditions for children. We will provide a full report and update on the waiting time issues for CAMHS through our governance structure, together with the actions we are taking to safeguard quality and the actions we are asking partner organisations to take to ensure we are delivering a whole system approach to this.

Integrated Care Boards

Integrated care boards (ICBs) have been told to cut their staffing costs by 30%. In a letter to local leaders, NHS England said the running cost allowances for ICBs will be subject to a 30% real terms reduction by 2025-26, with at least 20% to be delivered in 2024-25.

The Hewitt Review has recommended that 10 of the most mature integrated care systems should be given far greater control over their spending and operations from next April. The review also recommends a major reduction in central targets and a shake-up of funding rules. It asks government to set the service no more than 10 national targets in its annual mandate. NHS Providers have compiled a briefing from the report: here

Pennine Care welcomes the themes of the Hewitt review and looks forward to working with partners and with NHS England on the implications and recommendations of the review – particularly the view of taking a much more balanced approach to waiting time reporting and management across physical and mental health.

NHS Estates

NHS Providers has published a new report, No more sticking plasters: repairing and transforming the NHS estate, which explores the state of capital funding and allocations across the NHS provider sector and sets out how capital investment has the potential to transform the NHS. The report explains why major capital investment – at the system and national level – is crucial to enabling trusts to improve productivity, operational performance, and patient care across all sectors.

For Pennine Care, our capital envelope remains significantly below that which we need to both invest and modernise our estate. However, despite this, we continue to work hard to make best use of our limited capital envelope and pursue opportunities for joint working with local authority partners, which sometimes offer us ability to access capital support outside of normal NHS routes.

Trusts must seek additional approvals for new building developments if they cannot comply with a series of new green standards, including the total amount of carbon produced by projects. The NHS has published its net zero building standards, which aim to reduce emissions in the construction and running of new facilities.

Pennine Care has received and will comply with this request which will align with our 'Green Plan' and emerging estates strategy.

Covid Inquiry

There has been a second preliminary hearing on Module 1 (which concerns resilience and preparedness of the UK for the Covid pandemic). The Covid Inquiry has just published the agenda for the first preliminary hearing for Module 3 which looks at the impact of the pandemic on healthcare.

Campaigners say race should be made a central part of the UK's independent public inquiry into the pandemic. A letter sent to the chair of the Covid-19 inquiry, calls for it to look at "racism as a key issue" at every stage.

Pennine Care will continue to keep connected to the Covid Inquiry Hearings and will co-operate in full with them and any information requests which we receive.

Digital Improvements in the NHS

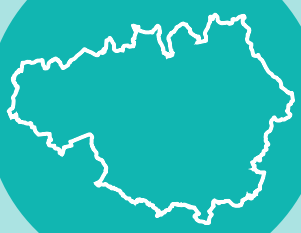
An independent expert panel reporting into the Commons Health and Social Care Committee has found the government is making inadequate progress on vital commitments to digitise the NHS.

Patients are set to benefit from improved protection as the Government will publish its new cyber security strategy for health and social care this summer.

Not withstanding the national challenges cited above, we have confirmed a clear investment and improvement plan for Pennine Care in line with our digital strategy and we are now implementing this.

Whilst we are disappointed with the levels of capital funding made available to us, we are working hard to make improvements across our infrastructure. Cyber security remains a high risk for all NHS organisations and we welcome this new cyber security strategy.

Greater Manchester update



Greater Manchester Mental Health NHS Foundation Trust - Stakeholder Briefing March 2023

Greater Manchester Mental Health's (GMMH) Trust Board have received findings from the independent investigation by the Good Governance Institute which looked at governance and assurance processes. The published report can be accessed here: Incidents and investigations | Greater Manchester Mental Health NHS FT (gmmh.nhs.uk).
Pennine Care has responded to the draft improvement plan published by GMMH with a range of comments and offers of collaborative support.

As part of our approach to learning and development, our Board will hold a development session in May on the ongoing findings and learning from GMMH and its review of governance and decision making.

Launch of Greater Manchester Integrated Care Partnership Strategy 2023 - 2028

A stakeholder briefing has been published summarising the vision, outcomes and challenges of the Greater Manchester Integrated Care Partnership Strategy. The link to the briefing can be accessed here and the full strategy can be accessed here:
We will welcome Warren Heppolette to our Board meeting in May to discuss next steps in relation to implementation and delivery of the Greater Manchester strategy.

In summary, the six key aims of the strategy are as follows:

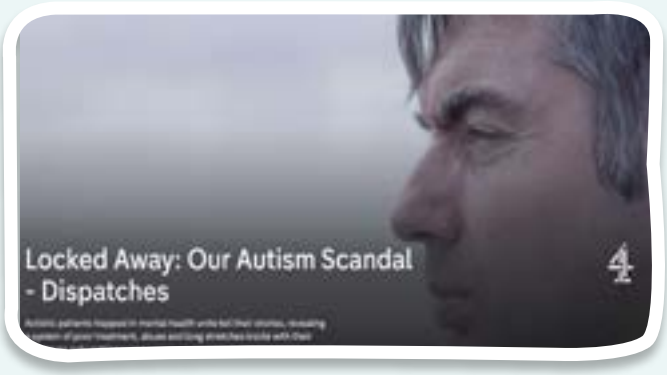
1. Strengthen communities
2. Help people get into – and stay in – good work
3. Recover core NHS and care services
4. Help people stay well and detect illness earlier
5. Support the workforce and carers
6. Achieve financial sustainability

Breightmet Centre for Autism in Bolton and Channel 4 documentary

NHS Greater Manchester Integrated Care Board has circulated a letter detailing the broadcast of a programme on Channel 4 regarding the treatment of inpatients with autism. Individual patient stories were included in the broadcast with one of the individuals living at the Breightmet Centre for Autism in Bolton, an independent hospital, run by ASC Healthcare Limited. The hospital takes admissions from across the country, and NHS Greater Manchester Integrated Care is the host commissioner as the hospital is in Greater Manchester.

There are ten people living in Breightmet, with six from the North West including Greater Manchester. The individual in the documentary is under the care of Lancashire and South Cumbria NHS Foundation Trust and has raised concerns on physical restraint, threats of restraint, name calling and lack of progress to support leaving hospital; all of which is both unacceptable and deeply distressing. The individual has since shared videos detailing their care with the Care Quality Commission (CQC), who conducted an unannounced visit focussing on safety and has since rated the centre as inadequate overall.

The letter outlined Greater Manchester Integrated Care's concerns regarding the care and patient safety provided. A rapid review of all patients who haven't undergone their annual review has been instigated and where the CQC marked their care as inadequate or required improvement. Greater Manchester Integrated Care fully support the NHS England national action plan 'Building the Right Support' and are working with partners regionally and nationally to look at what accommodation is required long-term. Pennine Care has been engaged as part of this process and we are connected to the learning and outcomes of the ongoing review.



Trust update

The Council of Governors have extended Evelyn Asante-Mensah's term as our Chair until October 2024.

Evelyn has signed the NHS Confederation Inclusive leadership pledge on 'Zero Discrimination Day'. The pledge aims to promote and support inclusive leadership so that change and innovation takes place while balancing everybody's views and needs.

Evelyn has featured in an article for The Guardian. The piece is part of a special Guardian series called 'Cotton Capital' and looks at the percentage of black leaders in Manchester and the lack of representation in prominent public positions.

Trust HQ Redesign

We have been looking at how we can change Trust HQ to provide more flexible working spaces and relocate some clinical services as part of a review of our properties in Tameside. We've completed engagement sessions with managers to understand how teams work – this included teams at Trust HQ and some Tameside clinical services.

A business case will be submitted to our value and investment group and Board in early summer. Whilst there are complex challenges with capital funding, we recognise the importance of adapting and using Trust HQ to benefit both our patients and colleagues.

Improvements to services and surrounding areas

Following suggestions from Ramsbottom Ward at Fairfield Hospital, patient feedback has led to extra activities and the ward, with the support of the volunteering service, are seeking a volunteer hairdresser for the ward.

Below is a summary of the improvements that our estates team have made:

- Improving gardens at Arden and Norbury wards (Stepping Hill Hospital)
- Walk-in showers and improved garden at Rowan ward, Cedar ward visitors room (Oldham Hospital)
- Birch Hill Hospital outdoor space where patients could grow vegetables, fruit, spices
- PLACE (patient-led assessments of the care environment) - above national average for 5 out of 6 areas and a review of hospital food also underway.
- Window and fire doors replaced across several wards
- Single use plastics reduction programme in place
- Setting up a new central system for taxi bookings

New Services

Radcliffe Place, our new £1.2m hospital avoidance service for people with a learning disability, is on track to open this spring. With four beds initially, it will provide short-term residential care to people aged 16-24 years, who are experiencing a crisis. The aim is to help them avoid hospital, enable recovery, with greater support for families and carers. It will be based in Bury and open to people across Greater Manchester.

Work has begun to refurbish our former Cobden psychiatric intensive care unit at Stepping Hill Hospital. This unit was previously for male patients, who are now at the new Walkerwood unit at Tameside Hospital. Currently, female patients who need psychiatric intensive care are admitted to a privately-run unit, sometimes a long way from home. The new unit at Stepping Hill Hospital, due to open this autumn, will provide care for six women and has been renamed Woodbank unit by patients and staff. Once open, the team will be able to safely discharge patients more quickly through linking directly with local services, such as rehab or supported housing.

Our new Pennine Care community rehabilitation team has launched. Part of our service transformation programme, the team will work across our five boroughs with people aged over 18 who have complex psychosis, e.g. schizophrenia, bipolar affective disorder, or psychotic depression. They'll lead on the safe and effective discharge of patients on our rehab units and continue to support them in the community, to reduce the likelihood of readmission. They'll also focus on bringing home patients who've been admitted to an out of area unit.

Digital improvements

Below is a summary of the improvements made by the digital team over the last month:

- Phone upgrade/replacement pilot, with phone on laptops (pilot with 100 Talking Therapies staff)
- New IT service desk automation system – saving 34 hours a week
- Digital Hubs drop-in service desk set up in Birch Hill and Trust HQ
- 50 Microsoft Surface Hubs to enable remote meetings and group working
- Revamp to ESR forms using Microsoft Power App – saving managers, HR and finance time

Other news

Pennine Care will be one of six 'discharge integration frontrunner' sites in the country - in partnership with the Northern Care Alliance and other health and social care partners across Bury, Oldham, Rochdale and Salford. Discharge integration frontrunner sites will lead the way in developing and testing radical new approaches to post-acute care that sees patients discharged to the right place, and with the right support, in a safe and timely manner. Our group will be called the Four Locality Partnership and will focus on the development of a dedicated unit to manage older patients with challenging and complex needs. A programme director will be recruited to lead the work.

We have recently become a member of the Healthcare Project and Change Association (HPCA). The new national professional body for all healthcare staff working in project delivery and change which means that all colleagues will have access to a wealth of training and supporting materials.

Our Women's Network produced lots of activities for International Women's Day on 8th March, including 'Get to know me' sessions with some of our inspirational female leaders, mini coaching sessions and personal development sessions on self-esteem and living life to the full.

Our new structured clinical management approach has launched and is offering more support to people with complex, emotional and relationship needs. It will help people experiencing challenges around healthy relationships, managing emotions and mood, impulsivity, self-harm, and suicidal thoughts.

Trust Governor elections will be taking place in due course. Communications have been circulated encouraging staff if they wish to stand for election as a governor, with virtual information sessions.

NHS colleagues are being encouraged to sign up to be Speakers for Schools as part of the NHS 75 celebrations. This involves speaking to young people about their career and the history of the NHS, to inspire the next generation and promote the 350 different careers available. Evelyn Asante-Mensah, our Chair, Anthony Hassall, Chief Executive and Clare Parker, director of quality, nursing and healthcare professionals, have been asked to join over 100 leaders across the country for a special element of this.

Trust Challenges and Improvements

Services

Demand for inpatient beds is still high, with delayed discharges due to pressures on the social care and housing system. This has resulted in a further increase in out-of-area placements. The other key targets that are still a risk include - access to talking therapies (previously called IAPT), eating disorders four-week routine access, staff attendance and staff turnover, my yearly conversation (staff appraisal), core and essential training. Pressures also continue in CAMHS, with a further increase in referrals (2400 a month). This continues to impact on waiting times (average wait of 23 weeks). The main waiting list challenge is neuro development disorder (eg: autism, ADHD). Despite this, our experience of care continues to be above the national average for mental health trusts.

We are now able to monitor delayed discharges in our beds by locality and ensure these are discussed in locality escalation meetings. These are impacting operational flow and addressing them remains – in our view – a priority for the Greater Manchester system.

Safety standards continue to be monitored with a key focus on seclusion and restraints. We have increased the number of substantive staff, but our agency costs are still a key risk.

Dr Simon Sandhu, medical director, briefed the quality group regarding concerns about the use of serenity integrated mentoring (SIM) in health and criminal justice settings. NHS England and NHS Improvement do not mandate the SIM model and is currently not formally endorsing or promoting its use. No service within Pennine Care demonstrate fidelity to the SIM model. All our services operate in accordance with patient confidentiality and data sharing law.

Operational Plan

We have submitted our draft operational plan 2023/24 to Greater Manchester Integrated Care. The plan highlights our priorities and includes activity, workforce and finance. It assumes no/minimal increase in activity levels from 2022/23. We finalised the plan over March and April and will then be working with services to develop their plans. We are feeding into the Greater Manchester operational plan for 2023/24, which is a challenging and complex piece of work.

Staff Survey

The NHS staff survey results were published on Thursday 9 March 2023. Our response rate was 47% - an 11% improvement on last year and the highest for at least five years.

Against all the People Promise themes we have made improvements against the previous year and are now at or above average in all but one of the themes. We have made significant improvements in whether care of patients is our top priority, recommending us as a place to work, acting fairly in respect of career progression and respecting individual differences. We have fallen in pay satisfaction, with people also feeling there are not enough staff for them to do their job properly, with unrealistic time pressures.

We are the most improved mental health and learning disability trust across the whole country as a good place to work. We're the second highest trust in Greater Manchester for being 'recommended as a place to work' (after The Christie), and the highest of the North West mental health and learning disability trusts for this question.

A detailed paper on the staff survey results is presented to the Board in May.

Other areas

A new smoking cessation project will be offering vapes for patients with a serious mental illness who smoke. Community services in Bury and Rochdale will support patients get off tobacco, reducing health inequalities and improving health outcomes.

We have provided specialist veterans mental health services for over 12 years via NHS Military Veterans' Service for Greater Manchester and Lancashire and the Transition, Intervention and Liaison Service (TILS) Northwest (one of three Op Courage - Veterans' Mental Health services). Op Courage's three services have now been brought together under one name - Op Courage: The Veterans Mental Health and Wellbeing Service. Pennine Care will host the Op Courage service across the Northwest of England.

Our single use plastic pledge, part of our green plan, has been launched. Between April 2022 and February 2023, we ordered nearly one million single use plastic items, costing just over £18,000.

To tackle this, the executive team have agreed that we will no longer be able to order single use products via procurement, unless there is a medical need or no alternative.

We have launched our new 'change champion' programme to support small scale change projects across the organisation. All colleagues can get involved by submitting a project to the strategic delivery hub. A maximum of 12 projects will be chosen every three months. They can include clinical practice or clinical/non-clinical service improvements.

We have signed up to the Equally Well UK Charter, which promotes and supports collaborative action to improve physical health among people with a mental illness. In the UK it's hosted by Centre for Mental Health in partnership with Rethink Mental Illness. This is an important part of our physical health strategy which is in development and also helping to reduce inequalities.

Celebrating success

Professor Prathiba Chitsabesan, our consultant child and adolescent psychiatrist, has been appointed as the national clinical director for children and young people's mental health services at NHS England.

Paul French, our clinical researcher has been appointed as senior research leader programme for nurses and midwives by the National Institute for Health and Care Research (NIHR).

Alie Salford, services lead for our military veterans service, has been appointed as a member of the National Advisory Group for the Royal College of Psychiatry Quality Network for Veterans Mental Health, alongside her role with us.

Prathiba, Paul and Allie will lead at a national level alongside their Trust roles.

Dr Nilika Perera, associate medical director and chief clinical information officer, has been appointed as our new deputy medical director.

Celebrating success

The Chief Executive welcomed 11 healthcare leaders and politicians from Denmark to our Trust at the beginning of March, with a packed tour across our boroughs. It was an opportunity to share our learning and also hear from them on how mental health, learning disability and autism services compare. The guests, who were on a three day visit to Greater Manchester, and visited our resilience hub, community CAMHS teams in Rochdale, CAMHS inpatient and crisis care pathway teams at Fairfield Hospital, psychological medicine post-covid service in Oldham, and Barn Countryside Visitor Centre to hear about our early intervention team's work with Lancashire Wildlife Trust.

Carla Moss, registered mental health nurse on Taylor Ward at Tameside Hospital, has had a research paper published in the International Journal of Mental Health Nursing. She was one of the contributors to the study *Assessing the impact of Instagram use and deliberate self-harm in adolescents: A scoping review.*

Dr Natasha Goakes, clinical psychologist in our Bury early intervention team, delivered a webinar alongside Jenni Lea from Lancashire Wildlife Trust for NHS England on how green social prescribing can tackle and prevent mental ill-health and address health inequalities. We have been working successfully with Lancashire Wildlife Trust to offer green social prescribing in Bury.

Research and innovation

Our new research strategy will be officially launched on 18th May. It relies on public participation, not just with patients, which is why we want to promote the new 'Be Part of Research' online NHS service which allows people to sign-up to research opportunities.

The latest Research for the Future newsletter has been published which a Greater Manchester wide service which can link up researchers to potential participants and is now open to all specialties.

The strategic impact report 2021/22 has been published by the National Institute for Health and Care Research (NIHR) Clinical Research Network (CRN) Greater Manchester. It demonstrates how the region's research community has provided over 80,000 local participants the opportunity to be part of research over the year. Pennine Care is mentioned as one of the local partner trusts and the report includes information about our transcranial magnetic stimulation (TMS) service for depression.

Dr Chris Taylor, consultant clinical psychologist in Bury and Anvita Vikram, research assistant, have co-authored *Trauma measures for use with psychosis populations.* The paper, which has just been published in the Psychiatry Research Journal, makes recommendations for good quality self-report measures to use when assessing trauma in people with psychosis.

New senior appointments (8c and above) started with the Trust March and April 2023

Mrs Chinonyerem Ibekwe - Clinical Lead for IAPT & Primary Care (Psychological Therapies) – 06/04/2023

Dr Gordon Milson - Associate Network Director for Psychological Therapies (CAMHS) – 06/04/2023

Awareness weeks and months

We promoted the following awareness days and weeks in April:

- Stress Awareness Month
- Easter (7-9 April)
- Ramadan and Eid al-Fitr (21 April)
- Bury PRIDE (29 April)

Listening and learning: Chair and Chief Executive meetings - March and April 2023

Below are listed a range of the engagement events which the Chair and Chief Executive have been involved with over the most recent period.

The Chair

- Combined North West System Leaders & Chairs Call x3
- Meeting with Natalie Kennerley from Manchester Metropolitan University
- The King's Fund provider collaboration conference
- International women's day - 'Get to know me' session
- North West Mental Health Trusts Chairs meeting
- Governor Pre-election Information Session x2
- Freedom to Speak Up Strategic Quarterly meeting
- Virtual Information Session for potential non-exec director candidates
- Governors Development session
- Meeting with Bill McCarthy, Chair, Greater Manchester Mental Health Trust
- Chair and CEO Ethnic Minority Network meeting x2
- BAME Assembly Leaders meeting x2
- Meeting with Richard Barker, Regional Director, NHS North West and North East
- LGBTQ+ Leaders Network Guiding Group meeting
- Tackling Health Inequalities Seminar, Rochdale
- Consultant Psychiatrist interviews
- Governor pre-election information session x3
- NHS Providers in conversation with Claire Murdoch, National Mental Health Director, NHS England
- Introductory meeting with Heather Caudle, Chief Nurse at Northern Care Alliance
- Meeting with Estephanie Dunn, RCN North West Regional Director
- CQC preparation session with David Holden from Good Governance Institute

The Chief Executive

- Executive Directors Development session
- Combined NW System Leaders & Chairs Call
- ONE Stockport Health and Care Board Development Session
- One Stockport Health & Care Locality Board
- Housing Strategy Workshop, Oldham
- Meeting with Mike Barker, Place Based Lead Oldham
- Quarterly exec director meeting - Specialist Network
- Chief Executive Team Brief x2
- Bury Locality Board
- CEO lunchtime listening session, Bury
- Greater Manchester Integrated Care Board Financial Recovery Sub Committee x2
- Meeting group of political health leaders from Denmark who were visiting Greater Manchester
- Freedom to Speak Up Strategic Quarterly Meeting
- Virtual Information session for potential Non-Executive Director candidates
- Greater Manchester Provider Federation Board
- North West CEO meeting
- Mental Health Trusts Chief Executives meeting (with Regional Leads and SROs)
- CEO lunchtime listening session at Royal Oldham Hospital
- Greater Manchester Health and Care Joint Planning and Delivery Committee
- CEO lunchtime listening session at Birch Hill Hospital, Rochdale
- Pennine Care Professional Nurses Forum
- North West Mental Health Learning Disabilities and Autism Regional Workforce and Supply Board
- CEO lunchtime listening session, Trust HQ
- Pennine Care / CQC Engagement meeting

The Chief Executive

- Greater Manchester Health and Care Digital Transformation Board
- CEO lunchtime listening session at Stepping Hill Hospital, Stockport
- Bury Integrated Care Partnership Meeting Leadership Group
- Trust Social Work event
- Meeting with Steve Rumbelow, Chief Executive Rochdale Council
- North West Mental Health Deep Dive meeting Q3 2022 – 23
- North West Mental Health Programme Board
- CQC preparation session with David Holden from Good Governance Institute
- Greater Manchester Leadership Workshop Part 3
- Meeting with Caroline Simpson, Chief Executive Stockport Council
- Greater Manchester Health and Care Digital Transformation Board 23/24
- Greater Manchester Provider Federation Board Development session
- Mental Health Trusts Chief Executives meeting (with Regional Leads and SROs)
- Senior leadership team South Network
- Meeting with Steve Rumbelow, Chief Executive Rochdale Council
- North West Mental Health Deep Dive meeting Q3 2022 – 23
- North West Mental Health Programme Board
- CQC preparation session with David Holden from Good Governance Institute
- Greater Manchester Leadership Workshop Part 3
- Meeting with Caroline Simpson, Chief Executive Stockport Council
- Greater Manchester Health and Care Digital Transformation Board 23/24
- Greater Manchester Provider Federation Board Development session
- Mental Health Trusts Chief Executives meeting (with Regional Leads and SROs)
- Senior leadership team South Network

The Chief Executive has also visited many teams across Pennine Care over the month. These include:

The Chair

- Stockport CAMHS with Bill McCarthy, Chair of GMMH and Richard Leese, Chair of Greater Manchester Integrated Care Board
- Prospect Place, Birch Hill Hospital

The Chief Executive

- Mental Health Liaison Team, Access Service and Home Treatment Service at Irwell Unit, Fairfield General Hospital
- Hope and Horizon Units, Fairfield General Hospital
- Community Mental Health Team North at Haughton House, Ashton-under-Lyne
- Tameside and Glossop secondary care psychological therapies services at Haughton Mews, Ashton-under-Lyne



Anthony welcoming Lynne Ridsdale to our services at Fairfield hospital and welcoming visitors from health and care services in Denmark, and Evelyn speaking about health inequalities in Rochdale.



Anthony with colleagues at Forest House in Oldham and Haughton House in Ashton

Pennine Care
NHS Foundation Trust

Report to the Board of Directors
Wednesday 3rd May 2023
Part I

Workforce Race Equality Standard (WRES) and Workforce Disabled Equality Standard (WDES) 2022/23	
Paper prepared by	Nicky Littler, Director of Workforce
Non-Executive sponsor	Liz Allen
Date of report	27th April 2023
Purpose of the report and action required	This report highlights the key findings from the Trust's 2022/23 Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) submissions. It showcases areas where the Trust has improved and where further work is required.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The WRES submission identifies the experiences of the Trust's Black, Asian and Minority Ethnic (BAME) colleagues in comparison with their white counterparts. The 2022/23 submission has shown some areas of improvement including: • The Trust BAME representation has increased 1.3% since 2022 to 17.9% in March 2023. • There has been a significant decrease in the likelihood of white candidates being appointed from shortlisting compared to BAME candidates, from 1.98 in 2022 to 0.67 which means BAME candidates are more likely to be appointed. • A significant decrease in the likelihood of BAME staff entering the formal disciplinary process from 3 to 1.1. • BAME colleagues are represented at board level positions, with a higher percentage compared to the overall workforce. Board representation is 28.6% in comparison to the workforce representation of 17.9%. The 2022/23 submission has shown continued areas of concern, including: • Underrepresentation of BAME colleagues at bands 8A and above • BAME staff reporting an increase in bullying, harassment and discrimination. • BAME colleagues believing the Trust provides equal opportunities for career progression and promotion.

	The WDES submission showcases the experiences of the Trust's Disabled colleagues in comparison with their non-disabled counterparts. The 2022/23 submission has shown some areas of improvement including: • Increase in the % reporting a disability (reduction in `unknown'). • Disabled colleagues are represented at board level positions, in comparison to the workforce representation, however, this is within the NED roles. The 2022/23 submission has shown some areas of concerns including: • No disabled colleagues in executive roles. • Whilst reducing, still high number 9.5% have not stated/unknown on their employee record. • Whilst improving in all staff survey indicators for the WDES since the last report, disabled colleagues still report more negative experience compared to non-disabled colleagues. Due to the change in reporting requirements, the data will be published by 31st May 2023 whilst work will continue on the actions to address the findings. This will form part of the refreshed Inclusion Plan which is required by 31st October 2023 for the reporting deadline.
Recommendation	Board to note the content of the report and approve publishing the data on our website
Where else has this report been considered and when?	Executive Directors – 2nd May

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus	X

Pennine Care
NHS Foundation Trust

Workforce Race Equality Standard (WRES) – 2022 to 2023

1. Introduction

The Workforce Race Equality Standard (WRES) is an annual data collection exercise which highlights the experiences of black, Asian and minority ethnic colleagues compared to their white counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract.

The WRES requires organisations to demonstrate progress against nine metrics specifically focused on race equality and suggests actions to address the disparities identified.

The data and statistics used in this report reflect Workforce indicators, NHS staff survey Indicators and a Board representation indicator.

The WRES provides an overview of the data from April 2022 to March 2023 and progress against the nine metrics of the WRES.

2. Background

The poor experiences of black, Asian and minority ethnic communities is well documented. The Equality Act of 2010, strengthened the duty on employers to address discrimination and advance equality for employees from different ethnic backgrounds, national origins and nationalities and employers are required to pay 'due regard' to eliminating unlawful discrimination, advancing equality of opportunity, and fostering good relations between groups.

In July 2014, the Equality and Diversity Council, led by NHS England and NHS Improvement announced it had agreed to undertake meaningful actions to ensure black, Asian and minority ethnic colleagues had equal access to career opportunities and received fair treatments in the workplace. The need for proactive action was further reinforced by the findings of the *Snowy White Peaks* report which starkly highlighted the fact that black, Asian and minority ethnic colleagues are largely excluded from senior management/leadership posts and across NHS Trust Boards.

Following the pledge from the Equality and Diversity Council, the Workforce Race Equality Standard (WRES) came into force in 2015/16 introducing a set of nine specific measures (metrics) that will enable NHS organisations to compare experience of black, Asian and minority ethnic colleagues and their white counterparts. This information allows NHS organisations to develop effective action plans to improve and enhance the experience of black, Asian minority ethnic colleagues within the workforce.

The 'No More Tick Boxes' report published by NHS East of England in September 2021, identifies the challenges black, Asian and minority ethnic people face throughout the recruitment process. Alongside data gathered from previous years of the WRES, there's evidence which shows that simply getting to an interview is an immense achievement candidate, considering the cumulative lack of support and opportunity they may have had. Unfortunately, black, Asian and minority ethnic candidates remain less likely to be appointed in posts compared to their white counterparts.

The past few years have been an incredibly challenging time for our black, Asian and minority ethnic workforce across the NHS. COVID-19 has highlighted the existing and deep-rooted

inequalities which exist. In addition, the murder of George Floyd and the Black Lives Matter movement shone a light on inequalities and created a catalyst for change.

The NHS constitution has a specific section that refers to the rights of colleagues. It recognised that it is the commitment, professionalism and dedication of colleagues working for the benefit of the people the NHS serves which really make the difference. High quality care requires high quality workplaces, with commissioners and providers aiming to be employers of choice. The WRES is important because research shows that a motivated, included, and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The main purpose of the WRES is:

- to compare the experiences of black, Asian and minority ethnic colleagues to their white counterparts
- to better understand the experiences of black, Asian and minority ethnic colleagues and enable a more inclusive environment
- to identify good practice and compare our performance with similar Trusts and
- use the information derived from the metrics to develop a local action plan and demonstrate progress against the indicators of disability equality.
- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce an action plan to address any differences in the workplace experienced by black, Asian and minority ethnic colleagues and their white counterparts and, improve black, Asian and minority ethnic representation at all levels in the organisation.

3. Reporting requirements

The following table sets out the reporting requirements for the WRES:

	Workforce indicators For each of these four workforce Indicators, compare the data for white and BME staff
1.	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.
2.	Relative likelihood of staff being appointed from shortlisting across all posts. Note: This refers to both external and internal posts **Data should be taken at year end.**
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. **Note: Data should be taken at year end.**
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff
5.	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
8.	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for white and BME staff
9.	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

The national data submission for 2023 is required by 31st May to the national WRES team and this report and action plan need to be published on the internet by the 31st October 2023 in line with the reporting requirements.

4. Workforce demographics

As of 31st March 2023, the total number of substantive colleagues employed within Pennine Care NHS Foundation Trust was 3944 (headcount). The table underneath shows the number of colleagues working in the Trust from different ethnic origins.

	31st March 2022		31st March 2023		Difference
White	2979	81.8%	3183	80.7%	-1.1
Black, Asian and minority ethnic	603	16.6%	708	17.9%	1.3
Ethnicity unknown	58	1.6%	53	1.3%	-0.3
Total	3640		3944		

There was an increase in the workforce over the 12 month period. The data indicates that the proportion of white and black, Asian and minority ethnic colleagues has changed as follows:

- 1.3% increase in black, Asian and minority ethnic colleagues as a % of the total workforce
- 1.1% decrease in white colleagues as a % of the total workforce

To have a good understanding of where our black, Asian and minority ethnic and white colleagues work, it's important to review the data further. The table underneath highlights ethnicity by pay bands.

WRES Indicator 1

Percentage of colleagues in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM within clinical and non-clinical colleagues groups

	Clinical colleagues						Non-clinical colleagues					
Pay band	**No of white colleagues**	**%**	**No of black, Asian and minority ethnic colleagues**	**%**	**Ethnicity unknown**		**No of white colleagues**	**%**	**No of black, Asian and minority ethnic colleagues**	**%**	**Ethnicity unknown**	
Band 2	42	59%	29	41%			194	85%	27	12%	7	3%
Band 3	483	77%	135	22%	9	1%	263	88%	34	11%	1	0%
Band 4	186	83%	36	16%	3	1%	184	92%	14	7%	1	1%
Band 5	236	63%	130	35%	6	2%	94	86%	14	13%	1	1%
Band 6	661	82%	131	16%	13	2%	36	82%	7	16%	1	2%
Band 7	385	88%	51	12%	3	1%	52	90%	6	10%	0	0%
Band 8A	165	91%	15	8%	2	1%	33	92%	3	8%	0	0%
Band 8B	42	93%	2	4%	1	2%	20	87%	2	9%	1	4%
Band 8C	26	90%	3	10%	0	0%	13	100%				
Band 8D	5	83%	1	17%	0	0%	7	100%				
Band 9	1	100%	0	0%	0	0%	2	100%				
VSM	1	100%	0	0%	0	0%	5	100%				
Other	1	100%	0	0%	0	0%	6	100%				
Consultant	31	36%	51	59%	4	5%						
Non-consultant career grade	4	24%	12	71%	1	6%						
M&D Trainee grade	1	20%	4	80%	0	0%						
TOTAL	**2270**	**78%**	**600**	**20.6%**	**42**	**1.4%**	**909**	**88.4%**	**107**	**10.4%**	**12**	**1.2%**

Data from WRES indicator 1 highlights that the majority of black, Asian and minority ethnic clinical colleagues work within bands 2 and 7 with the highest number in bands 3, 5 and 6. The majority of black, Asian and minority ethnic non-clinical colleagues work between bands 2 and 7 with a majority working at band 2 and 3. Furthermore, there is an underrepresentation in most of the senior pay bands 7 to VSM level in clinical and non- clinical roles, although there has been an increase in black, Asian and Minority ethnic colleagues in band 7 clinical roles from 7% to 12% in the last 12 months.

There are fewer black, Asian and minority ethnic colleagues working in non-clinical roles.

WRES Indicator 2 - Relative likelihood of colleagues being appointed from shortlisting across all posts. 1st April 2022 – 31st March 2023 (White v black, Asian and minority ethnic candidates)			
	White	BME	Ethnicity unknown
Number of shortlisted applicants	4378	1141	181
Number appointed from shortlisting	536	208	4
Relative likelihood of appointment from shortlisting	12.24%	18.23%	2.21%
Relative likelihood of white colleagues being appointed from shortlisting compared to black, Asian and minority ethnic colleagues	0.67		

Data source ESR BI

The figures for 2022/23 indicate the relative likelihood of appointments of white candidates compared to black, Asian and minority ethnic candidates has significantly improved since the previous report.

The relative likelihood has improved from 1.98 times more likely for white candidates to be successful in 2022 to 0.67 times in 2023.

The guidance states a value below 1 indicates that white candidates are less likely to be appointed than BME candidates.

WRES Indicator 3 - Relative likelihood of black Asian and minority ethnic colleagues entering the formal disciplinary process, compared to that of white colleagues entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.						
	1st April 2021 – 31st March 2022			**1st April 2022 – 31st March 2023**		
	White	**BME**	**Ethnicity unknown**	**White**	**BME**	**Ethnicity unknown**
Overall workforce	2979	603	58	3183	708	53
No of disciplinaries	24	15	0	28	7	0
Likelihood of colleagues entering the formal disciplinary process	0.81%	2.49%	0	0.88%	0.99%	0
Relative likelihood of black, Asian and minority ethnic colleagues entering the formal disciplinary process compared to White colleagues		**3**			**1.1**	

The data shows there has been a decrease in the proportion of black, Asian and minority ethnic colleagues being subject to disciplinary procedures compared to the last reporting period. The relative likelihood of black, Asian and minority ethnic colleagues entering the formal disciplinary process compared to White colleagues for 2023 is 1.1 compared to 3 in the last report.

The guidance states a value below 1 indicates that BME colleagues are less likely to enter formal disciplinary proceedings than white colleagues.

Whilst this is an improvement for substantive colleagues, the regular employee relations data monitoring shows a disproportionate number of black, Asian and Minority ethnic bank workers entering disciplinary process compared to white colleagues. This will be examined in more detail in the Bank worker WRES report.

WRES Indicator 4 - Relative likelihood of black, Asian and minority ethnic colleagues accessing non mandatory training and CPD compared to white colleagues. 1st April 2022 – 31st March 2023			
	White	**BME**	**Unknown**
Number of colleagues in workforce	3183	708	53
Number of colleagues accessing non-mandatory training and CPD	1992	444	38
% accessing training	62.58%	62.71%	71.70%
Relative likelihood of white colleagues accessing non-mandatory training and CPD compared to black, Asian and minority ethnic colleagues	1		

A value of “1.0” for the likelihood ratio means that white and BME colleagues are equally likely to access non-mandatory training or CPD. There was a 0.94 likelihood ratio in 2021/22.

The data shows there is equal access to non-mandatory and CPD training for all colleagues.

WRES Indicators 5-8

The following table provides the Workforce Race Equality Standard (WRES) National NHS Staff survey Indicators from 2022 survey.

The National NHS staff survey provides an insightful view about how colleagues are feeling working within the Trust. It should be noted that the survey takes place during a set period of time and showcases the feelings of colleagues during that time.

WRES Indicators 5 – 8 compare the outcomes of the responses for White and BME colleagues from the NHS staff survey (2022)				
		2021	2022	Trend
a) Percentage of colleagues experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	**White**	28.6%	27.1%	↓
	BME	33.3%	37.4%	↑
b) Percentage of colleagues who have personally experienced discrimination at work from managers/team leader or other colleagues in last 12 months	**White**	9.7%	6.5%	↓
	BME	12.8%	15.5%	↑
c) Percentage of colleagues experiencing harassment, bullying or abuse from colleagues in the last 12 months	**White**	22.5%	20.3%	↓
	BME	25.2%	24.1%	↓
d) Percentage of colleagues believing that the Trust provides equal opportunities for career progression or promotion.	**White**	56.1%	62.8%	↑
	BME	50.8%	45.4%	↓

The data presented shows areas of improvement for white colleagues, in all but one of the indicators set out above, black, Asian and minority ethnic colleagues reported a worsened position. In particular:

- **Indicator a)** ***colleagues experiencing harassment, bullying or abuse from patients, relative or public in the last 12 months***
    - Shows that whilst there has been a slight reduction for white colleagues from 28.6% to 27.1% there has been an increase for our black, Asian and minority ethnic colleagues increasing from 33.3% to 37.4%.
- **Indicator b)** ***colleagues who have personally experienced discrimination at work from managers and team leaders***
    - Shows that whilst there has been a decrease for white colleagues from 9.7% to 6.5% there has been an increase for our black, Asian and minority ethnic colleagues from 12.8% to 15.5%.
- **Indicator c)** ***colleagues experiencing harassment, bullying or abuse from colleagues in the last 12 months***
    - Shows that there has been a decrease for white colleagues from 22.5% to 20.3% and for black, Asian and minority ethnic colleagues from 25.2% to 24.1%

- **Indicator d)** ***colleagues believing that the Trust provides equal opportunities for career progression or promotion***
    - Shows that whilst there has been an increase for white colleagues from 56.1% to 62.8% there has been a decrease for black, Asian and minority ethnic colleagues from 50.8% to 45.4%.

There remains a concerning issue for our black, Asian and Minority colleagues experiencing harassment, bullying and discrimination that needs to be addressed.

WRES Indicator 9 Board representation indicator. Percentage difference between the organisations Board voting membership and its overall workforce. Difference (Total Board – Overall workforce)		
	White	**Black, Asian and minority ethnic**
Executive Directors	85.7% (6)	14.3% (1)
Non-Executive Director	57.1% (4)	42.9% (3)
Voting membership	71.4% (10)	28.6% (4)
Overall workforce	80.7%	17.9%
Difference (Voting membership – Overall Workforce)		+10.7%
Difference – Executive Directors compared to overall workforce		-3.6%

As of March 2023, figures highlight that out of 14 Trust board members, 4 non-executive directors (57.1% of the non-executive directors) identify as black, Asian and minority ethnic and 1 executive director (14.3% of the executive directors) identifies as black, Asian and minority ethnic. Overall, the board is representative of it's black, Asian and minority ethnic workforce. However, it should be noted that in comparison with the overall workforce, there is a lack of black, Asian and minority ethnic representation in Executive Director roles. In direct comparison data indicates that our black, Asian and minority ethnic workforce is represented in our Non-Executive Director roles.

5. Conclusion

Overall, the WRES collection for 2022/23 has highlighted some positive improvements including reduction in likelihood of BME colleagues entering disciplinary processes, recruitment data and improvements in some of the staff survey questions.

However, there are still areas of concern particularly in relation to BME employees experiencing bullying, harassment and discrimination.

The current inclusion plan will be updated to reflect the progress undertaken since the last report and further actions will be added following consultation with the race equality network and discussion through the EDI steering group.

The Trust is required to publish the WRES action plan by 31st October 2023.

6. Recommendations

- Note the findings of the report
- Agree to publish the data by 31st May 2023
- Develop and publish an action plan by 31st October 2023

23rd April 2023

Pennine Care
NHS Foundation Trust

Workforce Disability Equality Standard (WDES) – 2022 to 2023

1. Introduction

The Workforce Disability Equality Standard (WDES) is an annual data collection exercise which highlights the experiences of disabled colleagues compared to their non-disabled counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract.

The WDES requires organisations to demonstrate progress against the ten metrics specifically focused on disability equality and suggest actions to address gaps.

The data and statistics used in this report reflect Workforce indicators, NHS staff survey Indicators and a Board representation indicator.

The Workforce Disability Equality Standard (WDES) report provides an overview of the data from April 2022 to March 2023 and progress against the ten metrics of the WDES.

2. Background

The Equality Act, which came into force in 2010, strengthened the duty on employers to eliminate discrimination and advance equality of opportunity for Disabled employees. In the Act, disability is one of the nine protected characteristics, and employers are required to pay 'due regard' to eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations between groups.

In November 2017, there was a pledge by the Government to increase the number of Disabled people in employment by one million.

Following through the Governments pledge, the Workforce Disability Equality Standard (WDES) came into force on 1st April 2019 introducing a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of Disabled and Non – Disabled staff. This information will then be used to develop a local action plan and enable us to demonstrate progress against the indicators of disability equality as a means by which we will improve and enhance the experience of disabled staff within our workforce.

The 'social model of disability'[1] identifies that it is the societal barriers that Disabled people face which is the disability and not an individual's medical condition or impairment. 'Nothing about us without us' is a phrase used by the disability movement to denote a central principle of inclusion: that actions and decisions that affect or are about Disabled people should be taken with Disabled people.

The NHS constitution has a specific section that refers to the rights of staff. It recognised that it is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really make the difference. High quality care requires high quality workplaces, with commissioners and providers aiming to be employers of choice. The Workforce Disability Equality Standard (WDES) is important because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

[1] Scope.co.uk

The main purpose of the WDES is:

- to compare the experiences of Disabled and Non – Disabled staff.
- to better understand the experiences of Disabled staff and enable a more inclusive environment
- to identify good practice and compare our performance with similar Trusts and
- use the information derived from the metrics to develop a local action plan and demonstrate progress against the indicators of disability equality.
- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators,
- to produce an action plan to address any differences in the workplace experienced by Disabled and Non – Disabled staff, and,
- improve Disabled representation at the Board level of the organisation.

3. Reporting requirements

The following table sets out the reporting requirements for the WDES:

Workforce Metrics For the following three workforce metrics, compare the data for both Disabled and non-disabled staff.	
Metric 1	**Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce**. Organisations should undertake this calculation separately for non-clinical and for clinical staff. Cluster 1: AfC Bands - under 1, 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades **Note:** Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
Metric 2	**Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.** **Note:** i) This refers to both external and internal posts
Metric 3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** **Note:** i) This metric was mandated in 2020. ii) This metric is based on data from a two-year rolling average of the current year and the previous year. iii) **It must be noted that this metric looks at capability on the grounds of performance, rather than ill health.** Therefore, we request that organisations **only** submit data on those staff who are within performance management capability processes.

National NHS Staff Survey Metrics For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff.	
Metric 4 Staff Survey Q13a-d	**a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i. Patients/Service users, their relatives or other members of the public ii. Managers iii. Other colleagues **b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**

Metric 5 Staff Survey Q14	**Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**
Metric 6 Staff Survey Q11e	**Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**
Metric 7 Staff Survey Q5f	**Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.**
The following NHS Staff Survey metric only includes the responses of Disabled staff	
Metric 8 Staff Survey Q26b	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**
NHS Staff Survey and the engagement of Disabled staff For part a) of the following metric, compare the staff engagement scores for Disabled and non-disabled staff For part b) add evidence to the Trust's WDES Annual Report	
Metric 9	**a) The staff engagement score for Disabled staff, compared to non-disabled staff.** **Note:** This part of the metric is now solely a comparison between the engagement score for Disabled staff and non-disabled staff. **b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)** **Note: For your Trust's response to b)** **If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. **If no**, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the national WDES 2019 Annual Report.
Board representation metric For this Metric, compare the difference for Disabled and non-disabled staff.	
Metric 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.

The national data submission will be submitted by the deadline of 31st May 2023 to the national WDES team, and this report and action plan will be published on the internet by the 31st October 2023 as required.

We acknowledge that the data relating to staff who have declared their disability may still be low. We will continue to work with staff to improve the collection of data by creating an environment in which staff feel confident to disclose their disability.

WDES Indicator 1 (a)

Breakdown of the workforce by AfC clusters, Medical and Dental subgroups and very senior managers (including Executive Board members) – split between non-clinical and clinical groups

	Clinical staff						Non-clinical staff					
Pay band	**No of non-disabled colleagues**	**%**	**No of disabled colleagues**	**%**	**Disability unknown/not stated**		**No of non-disabled colleagues**	**%**	**No of disabled colleagues**	**%**	**Disability unknown/not stated**	
Band 2	65	92%	4	6%	2	3%	201	88%	10	4%	18	8%
Band 3	502	80%	44	7%	80	13%	244	82%	26	9%	27	9%
Band 4	184	82%	22	10%	19	8%	161	81%	22	11%	16	8%
Band 5	303	81%	35	9%	36	10%	89	82%	6	6%	14	13%
Band 6	642	80%	93	12%	71	9%	35	80%	5	11%	4	9%
Band 7	368	84%	35	8%	37	8%	50	86%	1	2%	7	12%
Band 8A	143	78%	25	14%	15	8%	32	89%	1	3%	3	8%
Band 8B	39	89%	3	7%	2	5%	18	78%	2	9%	3	13%
Band 8C	24	83%		0%	5	17%	11	85%	1	8%	1	8%
Band 8D	6	100%		0%		0%	7	100%		0%		0%
Band 9	1	100%		0%		0%	1	50%		0%	1	50%
VSM	1	100%		0%		0%	4	80%		0%	1	20%
Other	1	100%		0%		0%	10	100%		0%		0%
Consultant	72	84%	5	6%	9	10%						
Non-consultant career grade	12	71%	1	5.9%	4	24%						
M&D Trainee grade	3	60%		0%	2	40%						
TOTAL	**2366**	**81%**	**267**	**9%**	**282**	**10%**	**863**	**84%**	**74**	**7%**	**95**	**9%**

The data shows a higher proportion of disabled staff work in clinical roles 9% compared to 7% of non-clinical staff.

4. Workforce demographics

As of 31st March 2023, the total number of substantive staff employed within Pennine Care NHS Foundation Trust was 3944(headcount).

	31st March 2022		31st March 2023		
	No.	%	No.	%	Difference
Disabled	256	7%	341	8.65%	+1.65%
Not Disabled	2958	81.4%	3228	81.85%	+0.45%
Unknown	422	11.6%	375	9.5%	-2.1%
Total	**3636**		**3944**		

Out of the overall figure, the reported data indicates that 81.85% of staff employed by the Trust do not have a reported disability. 8.65% consider themselves to have a disability and 9.5% of people have not declared.

The reduction in `unknown' is moving in the right direction following work to support staff to record on ESR and increase reporting through the self-service process.

WDES Indicator 2 **Relative likelihood of staff being appointed from shortlisting across all posts. 1st April 2022 – 31st March 2023 (Disabled compared to Non-disabled)**		
	Non-disabled	Disabled
Number of shortlisted applicants	4787	452
Number appointed from shortlisting	681	89
Relative likelihood of appointment from shortlisting	0.14	0.19
Relative likelihood of disabled staff being appointed from shortlisting compared to non-disabled staff		0.72

The figures for 2023 indicate the relative likelihood of appointments of non-disabled staff compared to disabled staff stand at 0.14 (non-disabled) and 0.19 (disabled).

The data shows that non-disabled staff are 0.72 times more likely to be appointed from shortlisting compared to disabled staff. This has improved compared to the data from the previous report which was 1.3 times more likely.

The guidance states a figure below 1.00 indicates that Disabled candidates are more likely to be appointed from shortlisting.

WDES Indicator 3 **Relative likelihood of Disabled staff compared to Non – Disabled staff entering the formal capability process, as measured by entry into the capability procedure.** **This metric is based on data from a two-year rolling average.**		
	Disabled	**Non-Disabled**
Number of staff entering the formal capability process	0	0
Relative Likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff (*These are auto calculations undertaken within the Excel Spreadsheet provided to us by the National WDES team)*	0	

The data shows there has been a no formal capability cases in the past 12 months. This has stayed the same as the WDES report in 2022.

WDES Indicators 4-9

The following table provides the WDES National NHS Staff Survey Indicators:

Staff Survey Question		2021	2022	Trend
4a. Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives, or other members of the public in the last 12 months	**% Long term condition**	34.9%	34.3%	↓
	% No LTC	26.3%	25.6%	↓
4b. Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	**% Long term condition**	18.1%	13.9%	↓
	% No LTC	8.4%	7.5%	↓
4c. Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	**% Long term condition**	24.3%	23.7%	↓
	% No LTC	14.7%	13.7%	↓
4d. Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	**% Long term condition**	59.3%	62.5%	↑
	% No LTC	57.3%	64.9%	↑
5. Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion.	**% Long term condition**	51.7%	54.6%	↑
	% No LTC	57.7%	63.5%	↑
6. Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	**% Long term condition**	22.7%	15.6%	↓
	% No LTC	17.3%	11.7%	↓
7. Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	**% Long term condition**	38.8%	46%	↑
	% No LTC	49.4%	52%	↑
8. Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	**% Long term condition**	66.4%	**79.5%**	↑
9a. The staff engagement score for staff with a long-term condition.	**% Long term condition**	6.5	6.9	↑

As a comparison, the staff engagement score for people without a long term condition was **7.3** and the organisational average **7.1.**

Indicator 9b –Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard.

We have developed a positive ability network to support and facilitate people in our organisation with a long-term condition/disability to have a strong voice and influence areas of improvement in the organisation. We have worked with the network to develop a health passport that can be used to set out agreed adjustments that can be shared when colleagues move across the organisation.

A summary of the 2022 results compared to 2021 is set out below. 47% of the workforce completed the 2022 survey (1682) of which 31.6% reported having a disability (physical or mental health condition or illness lasting or expected to last for 12 months or more).

The National NHS Staff survey provides an insightful view about how staff are feeling working within the Trust. It should be noted that the survey takes place during a set period and showcases the feelings of staff during that time.

Overall, the data presented above shows an improving position in all of the indicators for both staff with a long-term condition and those with no long term-condition which is a positive improvement over the last 12 months.

However, the data also shows that, whilst there have been improvements for staff with a long-term condition since the previous survey, staff with a long-term condition continue to report a less positive experience compared to those without a long-term condition in all indicators.

We are committed to working with our Positive Ability staff network to address areas of difference and work together to bring about improvements.

Metric 10

Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated:

- **by voting and non-voting membership of the board**
- **by executive and non-exec membership of the board.**

	Non-disabled	Disabled
Executive Directors	7 (100%)	0
Non-Executive Director	71.4% (5)	28.6% (2)
Voting membership	85.7% (12)	14.2% (2)
Overall workforce	81.85%	8.65%
Difference (Voting membership – Overall Workforce)		+5.55%
Difference – Executive Directors compared to overall workforce		-8.65%

As of March 2023, figures highlight that out of 14 Trust board members, 2 non-executive directors declared a disability and no executive directors have declared a disability. Data highlights that the executive director profile is not representative of the disabled workforce whilst our non-executive directors is representative of our disabled workforce.

5. Conclusion

Overall, the WDES collection for 2022/23 has shown a number of areas of improvement, the data from the staff survey in particular shows there still remains a gap between the experiences of disabled colleagues compared to those without a disability.

The current inclusion plan will be updated to reflect the progress undertaken since the last report and further actions will be added following consultation with the positive ability network and discussion through the Equality, Diversity and Inclusion steering group.

The Trust is required to publish the WDES action plan by 31st October 2023.

6. Recommendations

- Approval to publish the data by 31st May 2023 deadline
- Develop and publish an action plan by 31st October 2023 deadline

25th April 2023

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Pennine Care
NHS Foundation Trust

Immediate response to media reports re: MA	
Paper prepared by	Anthony Hassall, Chief Executive
Board sponsor	Evelyn Asante-Mensah, Chair
Date of report	27th April 2023
Purpose of the report and action required	Provide assurance to Trust board on the review and immediate actions taken as a result of the recent case involving a non-executive director.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	Media contact received on Saturday 22nd April 2023 alerting the Trust to a series of social media messages on Twitter from a Non-Executive Director of PCFT. Fact finding completed by Monday 24th April 2023, considered by Chair and discussion with non-executive resulted in resignation with immediate effect. Immediate actions undertaken: • Review of recruitment process and actions agreed for future recruitment • Review of social media policy and work commencing to strengthen compliance checks • Chief Executive and Chair listening events to be held over next 2 weeks, including meeting with Rabbi Tomlin on 2nd May and offer to individual colleagues to meet. • Review of anti-racism training to broaden scope to ensure all areas of racism, prejudice and discrimination are covered.
Recommendation	Trust Board asked to note the contents of the report.
Where else has this report been considered and when?	

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	X
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	

Pennine Care
NHS Foundation Trust

Briefing paper for Trust Board

1. Introduction

This papers sets out the review, management and immediate actions arising from the recent conduct of PCFT non-executive director (MA).

2. Background and facts

On 22nd April 2023, a journalist from Jewish News alerted the Trust to a series of social media posts on Twitter from MA. These included tweets, sharing of other tweets and `likes' on tweets which were of an inflammatory and racist nature.

The journalist provided screen shots of a number of tweets, retweets and `liked' posts that MA had tweeted over a significant period of time. The earliest tweet shared with us was dated May 2021.

Jewish civil rights @jewish_uk tweeted on 22nd April 2023 naming MA and including Pennine Care in the tweet. By 2pm on Monday 24th April 2023 the tweet has been retweeted 31 times and attracted a series of comments, including from a number of very high profile individuals.

3. Management of concerns

On Monday 24th April 2023, a fact finding report was provided to the Chair with evidence of the tweets and available management options.

On Monday 24th April 2023 following discussion with the Chair, MA resigned from the role of NED at PCFT.

On Tuesday 25th April 2023 CEO and Chair communicated to the organisation the departure of MA and provided an offer of support to affected colleagues.

4. Further activity

By 27th April 2023, articles have been published in the Jewish Times, Jewish Chronicle, Israel National News, Health Service Journal, Manchester Evening News, BBC Radio Manchester and BBC North West TV. In addition, concerns have been raised by colleagues in PCFT and assurance sought regarding the trust approach to addressing antisemitism.

5. Immediate actions

A number of immediate actions have been agreed as follows:

5.1 Review of recruitment process

The recruitment documentation and process for the recruitment of MA has been reviewed. The appointment of MA was undertaken by an external recruitment agency, which included a report, by them, on his social media history. This report dated September 2020 stated social

media checks had been undertaken and 'no concerns' identified. The posts shared with the Trust date from May 2021 which is after the date of appointment.

Going forward, we will review this process of social media checks to ensure it is deep and thorough and will ensure that at least all senior appointments will be subject to formal social media checks. We will also include a self-declaration question in interviews asking for any known issues to be declared prior to appointment.

All Directors are expected to sign and confirm annually a 'Code of Conduct', which includes a commitment to the Nolan Principles of Conduct in Public Life. MA had signed this Declaration most recently in March 2023.

5.2 Social media policy

Social media is a useful tool in our library of materials which we use to engage with our widely dispersed population and with our colleagues. Our use of social media is governed by our social media policy, which we will now review to ensure it is as clear and strong as possible on the expectations of all colleagues and to see if any areas need strengthening in light of this case. All colleagues will be reminded of the policy and we will reinforce to senior leaders the responsibilities of employees on the use of social media and guidance on reporting concerns if people see inappropriate messages from colleagues.

We will also consider – by liaising with other organisations and subject matter experts, how we can test compliance with the policy, recognising the complexity of social media.

5.3 Chief Executive and Chair listening events

Over the next few weeks the Chief Executive has arranged to be in a number of sites across the Trust to be visible and available in order that colleagues can discuss any issues or concerns directly. We will include reference and reminder to all leaders of the need to be open to hearing any concerns addressed through our May Team Brief.

The Chair has reached out to colleagues through the interfaith network and the chaplaincy service to offer the opportunity to meet and discuss how they are feeling and anything more the Trust can do to help them feel safe and supported. The Chair and Chief Executive will meet Rabbi Channon Tomlin on Tuesday 2 May.

5.4 Anti-racism training

The Trust has delivered Anti-Racism Training over the past few years to a large number of colleagues. We will review the training content to ensure all forms of racism, prejudice and discrimination are covered in the training and deliver sessions over the next 6 months.

6. Recommendation

Trust Board are asked to note the content of the report.

26th April 2023

Report to the Board of Directors
3rd May 2023

Pennine Care
NHS Foundation Trust

Annual Business Plan	
Paper prepared by	Rachel Clayton – Head of Strategic Planning and Performance.
Executive sponsor	Gaynor Mullins- Director of Strategy.
Date of report	27th April 2023
Purpose of the report and action required	The attached paper is our Trust Annual Business Plan for 2023/24 for review and approval by Board
Executive summary / key issues for Board's attention (and links to other strategies etc.)	Pennine Care's Business Plan sets out our priorities for delivery during 2023/24 in pursuit of our big ambitions. In developing our priorities, we have • held workshops and engagement sessions where we have listened to our service users and carers, governors and colleagues • Taken account of the national planning priorities for Mental Health, Learning Disabilities and Autism, the Greater Manchester integrated care system strategy and locality plans. In addition to our Trust level Priorities our plan also includes individual plans on a page for each of our Networks and Care Hubs with the aim of ensuring there is clear alignment between the Trusts overall ambitions and our network and care hub plans. Our plans on a page will also be supported by detailed delivery plans which will describe in year milestones and deliverables. Our Business Plan is a live document that will be continually monitored, reviewed, and refreshed throughout the year to ensure it remains relevant and reflective of in year changes. Any changes will be agreed through our internal governance processes. An update on progress against the delivery plans and any changes to plans will be presented to Board each quarter in the Annual Business Plan update.
Recommendation	The Board are asked to review and approve the Annual

	Business Plan for 2023/24.
Where else has this report been considered and when?	The Annual Business Plan has been reviewed at a Senior Leaders Business Planning Summit on 3rd April 2023,Executive Directors on 17th April 2023 and the Leadership Event 24 April 2023..

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	X

If option three is selected, please complete the table on page 2

	Please indicate (X) which areas(s) of focus and describe the impact	
Area of focus		**Impact**
X	**1. Services: we will develop outstanding services that are safe, compassionate, fair, consistent in quality and sustainable; using digital technology to advance our improvements**	Annual Business Plan puts in place priorities to progess towards the key areas of focus e.g. clinical strategy implementation
X	**2. People: we will nurture the development of a capable, motivated and engaged workforce which realises the potential and talent of everyone; and that values experts by experience**	Annual Business Plan puts in place priorities to progess towards the key areas of focus e.g. leadership development plan
X	**3. Culture: we will create the right conditions for people to flourish by developing a just culture that is fair and inclusive; transparent, curious and outward facing, and that aims high, recognises success and creates pride and belonging**	Annual Business Plan puts in place priorities to progess towards the key areas of focus e.g. just culture focus
X	**4. Partnerships: we will make a full and meaningful contribution to our communities through our partnerships with service users and their carers, third sector, local communities and other organisations**	Annual Business Plan puts in place priorities to progess towards the key areas of focus e.g. Together Strategy

2023/24 Business Plan

Introduction

Our Trust strategy outlines our overarching vision and values along with our four big ambitions:

- Outstanding care
- Everyone leads a life they find fulfilling
- People with lived and living experience shape every decision
- All colleagues feel engaged and are involved in improvement.

This document is Pennine Care's Business Plan for 2023/24 and sets out our priorities for delivery during 2023/24, in pursuit of our big ambitions. It sets out the Trust overarching priorities, and those of our care networks and care hubs.

In developing our priorities, we have held workshops and engagement sessions where we have listened to our service users and carers, governors and colleagues to ensure our priorities reflect the views of those who work in our organisation and those who use our services.

Our priorities also take account of the national planning priorities for Mental Health, Learning Disabilities and Autism, the Greater Manchester Integrated Care System strategy and locality plans.

We recognise the need to continually improve and transform our existing services, develop new services and further enhance our estates and digital technologies and the 2023/24 plan sets out a significant programme of development and change. However, there has been a clear message through our engagement with colleagues that we need to stabilise current services focusing on safe staffing levels and core systems and processes as a priority this year. We have therefore ensured the following themes underpin our priorities:

- **Stabilise** – ensuring we have the basic's right for our staff, service users and carers to enable safe and high-quality care
- **Recover –** ensuring we have clear and focused plans to improve core pathways and processes
- **Transform** – drive forward our transformation and sustainability plans in line with the long-term plan.

Our Business Plan is a live document that will be continually monitored, reviewed, and refreshed throughout the year to ensure it remains relevant and reflective of in year changes, as described in the process below. Any changes will be agreed through our internal governance processes.

The plan will be further designed by our internal Communications team to identify the key priorities and plans in a format that is accessible to our full range of stakeholders.

Accountability and performance reporting

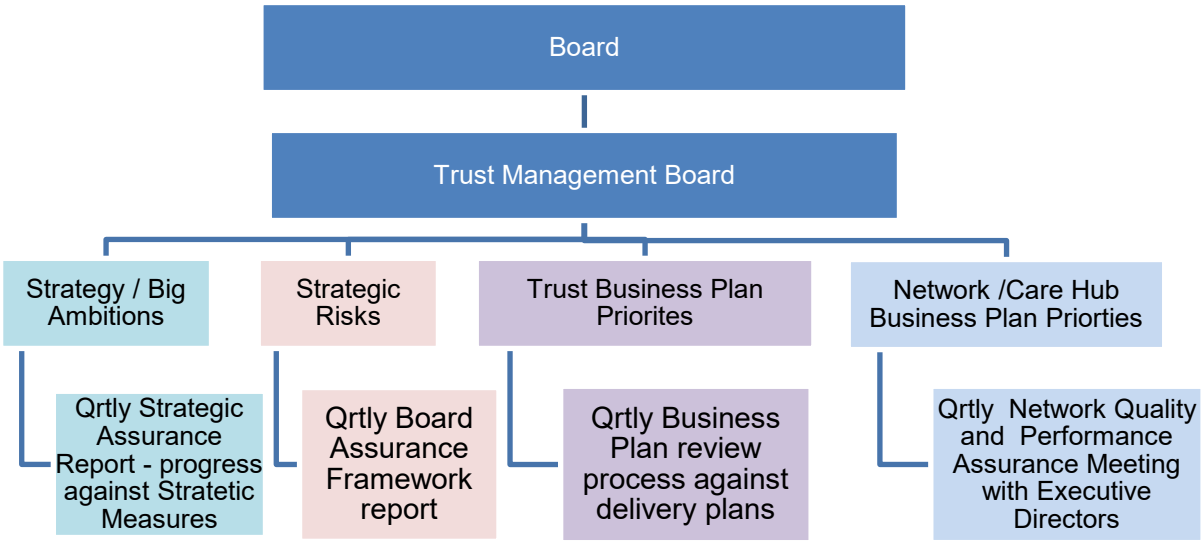
A quarterly strategic assurance and progress update will be presented to the Trust Board on behalf of the Executive Directors, incorporating the Board Assurance Framework (BAF), which outlines our strategic risks. The priorities outlined for 2023/24 will support management and mitigation of our strategic risks.

Performance against the Trusts Big Ambitions will be monitored through the development of strategic measures. Whilst the overall strategy as a whole will be supported, enabled, and informed by the full Executive Director team, each strategic measures has a defined Executive Director Lead(s) who will act as sponsor(s) to the associated delivery programme, acting on behalf of the executive team. Performance against each Strategic Measures will be reported as part of the Strategic Assurance Report presented to Trust Management Board and the Trust Board on a Quarterly basis.

Progress against the 2023/24 business plan and priorities will be monitored quarterly against agreed delivery plans and will be reported to Trust management Board and Trust Board in the Business Plan quarterly update report.

Performance against the Trust Key Operating Standards and oversight metrics will be reported to Trust Management Board and the Trust Board in the Monthly Integrated Performance Report.

Progress against objectives and priorities in the Network and Care hub plans progress monitored quarterly through the Network Operational Performance and Finance Meetings and the Quarterly Network Performance Assurance meetings with Executive Directors.



Our Vision : A happier and more hopeful life for everyone in our communities

23/24 Priorities

Stabilise, Recover and Transform

Outstanding care

Workforce Stability :
- Establishment of Safe Staffing standards across trust
- Establish recruitment & retention plans with care hubs/networks and hold workforce summit(s) to inform future workforce development

Financial Sustainability :
- Agree a secured investment plan to support sustainable clinical delivery and which addresses service variation / gaps
- Deliver planned commitments in the value improvement programme

Improve core data, systems and processes
- Complete roll out of Electronic Patient Record, Implement new stabilised IM&T network and telephony system, progress e-prescribing and e-rostering business readiness assessment and testing in pilot sites
- Implement the data and reporting improvement programmes
- Review digital management systems (e.g.. ESR, LMS, OHIO etc.) and develop improvement plan.

Key Operating and Quality Standards :
- Improve performance against our key operating and quality standards

Deliver our Statutory 'must-do's' Inc.
- Develop plans for implementation of MH Act reforms and Smoke free NHS

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Reducing Health Inequalities
- Progress programme inc. launch of external engagement and implementation of Patient and Carer Race Equality Framework

Clinical Models of Care
- Development and delivery of clear clinical operating model(s)
- Initiate Trauma informed/ responsive work programme

Service Transformation
- Progress in line with delivery plan

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services
- Implement our approved by lived experience award
- Implement peer support worker programme
- Implement the National Patient Safety incident response Framework
- Implement Patient experience improvement framework
- Establish collaborative care planning programme

All colleagues feel engaged and are involved in improvement

Just Culture & Compassionate Leadership
- Refresh and refocus the importance of just culture with clear priorities
- Deliver our management and leadership development programme

Workforce engagement
- Focus on meaningful engagement and action feedback from staff survey

Continuous Improvement
- Implement Improvement Framework

Performance and Accountability
- Implement Performance and accountability framework

Our Enablers

Clinical (New)
Approve, launch and commence Implementation

Together (New)
Approve, launch and commence Implementation

Leadership
Approve, launch and commence implementation

Equality , Diversity and Inclusion
Approve, launch and commence implementation

Finance and Sustainability
Approve, launch and commence implementation

Estates (New)
Approve, launch and commence implementation

Research and Innovation
Launch and Commence Yr. 1 Implementation

Green Plan
Yr. 1 delivery Plan

Digital
Yr. 2 delivery plan

Communications (refreshed Sept 22)

Quality
Yr. 3 delivery plan

People Plan
Yr. 3 delivery plan

23/24 key priorities aligned to Enablers

Clinical (New) ***Qtr. 1:*** *Approve, launch and commence Implementation*	Delivery of implementation plan including: • Development and delivery of clear clinical operating model(s) linked to transformation programme • Alignment of key enabling plans • Trauma informed work programme	**Research and Innovation - Year 1** ***Qtr. 1 Launch and commence implementation***	Launch, and focus on year 1 priorities: • Secure external funding bids; • Employ clinical academic posts; • Build our strategic partnership with MMU
Together (New) ***Qtr. 1-2*** *: Approve, launch and commence Implementation*	• Focus on year 1 priorities: Service users and carers; GMMH; Localities; VCSE (inc. Housing) • Launch approved by lived experience award • Deliver co-produced VCSE human factors event • Housing strategy developed and implemented	**Green Plan Year 1**	Continue to work towards our ambition to be net zero – • Provision of training to leaders and governors, • Develop and implement a utility management bureau service • pending approval of business case provide electric vehicle charging
Estates (New) ***Qtr. 1-2:*** *Approve, launch and commence implementation*	*Pending Approval of Business cases in Qtr. 1* • Complete of the Bury Estates review by Qtr. 4 • Commence Tameside estates review by qrt 2 with a view to completion in Spring/Summer 2024	**Quality (Yr. 3 – refreshed 2021)**	• Implement the National Patient Safety incident response Framework Refresh and refocus the importance of a just culture with clear priorities for 23/24 agreed. • Implement our refreshed improvement framework • Implement Patient experience improvement framework
Leadership ***Qtr. 4 :*** *Approve, launch and commence implementation*	• Deliver our 12 month management and leadership development programme in line with strategy outcomes. • Implement our Performance and accountability framework -Qtr. 2	**Digital (Yr. 2)**	• Complete roll out of Electronic Patient Record • Implement new stabilised IM&T network and telephony system by Qtr. 4 • *Pending Approval of Business cases in Qtr. 1 :*Commence e-prescribing and e-rostering business readiness assessment and testing in pilot sites
Finance and Sustainability ***Qtr. 1:*** *Approve, launch and commence implementation*	• Deliver the value improvement programme in line with plan. • To agree a secured investment plan to support sustainable clinical delivery and which addresses service variation / gaps.	**People Plan (Yr. 3 - refreshed 2021)**	• Launch refreshed recruitment brand by Qtr. 4 • Work with care hubs and network to establish recruitment and retention plans by qtr. 4 • Hold workforce summits to inform workforce development plan by qtr. 4
Equality, Diversity and Inclusion (New) *Qtr. 4 Approval and launch of strategy and plan*	• Launch external engagement regarding health inequalities during Qtr. 1 • Detailed implementation plan by end of qtr. 4	**Communications (refreshed Sept 22)**	• TBC

North Network 2023/24 Priorities

Stabilise , Recover and Transform

Outstanding care

Workforce Stability - Review and identify staffing gaps and future workforce requirements to support recruitment, retention plans and workforce plans
Financial Sustainability - Progress discussions to ensure priorities for investment are identified and fed into the contract negotiations processes.
Performance and Accountability - Continue to bolster governance arrangements inc. Monthly Assessment and Escalation processes. Ensure work is ongoing to achieve our aspirational CQC rating of, '*Good*'.
Data Culture - Train, support and develop managers at all levels to feel confident in the use of data for decision making and an improved data quality culture.
Key Operating and Quality Standards - Improve performance against our key operating and quality standards including improving our My Yearly Conversation and Core and Essential Skills Training compliance.

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Reducing Health Inequalities
- Identify unwarranted variation across services using the Patient and Carer Race Equality Framework to inform data collection, including the care planning workstreams.

Clinical Models of Care
- Review services in line with clinical strategy ensuring interventions are evidence-based and deliver the most effective outcomes.
- Progress digital solutions for the 24/7 helpline service and broaden service offer to include children and young people (pending business case).

Community Transformation Plans
- Mobilisation of the Living Well model as outlined in the Trust community transformation plan

Acute and crisis care transformation programme
- Implementation of Inpatient Standards across all wards
- Ensure sustainability of the UEC services inc progressing action to reduce A&E attendances for those in crisis.

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services
- Continue to incorporate the lived experience/living experience input into services ensuring services have the best patient outcomes at heart through the use of feedback to influence our service improvements.
- Include lived experience representatives in the recruitment process and at relevant meetings
- Continue Triangle of Care work specifically regarding the views and inclusion of carers in our services.

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership
- Ensure visibility of senior leadership creating opportunities for colleagues' voices to be heard and listened to. Empower our leaders through continuous professional development.

Continuous Improvement
- Encourage and empower our clinical colleagues to be innovative and continuously improve services using our improvement framework .

Workforce Satisfaction
- Use the result of our staff survey to continue to improve and develop our workforce and resilience.

Bury Care Hub 2023/24 Priorities

Stabilise , Recover and Transform

Outstanding care

Workforce Stability - Review of staffing requirements to support safer caseloads in CMHT in line with the bolster and sustain Funding, new Living Well Model and identify any recruitment and retention plans.
Financial Sustainability - Completion of Humphrey House relocation to 3KP.
Performance and Accountability - Completion of on-site manager evaluation and SMT away day from the midpoint review.
Data Culture - Support and develop our managers to feel confident in the use of data for decision making and improve our data quality culture.
Key Operating and Quality Standards

- Implement the Talking Therapies system maturity tool action plan to support improvement in performance and quality
- Implementation of Violence and Aggression Reduction QI project and Instillation of nurse call alarm systems.

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Reducing Health Inequalities

- Mobilise Older people home intervention team
- Mobilise Home treatment team to support 24/7 core fidelity.

Clinical Models of Care

- Review services in line with clinical strategy ensuring interventions are evidence-based and deliver the most effective outcomes.

Community Transformation Plans

- Mobilisation of the Living Well system including the development of a Living Well team, CMHT transformation, bolstering of the Assessment and Treatment team
- Strengthen Talking Therapies involvement within PCNs.

Acute and crisis care transformation programme

- Implementation of Inpatient Standards across Bury wards
- Continue mobilisation of A&E liaison Core 24.
- Deliver UECA model in line with evaluation and trust model.

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services

- Continue to incorporate the Lived experience/living experience input into services ensuring services have the best patient outcomes at heart.

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership

- Continue to ensure visibility of senior leadership throughout the year
- Complete the evaluation of on-site manager.

Continuous Improvement

- Engage with Quality Improvement Framework.

Workforce Satisfaction

- Use the staff survey results to continue to improve and develop our workforce and resilience.

Oldham Care Hub 2023/24 Priorities

Stabilise , Recover and Transform

Outstanding care

Workforce Stability - Review staffing gaps and develop recruitment and retention plans with a specific focus on Talking Therapies, liaison services and Safe haven
Financial Sustainability - Talking Therapies Review funding with Commissioners
Performance and Accountability - Continue to bolster the new governance arrangements inc the Monthly Assessment and Escalation processes within the network.
Data Culture - Support and develop managers at all levels to feel confident in the use of data for decision making and improve our data quality culture.
Key Operating and Quality Standards

- Improve MYC and CEST whilst improving sickness figures.
- Implement Talking Therapies system maturity tool action plan to support improvement in performance and quality in line with national standards.
- Improve current EIT level 2 NCAP and implementation of new Memory Assessment Service specification to ensure patients can be discharged from the service when medically suitable, increase medical provision and improve data quality .

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Reducing Health Inequalities

- Complete expansion of the Structured Clinical Management pathway for all age and full mobilisation of GMMOP service.

Clinical Models of Care

- Achieve PLAN accreditation and manage outcome measures from implementation of accreditation.
- Mobilisation of new centralised ECT model
- Implement a bookable room system for Adult Community teams and address gaps in outdoor areas on wards.

Community Transformation Plans

- Mobilisation of the Living Well model

Acute and crisis care transformation programme

- Successful implementation of Inpatient Standards
- Ensuring Core Fidelity ilinked to the Safe Haven 24/7 offer
- Improvement in patient flow through an improved gatekeeping process.

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services

- Continue to incorporate the lived experience/living experience input into services ensuring services have the best patient outcomes at heart.

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership

- Address staff survey feedback to continue to improve and develop our workforce and resilience.

Continuous Improvement

- Engage with Quality Improvement Framework.

Workforce Satisfaction

- Implementation of rest areas for staff within inpatient services.

Stabilise , Recover and Transform

HMR Care Hub 2023/24 Priorities

Outstanding care

Workforce Stability - Review and identify staffing gaps and future workforce requirements to support recruitment, retention and workforce plans.
Financial Sustainability - Safe implementation of new windows on the inpatient units and on the pathway for Hollingworth Ward.
Performance and Accountability - Sustaining 72 hour follow ups rate throughout the year and provide NICE concordant care in EIT ensuring the service is commissioned to the required NCAP level.
Data Culture - Develop managers confidence at all levels to use data for decision making, improving our data quality culture.
Key Operating and Quality Standards - Implementation of Inpatient Standards across HMR wards and full mobilisation of the Home Treatment Teams to core Fidelity.

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Reducing Health Inequalities
Maintain improvement in recovery rates and deliver successful implementation of Step 2/3 CPPD programme.
Clinical Models of Care
Embedded crisis care pathway; supported discharge in Crisis and Home Treatment Team; Implement new Clozapine initiation pathway to support reduction in occupied bed days.
Community Transformation Plans
Mobilise CMHT transformation in line with community mental health framework including implementation of the SCM pathway, new assessment framework and CPA working.
Acute and crisis care transformation programme
Sustaining UECA service through implementation of training plans and recruitment to the LMH service and improve attendance at Rochdale urgent care centre as an alternative to A&E.
Continue to address the identified gaps in Older Peoples services including wider MDT offer. Improvement plan to be developed and review internal interfaces between HITS/CMHT and SPOE.
Implementation of SLAs in Oasis, Rochdale Infirmary and NCA dementia friendly unit to avoid patients going onto general wards,bolstering the care home liaison offer and addressing the diagnostic backlog in MAS.

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services
Continue to incorporate the Lived experience/living experience input into services ensuring services have the best patient outcomes at heart.

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership
Maintain MYC and CEST whilst improving sickness figures and using our Staff Survey results carry out a targeted piece of work to address feedback.

Continuous Improvement
Implementation of Triangle of Care project in the John Elliot Unit reception.

Workforce Satisfaction
Use the results of staff survey to continue to improve and develop our workforce and resilience.

South Network 2023/24 Priorities

Stabilise , Recover and Transform

Outstanding care

Workforce Stability - Develop our people plan to support our workforce to have the diversity, skills and confidence to deliver the networks key priorities whilst ensuring colleagues have a voice.

Financial Sustainability:

- Work within our financial envelope and in line with SFIs to deliver financially sustainable services.
- Fully utilise MHIS and SDF investments by ensuring effective deployment in line with our operational business plan and deliver our value improvement target (of £0.6 million) through a process of bottom-up engagement that ensures staff contributions are valued in the delivery of financially efficient services

Performance and Accountability - Embed the new governance arrangements including the Monthly Assessment and Escalation processes.

Data Culture - Train, support and develop managers at all levels to feel confident in the use of data for decision making and improve our data quality culture.

Key operating and quality standards – Improve performance against the Trusts key operating and quality standards

Estates – explore options to continually improve the estate to make this fit for purpose for our colleagues and service users.

-

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Reducing Health Inequalities:

- Identify unwarranted variation using the Patient and Carer Race Equality Framework to inform data collection.
- Develop our partnerships with VCSE and others, utilising the principles of anchor institutions to develop strength and resilience in our workforce and communities to improve mental health outcomes.

Clinical Models of Care:

- **R**eview services in line with clinical strategy ensuring interventions are evidence-based and deliver the most effective outcomes

Community Transformation Plans:

- In line with the Trust wide community transformation plans, we will shape our community transformation priorities with our local population to improve mental health outcomes.

Acute and crisis care transformation programme:

- In line with the Trust wide Urgent and Emergency Care (UEC) transformation plans we will shape our transformation priorities with our local population to improve mental health outcomes.
- Realigning our core services to enable 24/7 access to crisis mental health support that is easy and accessible for all our local populations

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services:

- Grow our lived experience workforce and shape our plan, with lived experience central to this
- Build capacity & capability within our workforce that reflects the living experiences of our population
- Deliver trauma-informed approaches to safe care by listening to our patients and carers. Patients will be treated with kindness and compassion, with dignity and respect.
- Engage partners and lived experience in the co-design and co-delivery of services.

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership:

- Develop and nurture our workforce to foster a culture grounded in developing opportunities to enhance and grow psychological safety
- We will be compassionate leaders and create the conditions of psychological safety for colleagues and treat everyone with kindness, compassion dignity and respect

Continuous Improvement:

- Encourage and empower our clinical colleagues to be innovative and implement our improvement framework .

Workforce Satisfaction:

- Use the results of our staff survey to improve and develop our workforce and resilience as monitored via the People Plan

Tameside and Glossop Care Hub 2023/24 Priorities

Stabilise , Recover and Transform

Outstanding care

Workforce stability - Develop our people plan to support our workforce to have the diversity, skills and confidence it needs to deliver the networks key priorities whilst ensuring employees have a voice.
Financial sustainability - Deliver value for money and efficient services which support financial sustainability and quality improvement; contributing to our value improvement plan
Performance and accountability
- Fully embed the Monthly Assessment Process and ensure utilisation by all Service Managers
- Develop our reporting processes to support the triangulation of data

Data culture
- Train, support and develop managers at all levels to feel confident in the use of data for decision making and Improve our data quality culture.

Key operating and Quality standards
- To meet LTP requirements as it relates to Talking Therapies, Least restrictive practice, OAPS, CFRD, Annual Health checks
- Proactively monitor the demand and capacity requirements of our services, to ensure delivery of sustainable care.

Estates
- Ensuring estates for both staff and patients are fit for purpose; services may move following Tameside Estates review

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Reducing Health Inequalities:
- Develop our transformation plans in partnership and hold ourselves accountable in ensuring our populations are represented.

Clinical Models of Care:
- Review services in line with clinical strategy ensuring interventions are evidence-based and deliver the most effective outcomes.

Community, Acute and Crisis transformation plans
- Develop our community transformation and UEC plans ensuring they reflect and meet the needs of our local population.
- Evaluate the Living Well service offer to ensure it meets the needs of the local population and demonstrates effective partnership working.

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services:

- Engage partners and lived experience in the co-design and co-delivery of services.
- Expand the patient and carer voice through the development of the T&G involvement team
- Use Anchor Institution principles to grow our workforce with local people and support those with lived and living experience to gain access to meaningful paid and non paid employment

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership
- Develop and strengthen our leadership to create conditions of psychological safety for colleagues and treat everyone with kindness, compassion dignity and respect

Continuous Improvement
- Support our staff to embed a culture of continuous improvement and reflective practice.
- Support our staff to access appropriate training to enable continuous improvement.

Workforce Satisfaction
- Use the People Plan to support and develop our workforce.
- Use the staff survey rresults to monitor the delivery of the People Plan.

Stockport Hub 2023/24 Improvement Priorities

Stabilise , Recover and Transform

Outstanding care

Workforce stability - Develop our people plan to support our workforce to have the diversity, skills and confidence to deliver our priorities whilst ensuring employees have a voice
Financial sustainability - Deliver value for money and efficient services which support financial sustainability and quality improvement, contributing to our valueimprovement plan (£
Estates - Estates options to be explored for: - Stockport's Older Peoples Services and NHS Stockport Talking Therapies
Performance and accountability
- Fully embed the Monthly Assessment Process and ensure it utilised by all Service Managers
- Develop our reporting processes to support the triangulation of data

Data culture
- Train, support and develop managers at all levels to feel confident in the use of data for decision making and improve our data quality culture.

Key operating standards
- Meet LTP requirements as it relates to Talking Therapies, Least restrictive practice, OAPS, CFRD, Annual Health checks
- Proactively monitor the demand and capacity requirements of our services, to ensure delivery of sustainable care.

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Reducing Health Inequalities
- Develop our transformation plans in partnership and hold ourselves accountable in ensuring our populations are represented.
- Ensure existing D&A gaps of provision will be considered in service developments

Clinical Models of Care
- Review services in line with clinical strategy ensuring interventions are evidence-based and deliver the most effective outcomes.
- Development of new D&A roles to allow future growth of the service
- Mobilise the Living Well offer in Stockport in partnership with our wider system partners, enabling people to access the right level of support at the right time.

Community Transformation Plan
- Mobilise the Community Transformation Programme in collaboration with our wider system partners to reflect the needs of Stockport

Acute and crisis care transformation plan
- Implement the Inpatient Standards
- Develop the crisis offer to reflect local commissioning arrangements and enable patients to access the support at the right time

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services:

- Engage partners and people with lived experience in the co-design and co-delivery of services

- Use anchor Institution principles to grow our workforce with local people and support those with lived and living experience to gain access to meaningful paid and non paid employment

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership
- Develop and strengthen our leadership to create conditions of psychological safety for colleagues and treat everyone with kindness, compassion, dignity and respect

Continuous Improvement
- Support our staff to embed a culture of continuous improvement and reflective practice.
- Support our staff to access appropriate training to enable continuous improvement.

Workforce Satisfaction
- Use the People Plan to support and develop our workforce.
- Use the rstaff survey results to monitor the delivery of the People Plan.

Specialist Network 2023/24 Priorities

Stabilise , Recover and Transform

Outstanding care

Workforce Stability
- Improve recruitment and retention and increase the diversity of our workforce reflecting local populations through the delivery of care hub workforce action plans

Financial Sustainability
- Demonstrate visible system leadership to influence and advocate for the continued growth and improvement of MH and LDA services
- Deliver care hub financial actions plan to provide greater resource within the Network to improve quality and safety.
- Deliver £0.7m VIP efficiencies and reduce agency spend by 10% in year.

Performance and Accountability
- Embed strengthened governance and assurance processes to provide appropriate scrutiny and challenge/triangulation of qualitative and quantitative data sets.

Data Culture :
- Develop a new internal training offer for senior leaders focussing on data/performance analysis/impact of data/use of SPC

Key Operating and Quality Standards
- Improve performance against key performance and quality standards.

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Reducing Health Inequalities
- Continue to address unwanted variation across all localities.

Clinical Models of care
- Continue to develop evidence-based models of care that are underpinned by trauma and gender informed principles.

Service Transformation plans
- Deliver the Specialist Network Transformation agenda.

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services:

- Engage people with lived in experience in the co-design and co-delivery of new and existing services.
- Grow our workforce to increase the number of people who have lived experience.

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership
- Improve staff wellbeing and experience through compassionate and capable leadership demonstrated consistently by care hub and network leaders.
- Increase senior visibility in all areas.

Continuous Improvement :
- Encourage and empower our clinical colleagues to be innovative and continuously improve services using our improvement framework.

Workforce satisfaction
- Implement action plan informed by staff survey results
- Maximise meaningful training and professional development.

CAMHS Care Hub 2023/24 Priorities

Stabilise , Recover and Transform

Outstanding care

Workforce Stability
- Deliver workforce action plans to respond to staff survey data and review existing clinical roles to ensure consistency and quality alongside the development of new roles.

Financial Sustainability
- Review subcontracts to ensure these are good value and deliver quality whilst developing a standardised approach to sub-contract management
- Mobilise MHIS investment to improve vacancy levels and resulting underspend to improve service waiting times.
- Complete safe staffing reviews informed by the MHOST tool in inpatient areas to inform future investment priorities.

Performance and Accountability: Embed strengthened governance and assurance processes to provide appropriate scrutiny and challenge/triangulation of qualitative and quantitative data sets across all contracts.

Data culture: Care hub leaders to engage bespoke training to enhance focus on data/performance analysis/impact of data/use of SPC.

Key operating and Quality standards: Improve performance against key performance and quality standards.

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Reducing Health Inequalities
- Deliver our transformation plans to expand and enhance the mental health school teams programme in every locality.

Clinical Model of care
- Review and adapt our intervention offers for people with neurodiversity.

Service Transformation plans
- Implement the CYP transformation plans in line with the LTP including Implementing the '7 helpful habits' model across all localities and GM crisis care recommendations

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services:
- Engage people with lived in experience in the co-design and co-delivery of new and existing services.
- Provide resource to the Research Hub to support the progress of research that informs our models of care.

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership
- Improve staff wellbeing and experience through compassionate and capable leadership demonstrated consistently by care hub leaders.
- Increase senior visibility in all areas.
- Respond to staff survey data and quarterly pulse survey reviews.

Continuous Improvement
- Encourage and empower our clinical colleagues to be innovative and continuously improve services using our improvement framework.

Workforce satisfaction
- maximise meaningful training and development opportunities for staff through a training needs analysis across care hub.

Stabilise , Recover and Transform

Learning Disabilities Network 2023/24 Priorities

Outstanding care

Workforce Stability
- Deliver workforce action plans and continue to advocate for additional funding to address capacity and demand gaps identified in 2022/23.
- Implement the new clinical psychology leadership model
- Develop new roles (e.g. Peer Support Workers) to promote efficiency and maximise service capacity

Financial Sustainability
- Engage commissioners and system partners to address health inequalities and agree investment priorities.
- Improve vacancy levels and resulting underspend to improve service waiting times.

Performance and accountability: Embed performance reporting and improve levels of assurance with the new LD dashboard

Data culture
- Support high quality recording and analysis of data to bolster service improvement through bespoke training for service leaders.
- Continue to roll out EPR according to schedule (implementing dashboards)

Key operating and Quality standards: Improve performance against key performance and quality standards.

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Reduce health inequalities
- Continue to engage in the national STOMP - STAMP programme and reducing health inequalities agenda.

Clinical Model of care
- Continue to review and develop clinical pathways and implement special interest groups (clinically led and pathway associated)
- Initiate a QI-informed approach for targeting improvements to the model of care
- Safely cease the existing service delivered at Cambeck Close and re-design in collaboration with system partners

Service Transformation
- Mobilise Radcliffe Place admission avoidance service with full review of service impact

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services
- Further establish the LD Research Hub and commence research to support service improvements with the involvement of people with lived experience.
- Development of peer support worker roles.

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership
- Improve staff wellbeing and experience through compassionate and capable leadership demonstrated consistently by care hub leaders.
- Increase senior visibility in all areas.
- Respond to staff survey data and quarterly pulse survey reviews.

Continuous Improvement
- Encourage and empower our clinical colleagues to be innovative and continuously improve services using our improvement framework.

Workforce satisfaction
- Establish staff wellbeing group focussing on staff survey results
- Complete training needs assessment to maximise meaningful training and development opportunities for colleagues.

Stabilise , Recover and Transform

RHS Network 2023/24 Priorities

Outstanding care

Workforce Stability
- Deliver workforce action plans to respond to staff survey data and the nursing retention paper.
- Conduct Safe Staffing Reviews informed by the MHOST tool across all RHS units. Prioritise based on patient safety data and current agency spend.

Financial Sustainability
- Request additional investment from the LPC to close the gap in workforce models based on MHOST assessment.
- Reduce agency spend by 10%

Performance and accountability: Implement the new governance structure and develop/communicate the new branding with wider stakeholders

Data culture: Support high quality recording and analysis of data to bolster service improvement through bespoke training for service leaders.

Key operating and Quality standards: Improve performance against key performance and quality standards.

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Reduce health inequalities
- Deliver our transformation plan to further expand the community rehabilitation service.

Clinical Model of care
- Implement the recommendations from the national Getting It right First Time programme (GIRFT)
- Review clinical pathways and models of care informed by GIRFT.

Service Transformation
- Mobilise the new Community Rehab Team (CRT) and repatriate our out of area patients
- Redesign our RHS care hub in order to encompass its diversity, strengthen system partnerships, and play an active role within the LPC.

People with lived and living experience shape every decision

Embed Lived experience/living experience input into services:
- Engage people with lived in experience in the co-design and co-delivery of new and existing services.
- Expand and engage the service user / carer voice through a range of mechanisms.

All colleagues feel engaged and are involved in improvement

Just Culture and Compassionate Leadership
- Improve staff wellbeing and experience through compassionate and capable leadership demonstrated consistently by care hub leaders.
- Increase senior visibility in all areas.
- Respond to staff survey data and quarterly pulse survey reviews.

Continuous Improvement
- Encourage and empower our clinical colleagues to be innovative and continuously improve services using our improvement framework.

Workforce satisfaction
- Complete a training needs assessment to develop a meaningful professional development offer.

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Pennine Care
NHS Foundation Trust

2023/24 Plan	
Paper prepared by	Andrea Osborne, Deputy Director of Finance
Executive sponsor	Gaynor Mullins, Executive Director of Strategy Nicola Tamanis, Executive Director of Finance
Date of report	27th April 2023
Purpose of the report and action required	The purpose of the report is to present the final operational plan to the Board for approval. The 2023/24 final plan submission is due on 4th May 2023.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Trust has revised the OAPs trajectory in discussion with the ICB and system partners. This now reflects the planned impact of a reduction in delays and impact of additional discharge schemes supporting a reduction in OAPs in Q3 and Q4. The revised trajectory has been submitted with the caveat that this is dependent on wider system support to reduce delays and increased funding and could also be impacted if we continue to see an increase in referrals. The GM ICS has agreed a breakeven financial plan for 2023/24. The plan includes a system efficiency target in addition to individual organisational efficiency targets of c£100m. It is the responsibility of all organisations to contribute to the system efficiency target to deliver the breakeven position planned for 2023/24. PCFT are planning to deliver a breakeven position as part of the overall plan for GM ICS.
Recommendation	The Board are asked to approve the 2023/24 Final Plan for submission on the 4th May recognising the risks and mitigations highlighted in the report.
Where else has this report been considered and when?	The financial plan was considered at P&FC at its meeting on the 26th April although it is important to note that the proposal for the final plan had not been shared with providers until after the P&FC meeting on the 26th April 2023.

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	X
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	

NHS
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2023/24 Operational Plan
April 2023

Maximising potential

Operational Performance: Revised OAPs Trajectory

Pennine Care NHS Foundation Trust

The revised trajectory assumes:

- Demand remains at the same level as seen during qrt 4 2022/23
- A 2% reduction in OAPS based on internal flow improvements
- Commitment from system and place to support a reduction in LA delays: A 25% reduction in LA delays could support an 8% reduction in OAPs days *(based on Qrt 4 OAPs days and delayed days due to social care and or supported accommodation)*
- Discharge schemes are funded
- GM ICS has established an OAPs task and finish group reporting into the GM MH Crisis board. This is to address the systemic issues driving OAPs and monitor performance against trajectory

OAP Trajectories	qrt1	qrt2	qrt3	qrt4
Revised Trajectory	2,425	2,413	2,172 10% reduction from Qrt 2	1,690 30% reduction from Qrt 2

23/24 Indicative Final Plan

Pennine Care
NHS Foundation Trust

	£'m	£'m
22/23 exit run rate		**20.0**
Further pay award changes	0.5	
Band 2 - 3 Agenda for Change	1.1	
Shortfall recurrent efficiency 22/23	1.6	
Sub Total Full Year Impact		**3.2**
Net cost of Inflation 23/24		4.5
Non GM income flow		-0.6
Local cost pressures		0.2
23/24 recurrent efficiency 1.8%		-4.3
Recurrent Underlying Deficit		**23.0**
System support		-10.2
System inflationary growth		-2.5
Trust managed risk : e.g. delayed mobilisation of investments		-3.2
NR Efficiency at 1.9%		-7.1
Indicative Final Submission		**0.0**

Workforce

Pennine Care
NHS Foundation Trust

Closing WTE	19/20	20/21	21/22	22/23	23/24	In Year Change
Substantive	3,347.6	3,330.3	3,284.0	3,594.8	3,705.2	110.4
Bank	318.2	422.9	432.6	335.3	331.9	(3.3)
Agency	132.2	153.1	168.4	195.6	185.8	(9.8)
Total WTE	**3,798.0**	**3,906.3**	**3,885.0**	**4,125.7**	**4,222.9**	**97.3**

Agency £	11,022.0	7,129.0	10,786.0	14,014	12,960.0
% of total pay	5.7%	4.1%	5.9%	6.8%	6.2%

Value Improvement Programme (1)

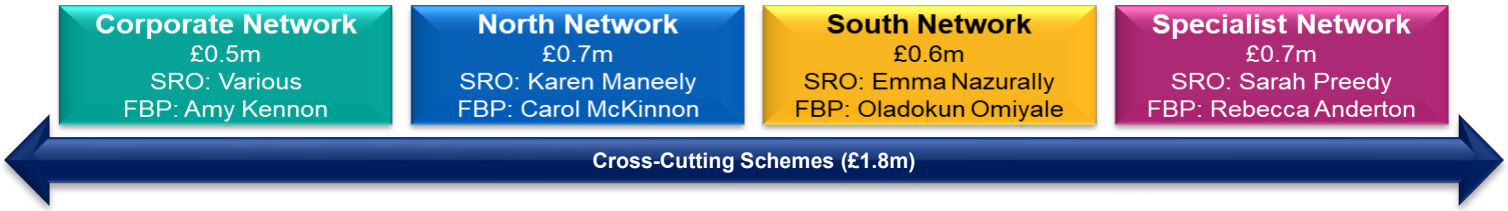
Pennine Care NHS Foundation Trust

	2019/20	2020/21	2021/22	2022/23	2023/24 Target
Delivered Non Recurrently	4,612	3,779	8,526	9,217	7,133
Delivered Recurrently	6,638	898	1,545	4,179	4,294
Total Delivery	**11,250**	**4,677**	**10,071**	**13,396**	**11,427**

2023/24 Value Improvement: Progress (2)

Pennine Care NHS Foundation Trust

- Targets delegated to Networks of 1.1% in February 2023
- Additional target from cross-cutting schemes to be identified
- Total Target for 23/24 = £11.5m



- Scheme guide provided to all leads for information
- Meetings held in April to discuss schemes – financial and non-financial
- Deadline for 'pipeline' scheme generation – **30 April 2023**
- Deadline for baseline data (where applicable) and trajectory by **end of May 2023**

Types of Scheme – There are different types of schemes which could be recurrent (permanent) or non-recurrent (temporary, in-year only) – as shown below:

Cash-Releasing

These are schemes where money can be completely removed from a line within a budget (cost centre) (eg making a skill mix change)

Cost-Avoidance

These are schemes where money is being spent BUT you do not have the budget to pay for it...so you avoid the overspend on your budget (eg agency costs)

Invest-to-Save

These are schemes where you can demonstrate a saving will be generated if investment is provided – the saving must exceed the cost

Income Generation

These are schemes where you intend to generate income over and above any existing income target in your budget (eg new or additional income)

Efficiency

These are schemes with no monetary value but demonstrate increased productivity within the same cost envelope

GM 2023/24 Capital Plan

Pennine Care
NHS Foundation Trust

Trust	Pre-Committed	Depn	Bespoke	Current total	Share £13.1m	Revised Total
MFT	£16.3	£39.9	£20.0	**£76.2**	**-£2.76**	**£73.44**
CFT	£0.0	£21.3	£0.0	**£21.3**	**-£1.47**	**£19.82**
NCA	£0.1	£59.5	£20.0	**£79.6**	**-£4.11**	**£75.49**
BFT	£0.0	£13.7	£0.0	**£13.7**	**-£0.95**	**£12.73**
TGICFT	£5.1	£5.9	£0.0	**£11.0**	**-£0.41**	**£10.56**
WWLFT	£0.0	£12.5	£0.0	**£12.5**	**-£0.86**	**£11.64**
PCFT	£0.0	£5.6	£0.0	**£5.6**	**-£0.38**	**£5.17**
SFT	£5.0	£16.6	£0.0	**£21.6**	**-£1.15**	**£20.47**
GMMHFT	£6.4	£14.7	£0.0	**£21.1**	**-£1.02**	**£20.08**
Total	**£32.9**	**£189.6**	**£40.0**	**£262.5**	**-£13.1**	**£249.4**

Feb Subm	**£281.4**
Improve	£32.0

Plan Risk	
Envelope ->	**£153.5**
Add back asceptics	-£5.0
Envelope for CDEL	**£148.5**
GM Share of the £300m	£16.3
5% tolerance	£8.5
Other additions to envelope	**£24.8**
Total Operational cap	**£173.3**
Capital Ask	£249.4
GAP	**-£76.1**
Explained by:-	
PAT transaction	-£40.0
CDEL - Depn Shortfall	-£36.1
Residual balance	**-£76.1**

5 Year Draft Capital Plan

Capital Scheme Description	Plan 31/03/2024 £'000	Plan 31/03/2025 £'000	Plan 31/03/2026 £'000	Plan 31/03/2027 £'000	Plan 31/03/2028 £'000
EPR Optimisation	309	790	500	500	500
EPMA	412				
E-Rostering	870				
IT - networks	374				
IT - telephony	183				
IT - other incl. replacement devices	1,290	1,480	1,800	1,500	1,500
DIGITAL	**3,438**	**2,270**	**2,300**	**2,000**	**2,000**
Estates utilisation, essential works, minor improvements	100	100	100	100	100
Medical Equipment	50	50	50	50	50
Backlog maintenance	700	700	700	700	700
Patient safety - ligature risks	200	500	200	200	200
Window replacement (£4.8m)			500	1,000	1,000
Female PICU	1,564				
3 Knowsley Place	1,100				
Bealeys Hospital		200	1,700		
Trust HQ redesign		1,200			
Health Based Place of Safety		1,300			
Estate Strategy: Oldham				1,000	
Estate Strategy: Stockport				500	500
Estate Strategy: Rochdale					1,000
ESTATES	**3,714**	**4,050**	**3,250**	**3,550**	**3,550**
TOTAL	**7,152**	**6,320**	**5,550**	**5,550**	**5,550**
PDC Funded Schemes					
Frontline Digitalisation	1,000	750			
HBPOS	1,295	1,780			
Total	**2,295**	**2,530**	**0**	**0**	**0**
TOTAL EXPENDITURE	**9,447**	**8,850**	**5,550**	**5,550**	**5,550**
Funded by					
Depreciation	5,600	6,303	5,605	5,605	5,605
PDC	2,295	2,530			
System Gap	(430)				
GMMH Tfr	700				
TOTAL FUNDING	**8,165**	**8,833**	**5,605**	**5,605**	**5,605**
Over / (under) commitment	**(1,282)**	**(17)**	**55**	**55**	**55**

Risks and Mitigations

Pennine Care
NHS Foundation Trust

Description	Risk	Mitigation
Delivery of the OAPs Trajectory	There is a risk that we do not meet the 2023/24 planned reduction in OAPs particularly if we continue to see an increase in referrals We have revised our OAPs trajectory in discussion with the ICB and system partners. This now reflects the planned impact of a reduction in delays and impact of additional discharge schemes supporting a reduction in OAPs in Q3 and Q4.	Wider system support to reduce delays and increase funding, particularly for the discharge schemes. GM ICS has established an OAPs task and finish group reporting into the GM MH Crisis board. This is to address the systemic issues driving OAPs and monitor performance against trajectory
Inflationary Risk	There is a risk that inflation exceeds our planning assumptions. There is a specific risk that pay inflation exceeds national funding allocations	Planning assumptions are in line with national planning assumptions except where actual inflation is known. Estimates have been made to account for the specific impact in 2022/23 once the pay settlement has been agreed.
Agency Spend	The 23/24 planning guidance advises agency expenditure should be no greater than 3.7% of total pay costs. During 2022/23 agency expenditure was c7% of total pay costs	An executive oversight group has been established to provide scrutiny to the plans to address the agency spend. The Trust is also preparing a business case to implement E-Rostering

Risks and Mitigations

NHS
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Description	Risk	Mitigation
Delivery of the Value Improvement Targets	The Value Improvement programme presents a significant challenge at 4.3% with 1.8% to be delivered on a recurrent basis. The programme is still maturing with plans for delivery on a recurrent basis currently below plan	Targets have been allocated to the Network and Corporate Teams. The PMO are meeting with all Network and Corporate leads to discuss schemes and support with the identification and delivery of schemes
System Financial Risk	While a break even plan has been agreed for PCFT, there is a system risk held by the GM ICS of c£115m which we are required to contribute to, this is in addition to our Trust level efficiency target	A PMO will be established to develop a recovery framework / plan for GM.
Potential CQC Inspection	There is a risk that any recommendations from a CQC inspection will impact on our cost base	The Trust has met all recommendations from the last CQC inspection and is making good progress on our strategic priorities
Industrial Action	There is a risk that industrial action will continue and the measures put in place to mitigate the industrial action will increase our costs	The Trust is well prepared for industrial action but there is no additional funding to support any increase in costs as a result of this action
Capital Programme	The availability of capital is limited. The plans across GM Providers remain above the envelope. The capital programme for PCFT is oversubscribed by c£1m	The capital planning group will review the capital investment plans to re-profile and prioritise schemes over the 5 Year Capital Programme. Risks will be captured and reported back to PFC and Board in May and June respectively

Recommendations

Pennine Care
NHS Foundation Trust

- The Board is asked to approve the revised OAPs trajectory
- The Board is asked to approve the submission of a breakeven plan
- The Board is asked to note the GM system pressure of c£115m which is held in the GM IC position and the role of PCFT in mitigating this pressure
- The Board is asked to note the progress and risks to delivery against the 2023/24 Value Improvement targets
- The Board are asked to note the progress to develop the 5 Year Capital Plan, the final plan will be presented to P&FC in May and subsequently the Board in June for approval

2023/24 Plan: Next Steps

Pennine Care
NHS Foundation Trust

- 2023/24 Plan Resubmission: 4th May
- A system wide PMO will be established. It will report into the NHS GM ICB Board via a Board Committee. The PMO will ensure that GM has sufficient narrative to adequately articulate why the system has seen material increases in its workforce but a corresponding reduction in activity when compared to pre-COVID levels. The PMO will facilitate the process and agree with system partners the impact on money, workforce, activity and performance metrics, and agree the changes on the impacted organisations.

Report to the Board of Directors
3rd May 2023

Pennine Care
NHS Foundation Trust

Clinical Strategy	
Paper prepared by	Heather Bell, Deputy Director of Strategy
Executive sponsor	Simon Sandhu, Executive Medical Director
Date of report	27th April 2023
Purpose of the report and action required	The paper sets out the proposed Clinical Strategy for the organisation for the next 5 years. This is firmly aligned to the national and regional strategies.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Clinical Strategy 2023-2028 sets out the ambition for our clinical services, in our journey to achieve our overall Trust vision. The strategy, clinically led and developed, describes the delivery of a high quality, person and community centred model. Care will be consistently delivered based on evidence-based approaches with lived experience and quality improvement at its heart. In line with the national Long Term Plan for mental health, over time we would anticipate a reduced need for inpatient stays for our service users, recognising that their home and family provide the best environment to support recovery. We will facilitate this by a significant expansion of our offer into primary care, our community services and our crisis and urgent care approach. When people do need an inpatient stay, we will deliver a timely, skilled and therapeutic intervention in the best environment possible. The strategy details how we will build on our position as a highly specialised mental health, learning disability and autism provider to deliver care and / or advice at a range of levels from wellbeing to specialist services. As well as outlining our future clinical model, the strategy describes the way in which care will be delivered. This is through the consistent translation and grounding of our values (Kindness, Fairness, Ingenuity and Determination) into our clinical practice, via a highly skilled, trauma-informed and fully expanded multi-disciplinary team, working in partnership with a range of agencies. The strategy sets out the full range of enablers which are required to deliver on the ambitions – acknowledging that this represents a programme of complex change. This includes significant development in our digital support, estates and research and development capability. To fully deliver the strategy we will need to be courageous and embrace change. Our engagement has told us that our colleagues have the will, experience and behaviours to allow us to all work

	together on this exciting development with, and for, our service users, their families and communities.
Recommendation	The Board are asked to review and approve the Clinical Strategy 2023-28
Where else has this report been considered and when?	The strategy document has been reviewed by Trust Management Board on 19 April 2023.

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	X

If option three is selected, please complete the table on page 2

	Please indicate (X) which areas(s) of focus and describe the impact	
Area of focus		**Impact**
X	**1. Services: we will develop outstanding services that are safe, compassionate, fair, consistent in quality and sustainable; using digital technology to advance our improvements**	The strategy translates the ambitions set out in the orgamisational strategy, describing how we will progress these ambitions over the next five years.
X	**2. People: we will nurture the development of a capable, motivated and engaged workforce which realises the potential and talent of everyone; and that values experts by experience**	The strategy identifies our people as a key enabler and asset and identifies a number of workforce development issues including the development of a trauma informed workforce and the development of multi-disciplinary teams.
X	**3. Culture: we will create the right conditions for people to flourish by developing a just culture that is fair and inclusive; transparent, curious and outward facing, and that aims high, recognises success and creates pride and belonging**	The strategy is grounded in our Trust values of kindness, fairness, ingenuity and determination. It describes the translation of these into clinical practice.
X	**4. Partnerships: we will make a full and meaningful contribution to our communities through our partnerships with service users and their carers, third sector, local communities and other organisations**	The strategy has a strong theme around partnerships, recognising that we cannot deliver the strategy in isolation. The development of the Together Strategy will align with the partnership ambitions described within the clinical strategy.

Clinical Strategy

Developing a clinically led strategy together

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Clinical Strategy 2023-2028

Values into Practice

Contents

Executive Summary

1. Introduction
2. Mental Health Strategy 2017-22
3. Our organisational strategy
4. National and regional context
5. Strategy consultation
6. What are the needs of our population?
7. What's our starting point?
8. What are our must do's?
9. What can't we do?
10. Our clinical model
11. How will we deliver care?
12. What will stop us succeeding?
13. Delivering our clinical strategy together: Enabling Strategies
14. Delivery Plan
15. Summary

Executive Summary

The Clinical Strategy 2023-2028 sets out the ambition for our clinical services, in our journey to achieve our overall Trust vision.

The strategy, clinically led and developed, describes the delivery of a high quality, person and community centred model. Care will be consistently delivered based on evidence-based approaches with lived experience and quality improvement at its heart.

In line with the national Long Term Plan for mental health, over time we would anticipate a reduced need for inpatient stays for our service users, recognising that their home and family provide the best environment to support recovery. We will facilitate this by a significant expansion of our offer into primary care, our community services and our crisis and urgent care approach. When people do need an inpatient stay, we will deliver a timely, skilled and therapeutic intervention in the best environment possible.

The strategy details how we will build on our position as a highly specialised mental health, learning disability and autism provider to deliver care and / or advice at a range of levels from wellbeing to specialist services.

As well as outlining our future clinical model, the strategy describes the way in which care will be delivered. This is through the consistent translation and grounding of our values (Kindness, Fairness, Ingenuity and Determination) into our clinical practice, via a highly skilled, trauma-informed and fully expanded multi-disciplinary team, working in partnership with a range of agencies.

The strategy sets out the full range of enablers which are required to deliver on these ambitions – acknowledging that this represents a programme of complex change. This includes significant development in our digital support, estates and research and development capability.

To fully deliver the strategy we will need to be courageous and embrace change. Our engagement has told us that our colleagues have the will, experience and behaviours to allow us to all work together on this exciting development with, and for, our service users, their families and communities.

1. Introduction

We are committed and passionate about the delivery of outstanding mental health, learning disability and autism care for our service users, carers and the wider communities which we serve. This is evident in the engagement activity undertaken to develop this strategy, with feedback from a range of clinicians, service users and stakeholders consistently promoting the compassion, commitment and highly specialised expertise that is the bedrock of our services.

We know that there is more that we can, and need to do, in our pursuit of outstanding care.

Therefore, this strategy is intended to support the delivery of a real sea change, harnessing the assets within the organisation, and outside, to ultimately deliver an improved service offer and better outcomes for our service users. There will always be things we can continuously improve within the organisation, but there are other areas where we need help and support to deliver the desired change.

This development of this strategy has been clinically led, through the Executive Medical Director and the senior clinical team, in addition to seeking out the views of a range of stakeholders, most importantly our service users and their carers.

The strategy sets out both the way in which we see services developing and improving over the next five years, but also confirms our priority areas and the way in which we will deliver care – the what, and the how. The latter is grounded in our embedded Trust values (kindness, fairness, ingenuity and determination) and the consistent delivery of these into our clinical practice.

Is summary our strategy commits to:

- Placing our service users at the centre of our clinical practice, in the co-production of care but also through involvement in decision making about service development;
- The delivery of safe, evidence-based and consistent clinical models across our localities via the reduction of unwarranted variation and a true multi-disciplinary approach;
- Retention of our strong identity as a specialist mental health, learning disabilities and autism provider, building on this, but also maximising the opportunities of the integrated care system to support increased use of our clinical expertise in a broader range of mental health and wellbeing provision;
- To transform our services in line with the long-term plan and evidence-based approaches:
    - Growing our community and crisis/urgent care services to keep people out of hospital wherever possible;
    - Redesigning our inpatient offer to make this more specialised, more therapeutic and delivered in the best environment possible
- Delivering clinical services from the best estate that we can provide – we will look to continually improve our inpatient and community facilities to ensure they are in the right place, fit for purpose and enable recovery;
- A series of delivery principles and approaches grounded in our values;
- Acknowledging our strengths, but also recognising where we need to work together with others to deliver improvements to our care;
- Continued advocacy for mental health, learning disability and autism services to promote and deliver parity of esteem for our service
- Identifying and addressing health inequalities in the delivery of our clinical care.

2. Mental Health Strategy 2017-2022

We published our previous five-year mental health strategy in March 2017, a year after the national publication of the Five Year Forward View for Mental Health. Looking back on our priorities and commitments in that strategy, it is positive to see that so many service developments and changes have materialised across the organisation, and that we have been successful in delivering these, including:

Our clinical strategy for 2023-2028 will build on the successes we have already achieved over the past five years. In this clinical strategy we will describe the principles we will embed across all services in the organisation, articulate the priority areas of focus with regards quality improvement and transformational change and highlight steps in the journey of delivery.

3. Our organisational strategy

Our organisational strategy, refreshed in 2022, sets out our vision and four big ambitions.

One of our key areas of focus is **'Services'** with a commitment to:

> *"Develop outstanding services that are safe, compassionate, fair, consistent in quality and sustainable; using digital technology to advance our improvements".*

To deliver this, and in consultation with our service users and carers, our strategy sets out the following priorities:

- My care is evidence-based, effective and safe
- My hopes are recognised
- I get consistent help when I need it, wherever I live
- There is a community first approach
- Services are efficient and sustainable

Our Trust strategy also sets out (at a high level) our offer around wellbeing, core mental health and learning disability services and our specialist services, as well as our commitment to work within each of our localities, recognising their unique differences and priorities, as follows:

This clinical strategy will be a significant enabling tool within the organisation and will be cognisant of all the above. However, this strategy will go further, describing the principles we wish to embed, and the priority areas of focus, with an overall aim of ensuring that every service user receives outstanding care and has the opportunity to lead a life that they find fulfilling.

4. National / Regional context

4.1 National context

The national NHS Long Term Plan (LTP) for Mental Health was published in 2019 and sets out a range of ambitious targets for improving services:

- Increase in the numbers of children and young people from 0-25 years accessing timely and appropriate support;
- Thousands more adults being able to access talking therapies for common disorders;
- People with moderate to severe mental illness having improved access to quality care across primary and community teams;
- Inpatient stays to be short, purposeful and close to home, supported by quality community-based services to support ongoing care;
- Perinatal mental health care for women who need specialist mental health care during or after pregnancy;
- The provision of single points of access and timely crisis services for everyone.

For learning disabilities and autism, the LTP sets out the need to:

- Improve community-based support so that people can lead lives of their choosing in homes not hospital;
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children with the most complex needs;
- Make sure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability and autistic people and their families;
- Reduce health inequalities, improving uptake of annual health checks, reducing over-medication and taking action to prevent avoidable deaths through learning from deaths reviews (LeDeR);
- Continue to champion the insight and strengths of people with lived experience and their families and become a model employer of people with a learning disability and autism;
- Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people.

Our Learning Disabilities Strategy was developed in response to the above.

The Trust has also established an ambitious transformation programme to deliver these changes, detailed further below, to ensure that our services and pathways are delivering the requirements of the LTP and the Greater Manchester Mental Health Strategy.

4.2 Greater Manchester Mental Health Strategy

Pennine Care delivers services within the Greater Manchester (GM) Integrated Care System (ICS). Prior to the formation of the ICS, the GM Partnership developed a mental health strategy for improving child and adult mental health services, narrowing the gap in life expectancy, and ensuring parity of esteem with physical health. The strategy proposed a whole system approach including involvement from the Independent and Voluntary, Community, Faith and Social Enterprise (VCSE) sectors, to improve the mental health and wellbeing of individuals and their families, supported by resilient communities, inclusive employers and services that maximise independence and choice.

The existing strategy is being refreshed and is currently in draft form awaiting final sign off. 'Doing Mental Health Differently' 2023-28 reaffirms GM's approach to a whole system approach and describes a vision for a "mentally health city region where every child, adult and place matter". This is underpinned by the five shared missions:

- People will be part of mentally healthy, safe and supportive families, workplaces and communities.
- People's quality of life will improve through inclusive, timely access to appropriate high-quality mental health information, support and services.
- People with long-term mental health conditions will live longer and lead fulfilling and healthy lives.
- People will be comfortable talking about their mental health and wellbeing and will be actively involved in any support and care that they receive.
- The mental health and wellbeing system recognises the inequality, discrimination and structural inequity people experience and are committed to developing more inclusive services and opportunities that people identify with and are able to access and benefit from.

5 Developing a clinically led strategy together

5.1 Consultation approach

In developing this strategy, we have considered the views of a wide range of stakeholders including clinical colleagues, our service users and their carers, Governors and system partners. To do this we have used a range of communication methods including:

- A large engagement launch with senior leaders and clinicians;
- Attendance at service user and carer forums;
- Clinically led engagement workshops;
- Attendance at clinical team meetings and away days;
- Localised engagement via our care networks and hubs;
- An online survey, accessible to everyone (and attracting responses from colleagues, service users, carers, partners and the general public) which asked the following questions:
  - What is good about our services? What would you like to retain?
  - What would you like to change?
  - What does outstanding care look like to you?

The feedback from this engagement has directly informed the development and content of this strategy, and is summarised in the sections below:

5.2 What do we want to retain?

The most significant theme emerging from engagement was the caring, compassionate and committed approach of our colleagues within the Trust. It was recognised that our colleagues have, especially over recent times, had to overcome challenging circumstances but have delivered care which is person-centred and compassionate, with a high level of knowledge and skills. Linked to this was the focus on the wellbeing of our colleagues, recognising the need to invest in health and wellbeing approaches to support and retain our excellent clinicians.

Another key theme was the culture of Pennine Care and the sense of a 'Pennine Care family.' The day-to-day delivery of our values (kindness, fairness, ingenuity and determination) is evident and appreciated as a real strength of the organisation.

Coupled with ingenuity and determination is a sense that as an organisation we are continuously striving for improvement and eager to embrace innovative ideas and evidence-based practice; something which we will embrace through the implementation of this strategy and its synergy with our Research and Innovation strategy.

5.3 What needs to change?

We appreciate that there will always be scope for improvement and were keen to understand the improvement priorities through the development of this strategy.

We heard from our services users and carers that they want services to be more responsive, accessible and tailored to individual needs. They want to have an active role in their care and expect that plans and decisions are made collaboratively with them. They want to feel listened to and respected as individuals. They don't want to tell their story multiple times or feel 'handed off' between different services or practitioners. Care should feel seamless and wrapped around their needs.

Carers specifically talked of wanting to have confidence in the skills and expertise of staff who look after their loved ones. They want to be able to contact professionals when needed, and not have to go through several people to find advice and support. They expressed concerns that their family members with complex needs would be discharged from specialist services without easy access back in. Ultimately, carers said they never want to be left feeling 'abandoned'.

Our colleagues want to see true commitment to multi-disciplinary working, with improved understanding of the role and value of the broader MDT including pharmacy, allied health professionals (AHPs) and psychological therapy colleagues. This would be supported with clinical skills development, research and innovation and increased clinical leadership and involvement. We will empower colleagues to harness our improvement potential and embed our commitment to trauma-informed models of care.

Our partners want to see more social prescribing and partnership working with our VCSE colleagues, more employment and educational opportunities and increased provision within the community.

A theme across all groups was the need to have a more consistent service offer, recognising that for several reasons, services have developed differently within each of our five localities creating gaps in provision. We are committed to delivering consistent, high-quality pathways across all our localities, reducing unwarranted variation, whilst recognising that these need to be tailored to the differing needs of our local populations.

5.4 What does outstanding care look like? (Design as diagram)

The responses to this question build on the thematic summary above. Responses were wide-ranging and included:

Care delivery

- Consistent, evidence-based high-quality care

- Accessible, responsive, holistic, co-ordinated and integrated
- Recovery focussed
- Trauma-informed
- Culturally appropriate
- Care delivered as close to home as possible, supported by fewer yet higher quality inpatient services and with bolstered community and crisis provision
- Increased partnerships and connectivity with communities
- Increased use of shared decision making and enhancement of self-management approaches
- Embracing the range of new digital technology

Workforce

- Multi-disciplinary teams with increased representation of psychological therapy, pharmacy and allied health professionals
- Clinically led
- Highly skilled and knowledgeable with experts in the field
- Stable and motivated workforce for the future

Culture

- Positive
- User led
- Inclusive

6. What are the needs of our populations?

We know that nationally, people with severe and enduring mental illnesses have a significantly reduced life span, living approximately 15-20 years less than the average. This is an unacceptable statistic and drives our passion to reduce this, and to ensure that everyone leads a life they find fulfilling.

We also know that there is a high level of need for mental health services amongst our local populations (JSNA data):

Bury	Oldham	Rochdale
• 9% children and young people have a mental illness. • 15.3% people have depression and anxiety, compared with a national average of 13.7%. • More people are living in (the same) areas of deprivation now than in 2015.	• 1.03% people have a serious mental illness, higher than the national average of 0.94% • 12% of adults are living with depression, compared to the national average of 10.7% • Health and wellbeing of children is worse than the England average	• 14.5% people aged 18+ and above are recorded as having depression. • Premature mortality in adults with severe mental illness is at a rate of 187.4 per 100,000, making Rochdale the 4th worst across the northwest region. • One in 680 people in the Rochdale borough are without a home.

• Predicted that the number of adults with a mental health disorder will increase by 3.5% across all disorders by 2040. This equates to around 20% of the total population.	• Higher levels of deprivation and crime, and lower levels of educational achievement.	
Stockport • Significantly more people with high anxiety than England average. • 17% adults have a diagnosis of depressive disorder. • Two thirds of those with depressive disorder are aged 30-60. • On average between 20-30 suicides and deaths of undetermined intent occur each year.	**Tameside and Glossop** • 1 in 10 5-17 year olds have a mental health condition. • Approximately 21,649 adults aged 18 to 64 years in have a common mental health condition such as anxiety or depression • Nearly 10,000 adults are estimated to have two or more mental health conditions.	

7.Where are we starting from?

We know from benchmarking data and internal and external mapping exercises that:

- The cost per adult acute bed (£93k) continues to be significantly lower than the national average £179k (2022).
- Adult (28.2) and older people's (47.7) acute bed numbers are higher than the national average (20.5 and 42.4 per 100,000 population respectively).
- Bed occupancy rate (excluding leave) continues to be higher (adults 95%, older people 94%) than the national average (90% adults, 85% older people).
- Adult acute mean length of stay (days, excluding leave) continues to be slightly higher (38) than the national average 35 (2022). Older adult mean length of stay has increased to 95 (2022), this is considerably higher than the national average 78 (2022).
- Section 136 Assessments per 100,000 resident population continue to be considerably higher than the national average.
- Adult acute registered nurses per 10 beds has increased slightly to 5.3 (2022) but this continues to be considerably below the national average 7.9 (2022).
- CMHT cost per patient rose considerably to £1934 (2022), however, this remains considerably below the national average of £4408 (2022).
- Section 136 suites are not commissioned and Section 136 assessments per 100,000 population are considerably higher than the national average (32%).
- Gaps in older people services, particularly in Bury where there is a small CMHT, resulting in significant out of borough admissions.
- CAMHS services - not fully commissioned to age 18 consistently across all boroughs.
- Inconsistent alternatives to admission services commissioned, and no crisis cafés.
- A challenging estate, especially for our inpatient services, with some services not having direct access to outdoor space and some without ensuite facilities. Recent PLACE results have shown PCFT are ahead of National Average in 5 out of 6 areas, with the one below average – 'Condition, Appearance and Maintenance';

- Digital Maturity Assessment Index score is currently around 1.8 (out of 5), making us the lowest in GM. This has improved significantly, however, there is lots more to do to improve our position.

This reflects a picture of historic under-investment across our localities. We also have number of strategic risks which are outlined in section 12, with associated mitigation plans.

However, we also have a range of assets on which to build, including:

- Our colleagues are committed to high quality care and continuous improvement;
- Greater engagement and involvement of people with lived and living experience through enhanced working with our service users and carers;
- Our values – kindness, fairness, ingenuity and determination – which are demonstrated in day-to-day practice;
- Our expertise in mental health, learning disability and autism;
- The opportunities afforded by a range of partnerships including the voluntary, community, faith and social enterprise sector (VCSE)
- An opportunity to further raise the voice and profile of mental health services across Greater Manchester through our provider and locality partnerships.

8. What are our must-do's?

As an organisation there are several must-do's which will affect and influence our clinical strategy implementation. These include:

- Delivery of the Long Term Plan for Mental Health which sets out an ambitious transformation plan for mental health services;
- Statutory responsibilities such as CQC (Care Quality Commission) improvement plans;
- Delivery of our contractual requirements including performance and quality/safety standards;
- Working as a proactive system partner, both at a Greater Manchester level, and with our locality systems, as part of the new integrated care system
- Delivery of care in the spirit of our values, treating everyone (including service users, carers, colleagues and partners) with kindness and fairness.

9. What we won't do

It is equally important for us to understand the things that we won't compromise on in the delivery of our clinical strategy i.e., our 'red lines'. These include:

- Anything which compromises the safety of our service users, carers and colleagues. This could relate to their mental or physical health, or their emotional and psychological wellbeing;
- No admission of a service user in an environment which is going to be detrimental to their health and wellbeing. This needs consideration on a case-by-case basis but includes admissions to Section 136 suites, and admissions of children and young people and service users with learning disabilities and autism onto adult inpatient wards.
- Allow any service user or carer to 'fall through a gap' between services – we must ensure a clear and safe transition;
- Allow someone to remain on a waiting list without regular review or monitoring process;

- Colleagues not having the right skills and knowledge to deliver on their care / clinical responsibilities.

10.Our clinical model

10.1 Overarching model

Through the engagement process we heard of the strong identity and history of Pennine Care as a specialist mental health, learning disabilities and autism provider. Whilst wanting to retain and strengthen this position, we understand the need to operate in an integrated care system and in line with the national direction of travel to break down boundaries between health, social and VCSE organisations in the pursuit of improved patient care.

In refreshing our strategy during 2022, we consciously adopted a broader view with our commitment to 'everyone being supported to lead a life they find fulfilling'. Here we recognised that there was an opportunity for an enhanced offer to our localities and communities.

We also know that our current core and specialist service configurations are more weighted towards inpatient services. This is confirmed by national benchmarking data which suggests a need to redress the balance.

As an organisation, we are committed to working with system partners to deliver this ambition through a negotiated change in investment priorities. This is not simply about bringing us in line with the national average, but represents our commitment to service users and carers – we want to keep our service users at home with their families and carers wherever possible as we recognise that this connectedness and care supports sustained health and wellbeing.

Our overarching strategy defines our core offer as:

	Wellbeing	**Core mental health and learning disability services**	**Specialist services**
We will	Strengthen relationships and work in partnership with local organisations to promote good mental health and wellbeing Adopt a system leadership role for mental health and learning disability services in the localities. Offer our specialist advice and expertise around mental health provision and prevention, acknowledging that some people will benefit from services provided by our partners and outside of our core and specialist provision. Advocate for people who experience health inequities	Deliver a full range of high quality, evidence based mental health, learning disability and autism services for those with more complex needs. Transform our services in line with the long term plan, within our financial boundaries. Effectively manage demand using quality improvement and innovative approaches, to ensure that we are able to deliver high quality services	Become a partner of excellence Broaden our offer across specialist services where appropriate Develop and support specialist services including CAMHS, Drug and Alcohol, Military Veterans and specialist learning disability and autism provision. Adopt a leadership role, in agreement with partners, across a broader footprint e.g. at a full GM or regional level.
Our clinical strategy	**Wellbeing**	**Core mental health and learning disability services**	**Specialist Services**

will deliver			
	Continued and strong VCSE, community and primary care delivery in this area. We will support an enhanced provision across all our localities and will provide advice, leadership and strong partnership working to ensure smooth pathways and transition.	A redefined core offer with a radically different community model, based around Living Well principles. This moves us away from a primary / secondary care split and sees the development of a seamless, fluid multi-disciplinary approach which will reduce the need for referrals and hand-offs. This is based on: • A multi-disciplinary team located within all primary care networks (PCNs) • a specialist mental health team who will provide more support when required. A significantly enhanced and consistent crisis / out of hospital offer (all ages) will help keep people at home with their families and carers. The vision would be for a consistent crisis offer across our localities including: • Crisis Resolution Home Treatment / Home Intervention Teams • Crisis cafes • Safe Havens • Rapid Response • Section 136 hub We will continue to deliver a range of specific community services.	As we seek to keep people out of hospital wherever possible, the future would see our inpatient services as a smaller but more highly specialist resource. Person-centred support will be provided in a therapeutic and fit for purpose environment with a highly specialised staff team. Estates should be improved to make all bedrooms ensuite and improve access to outdoor space. We aim to develop specialist hubs which would build on our specialist provision which currently includes CAMHS, PICU, Secure and Rehabilitation Services.
Enabled by	The implementation of evidence-base, trauma-informed approaches Enhanced partnerships across the whole pathway Service users and carers shaping every decision Our service transformation programme An effective and sustainable, multi-disciplinary workforce High quality, fit for purpose estate A negotiated change in investment priorities with the integrated care system		

Over the lifetime of the strategy, we would expect a change in the shape of the organisation through the delivery of the following outcomes from our transformation programme:

- Reduced inpatient admissions
- Reduced length of stay
- Reduced Delayed Transfers of Care

This would support an improvement in patient flow, allow for repatriation of our service users who may have to access services away from Greater Manchester, and create the potential for a redesign of inpatient facilities.

As well as contributing to the above improvements, through our community transformation programme (including the development of the Living Well model and the placement of mental health specialists into the Primary Care Networks), we would expect our transformation programme to support:

- A reduction in referrals to the specialist community services

This would create additional capacity to undertake more trauma-informed approaches and generate time for research and innovation activity.

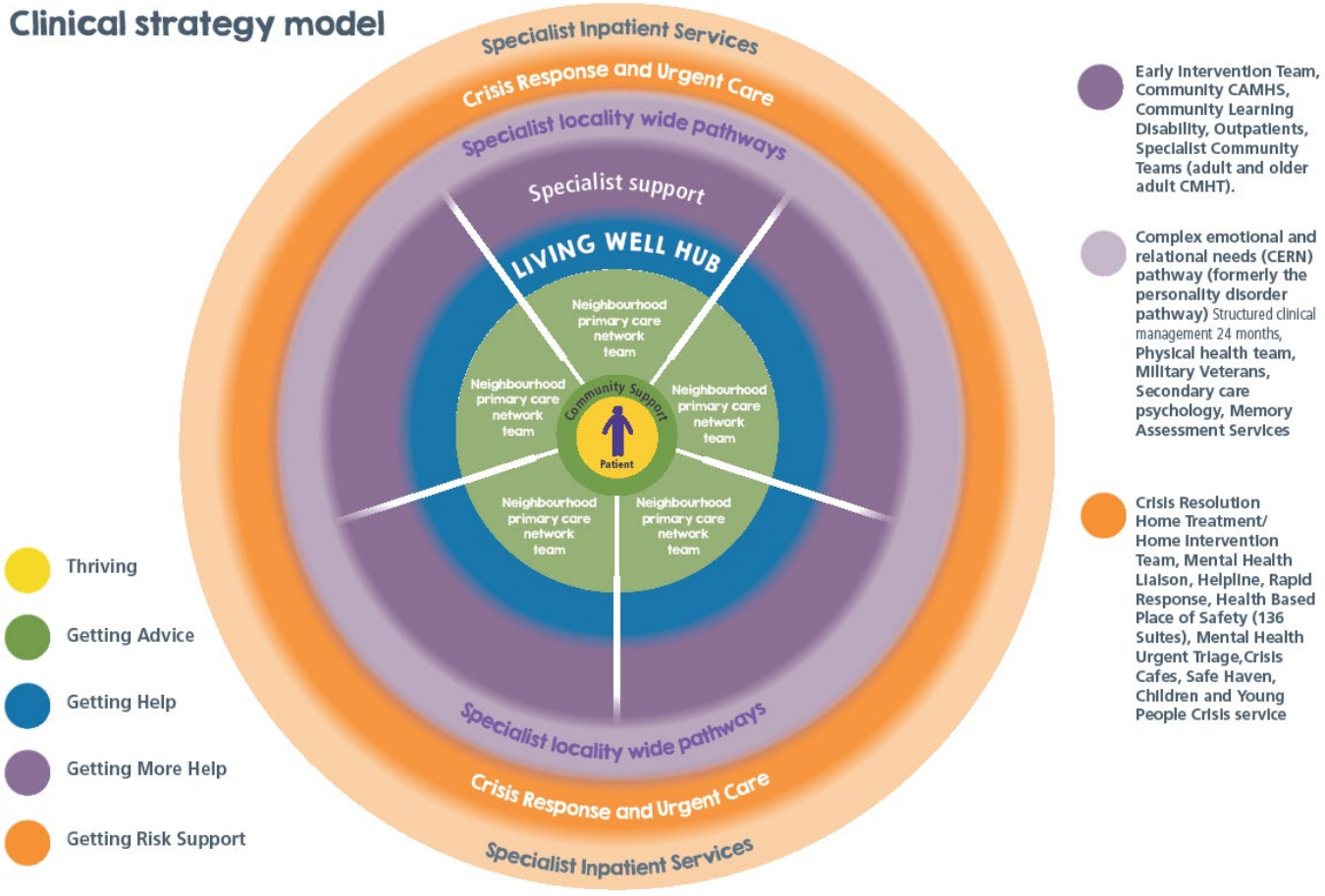
Through the development in our urgent care models of care, over the lifetime of the strategy we would also anticipate a:

- Reduction in A&E attendance
- Reduction in Section 136 detentions

This would support improvement in the patent experience by keeping service users within their communities wherever possible.

We have commenced a modelling exercise to work through the impact of the above but also model the ongoing impact of rising demand and existing service pressures.

During the lifetime of this strategy our clinical model will be shaped to reflect the figure below:



10.2 Clinical Services

We provide a range of amazing clinical services to our local populations. These are detailed in appendix a, summarising the purpose of the service and the associated development plan over the coming years. This will support us in moving towards the direction outlined above.

11. How will we deliver care?

From the engagement activity undertaken, it was clear that our clinical delivery model has a strong foundation in our Trust values of: Kindness, Fairness, Ingenuity and Determination. This strategy underpins these values with a set of key principles which cut across all of our services, and set out **how** we will work and provide care to those in our services.

We believe that having a shared set of principles will support us in our aim for delivering outstanding care and to consistently deliver high quality care for local people. We want these principles to guide our clinical teams and support them in their practice, as well as providing clear standards and expectations in terms of the behaviours and actions that we expect our staff to abide by and hold themselves accountable to.

11.1 Kindness

This emerged as a strong theme in terms of what we should retain from existing practice. This was important for all our stakeholders, retaining our kind, caring and compassionate approach to care delivery and the overt delivery of our values in day-to-day practice.

We know, however, that we can build on this, to deliver continuously improved care for our service users. The key principles supporting the delivery of this theme are:

Recovery focussed	One of our big ambitions is to ensure that every service user has an opportunity to lead a life that they find fulfilling. Recovery means different things to different people. We commit to 'working with' rather than 'doing to' people – to ensure we put people first and that decisions about their care are taken with them, and that we adopt a holistic approach. We want to focus on peoples' strengths – what individuals *can* do and what they want to achieve, with a strong focus on supporting people to develop the knowledge and skills to help themselves to stay well and lead a meaningful life. This will be supported by therapeutic estate configurations and workforce development.
Trauma-informed	We are committed to ensuring that our conversations, assessments and treatments are informed by our understanding of the impact of difficult life experiences and events. Trauma informed care is an approach based on an awareness of the high prevalence of trauma in the lives of people accessing our services, the effects of trauma experiences and the potential for trauma or re-traumatisation to occur in the context of care. Trauma informed care offers opportunities to improve service users' experiences, improve working environments for staff and service users, increase job satisfaction and reduce stress levels by improving the relationships between staff and patients through greater understanding, respect and trust.
Community first	Whenever and wherever possible, we want to care for people close to their homes and within their community. We are committed to working with our partners to develop 24/7 crisis services and robust community services which can intensify care and support when appropriate. Where needed, inpatient stays will be short, purposeful, close to home and linked with high quality community-based services. Our current service configuration is overly weighted towards inpatient services. This is confirmed by national benchmarking data which suggests we need to redress the balance of investment in inpatient versus community provision. As an organisation, we are committed to working with system partners to deliver this ambition and provide opportunities to configure inpatient provision to reduce ward bed numbers and increase the availability of more therapeutic space with en-suite facilities and access to outdoor areas.

11.2 Fairness

Inclusive	We will work to provide care and support that meets the differing needs of our communities, reflects the diversity of our population and is inclusive of all. We will work with our partners to ensure that there is equity in access and provision of services. We will be respectful and non-judgemental and build services that are person-centred and focused on supporting individual needs.

Reducing unwarranted variation	Currently, we do have a degree of variation across our services. In some cases, there are good reasons for this. In other cases the reasons for variation can be more difficult to justify – these can offer opportunities for improvement. Through our service transformation programme, we will work together across our care networks and hubs, and in partnership with others, to eliminate this unwarranted variation.
Reducing health inequalities	We provide services to a large and ethnically diverse population with some areas experiencing extreme deprivation. Health inequities are seen throughout our populations. Data shows that people from impoverished and more ethnically diverse communities have poorer access to services as well as worse mental health outcomes. Long term unemployment, poverty and poor housing, homelessness, substance misuse and social isolation are significant factors across our localities. People in our communities have a better understanding of local need and therefore we are committed to working with localities to tackle these health inequities.

11.3 Ingenuity

Doing things differently	Whilst building on sound, evidence-based practice, we will embrace innovation and change, doing things differently to how we have previously in pursuit of outstanding care and best value. We will always do this in collaboration with service users and carers. We recognise that this can be challenging and may involve an element of risk or 'letting go of the past'. For example, our current living well developments will break down traditional barriers, require the adoption of new roles and will require enhanced partnership working including sharing of patient data.
Co-production	One of our big ambitions is that people with lived and living experience shape every decision. We want our services to be the best they can be for everyone who uses them. The feedback, views and experiences of our services users, along with their families and carers, can help us develop, deliver and improve. We are committed to co-production and working with our experts by experience to achieve collective outcomes. The approach is value-driven and built on the principle that those who use our services are best placed to help design it.
Understanding our strengths, and those of others	We will be clear about the ways in which we can add value to mental health, learning disability and autism pathways. This will allow us to recognise that we are not the right partner to deliver certain elements and will allow us to work with partners to shape the future model. Partnering with other organisations, and playing a lead role in local decision-making, will help us to innovate and develop our services, as well as sustaining our clinical service offer.
Clinically-led and evidence based	We want our service development and delivery to be clinically led. We have invested considerably in our clinical leadership structures in support of this. We commit to delivering services which are based on the best available evidence and research, and in line with national best practice
Multi-disciplinary team working	Multi-disciplinary working involves appropriately using knowledge, skills and best practice from multiple disciplines (e.g. nursing, medical, pharmacy/medicines, psychology and AHP) and across service provider

	boundaries (e.g. health, social care and VCSE). We want to ensure that our models of care provide interventions where a range of professionals work together to support people's needs, promoting the best environment for ingenuity. The Long Term Plan sets out in detail a vision for new models of care which emphasis the need to dissolve traditional boundaries between primary care, community services and hospital-based services, recognising that this divide has become a barrier to the delivery of personalised and co-ordinated care.

11.4 Determination

The heart and voice of mental health, learning disabilities and autism	We will proactively raise awareness of mental health, learning disabilities and autism within our communities, normalising it and working to eradicate stigma. We will be the voice of mental health within our communities, ensuring that mental health is part of the conversation within local systems, seeking to secure parity of esteem for our service users.

12. What will stop us succeeding?

Our key strategic risks, how they impact on our clinical strategy, and our proposed mitigation plans are set out below:

Strategic Risk	Impact on strategy	Mitigation
Failure to provide safe healthcare	This would significantly compromise the ambitions set out in this strategy; this strategy itself is a mitigation for this risk.	• Quality strategy programmes around clinical effectiveness, safety, service user involvement and Quality Improvement. • Robust performance and assurance framework.
Overwhelming demand	Unable to deliver on strategy requirements; inability to balance care delivery and the transformation programme	• Partnership working to manage demand – ICB (Integrated Care Board), GM and locality levels. • Capacity and demand modelling. • OPEL (Operational Pressures Escalation Levels) approach. • Service transformation programme.
Competition for staff	Strategy delivery compromised if we don't have a sufficiently skilled and motivated workforce, displaying the Trust values in day-to-day practice.	People Plan including: • Exploration of alternative roles. • Development of new and innovative recruitment initiatives. • Investment in retention approaches.
Major Incident	The Covid-19 pandemic demonstrated the destabilising impact of a major incident on our clinical care delivery.	• Strengthened business continuity and incident plans, including cyber-security.

	Cyber-threats are increasing in prevalence which could impact on our clinical systems.	• Information Governance training. • Improved partnership working.
Loss of stakeholder support	Could impact upon reputation and/or service models	• Investment of time and effort into partnership working at ICB, Locality and service level including working with the VCSE. • Together strategy development – including the involvement of service users and carers.
Failure to achieve financial sustainability	We need the organisation to be financially viable to support ongoing provision of care to our local populations.	• Ongoing conversations with system colleagues regarding investment levels for mental health. • Value Improvement Programme to support internal efficiency reviews. • Financial controls.

13.What will help us succeed: delivering our clinical strategy together

13.1 Key enablers

As a large organisation, we know that one document cannot deliver such complex change in isolation, but is dependent upon a range of broader factors. Delivery of our clinical strategy requires a strong interdependency with a range of enablers, which are summarised below:

13.1.1 Quality

The Quality Strategy 'Putting patients first' forms a foundation for the clinical strategy, with its key focus on:

- Well led
- Patient Safety
- Patient engagement and involvement
- Clinical effectiveness
- Quality improvement

Underpinning this is the ambition to be a learning organisation, that is a place where there is strong focus on education and training and supporting our staff to develop expertise and continually learn. We recognise that our staff make difficult decisions every day and sometimes things do go wrong. Our commitment to embedding a 'Just Culture' and creating a safe and supportive environment in which people can learn from mistakes is one of our quality priorities. We want to encourage our staff to innovate and share their innovative ideas to help us transform our services, however big or small scale. Some of the smallest changes can make the biggest difference, and we need to harness ingenuity in our colleagues, service users and community to continuously improve clinical delivery.

13.1.2 Partnership / Together Strategy

We can't deliver this strategy on our own, but through effective working with several partners. Our developing together strategy will set out the way in which we will work with our patients and carers, identifying opportunities to work better and improve patient care with partners across Greater Manchester, but also within our localities and neighbourhoods to support recovery and wellbeing.

13.1.3 People Plan

Our colleagues are a fundamental asset. Delivery of the clinical strategy is dependent upon the recruitment and retention of knowledgeable, skilled and motivated colleagues, who deliver care in a manner which reflects our Trust values. We are aware that there are significant challenges with workforce supply but we have a wide-ranging workforce programme in place, set out in the People Plan under the following headings:

- Effective and Sustainable workforce
- Capable and skilled people considering how we grow our own talent and develop roles for the future
- Effective leadership
- Health, Wellbeing and Staff engagement including an enhanced focus on psychological safety

13.1.4 Medicines Optimisation

"Medicines optimisation... helps people improve their outcomes by taking their medicines correctly, choosing the medicines that are right for them, avoiding taking unnecessary medicines, reducing wastage of medicines and improving medicine safety".

This approach is fundamental to supporting the delivery of outstanding, safe and sustainable clinical delivery.

Additionally, our pharmacy colleagues, systems and processes are a key enabler to the delivery of the clinical strategy and transformation programme including:

- Commissioned medicines pathways in the Living Well model, based on Greater Manchester Medicines Management Group (GMMMG) and Shared Care Task and Finish Group recommendations.
- The Living Well model will also facilitate collaborative working with PCNs to support service users to remain under primary care services with quick access to advice and support if needed;
- Maximised digital opportunities e.g. implementation of Electronic Prescribing and Medicines Administration (EPMA) will improve medicines safety and discharge medicines service will improve shared decision making and communication of key medicines information which in turn will reduce readmissions on discharge;
- Effective and embedded leadership of medicines optimisation throughout services with pharmacy professionals located in multidisciplinary teams.

13.1.5 Estates

We are developing the clinical strategy in parallel to our estates approach, providing a great opportunity for strong alignment. The key principles of the emerging strategy have a strong congruence to our clinical strategy priorities, as follows:

- Locations that are in the right place for the needs of their occupants – this connects with our community first approach;
- Buildings are conducive to improving mental health and recovery – environment can be a significant factor in improving the patient experience and supporting recovery;
- Facilities that support multi-agency approaches to mental and physical health – this recognises the current development of integrated teams such as within the Living Well developments, but also includes the provision of good rest facilities for our colleagues to support their health and wellbeing;
- A sustainable and efficient estate using technology to minimise impact;
- Consideration of the impact on equalities across our communities.

In addition, national guidance for inpatient services exists and we work towards achieving compliance for all our wards. This includes:

- Areas are light and airy, preferably on the ground floor with direct access to outdoor space;
- Wards have a maximum of 15 beds;
- All patients have separate bedrooms with en-suite facilities.

Recognising the importance of physical wellbeing to recovery and good mental health, our approach to catering will also continue to focus on the provision of high quality, appetising and nutritious meals.

We know that there are constraints on estate and capital funding but we will work with estates colleagues to pursue the continual improvement of our estate to support better service user outcomes. Our transformation will directly enable the consideration of the configuration and utilisation of our current inpatient estate, which will also support the above objectives.

Over the lifetime of the strategy, we will work to pursue new estate configurations (such as more centralised bespoke campus facilities) to deliver befits for our service users and colleagues.

13.1.6 Digital

The thoughtful application of digital technologies and the intelligent use of information is a critical enabler of the clinical strategy:

- Designing technology to support the delivery of pro-active and prevention focused mental health services
- Integrating systems and data to provide people focused, holistic care e.g. sharing data across primary, community, and mental health and learning disability care settings
- Delivering digitally enabled models of therapy e.g. to support concordance with treatment or sign-posting patients to access the right resources
- Digital technology can enable an agile way of working to support delivery of care in the right place and create seamless pathways.

All programmes are aimed at increasing our Digital Maturity Assessment Index score to put us in the best position to continually improve our care delivery.

13.1.7 Research and Innovation

The vision of the Research and Innovation Strategy directly supports the aspirations of this strategy, focussed on delivering outstanding, evidence-based care for our service users:

To become a pioneer of research to support the delivery of sustainable mental health, learning disability and autism services that deliver the best outcomes for patients

Through the development of our research infrastructure and programmes, we can also support recruitment and retention of a skilled and motivated workforce, and offer enhanced opportunities for the involvement and engagement of those with lived and living experience.

13.1.8 Health Inequalities

Understanding and addressing health inequalities that exist across our populations is essential if we are to deliver effective and high quality care. We are developing our approach across the organisation and shaping work with our communities to enable us to better understand the different challenges for minoritised groups leading to inequalities. We are committed to working with partners within localities to identify and tackle these health inequalities.

An integral part of this work will be to improve the data available for our own services and patients in relation to access, experience and outcomes.

We are working with certain population groups on the Advancing Mental Health Equalities (AMHE) quality improvement programme and will be implementing the Patient and Carer Race Equality Framework (PCREF) which will provide a structured approach with learning informing our service improvements to lead to more inclusive services that are designed to address inequalities.

13.1.9 Physical Health

It has been beneficial that we have been undertaking focused work on physical health during the development of this strategy.

Our approach to physical health must form a significant element of our overarching clinical strategy and approach to reducing health inequalities, recognising that mental and physical health and inter-dependent.

The draft physical health plan sets out a clear vision that:

People with a mental health condition, learning disability or autism receive the same quality of physical healthcare as the general population resulting in the elimination of unnecessary health inequalities.

With our mission being that:

Service users are supported to live healthy lives and are empowered wherever possible to make informed choices in relation to their physical healthcare.

To achieve this we will:

- Work in collaboration with partner organisations to achieve better physical and mental health outcomes for service users and carers.
- Promote access to health improvement initiatives and develop steppingstones to make this access easier.
- Embed the provision of health promotion within the trust to support service users to address their health-risk behaviours.
- Ensure our service users are supported to achieve the best possible physical health

status, in addition to providing excellent mental health, learning disability and autism care and support.

- Ensure that staff are confident in their knowledge and skills to support service users in achieving their best possible physical health outcomes.

The implementation vehicle of the physical health plan will be the physical health steering group, but will be a key aspect of the delivery plan for this strategy.

13.1.10 Suicide Prevention

Our suicide prevention plan is also in development but will set out our ambition to reduce suicide rates in our service user population through a range of evidence-based approaches and compassionate and responsive practice.

13.1.11 Green Plan: Sustainable models of care

The NHS Long Term Plan set out a commitment to deliver a new service model for the 21st century. For the NHS to reach net zero emissions, new service models must include a focus on sustainability and reduced emissions. Applying net zero principles across all clinical services is critical, considering carbon reduction opportunities in the way care is delivered now and in the future is essential.

14.Delivery Plan

We recognise that we cannot move to this new model overnight and this requires support from our partners and additional investment. However, we believe that we can deliver our big ambitions.

We know that there are some things which we can prioritise and deliver including:

- A realistic transformation plan, supported by defined investment which includes our new community model and a focus on acute and crisis work to improve efficiency, quality standards and divert activity from inpatient services;
- Address known areas for improvement e.g. unwarranted variation and implementation of trauma-informed care;
- The development of the right partnerships which will support us to move towards our ambition of outstanding care.

We will continue to engage in conversations in support of increased investment into mental health, learning disability and autism services. Our short-term priority would be to engage the system in a ‘levelling up’ approach which aims to deliver both consistent investment across Greater Manchester, but then increasing to the national average as a minimum. This will allow us to address some of our know gaps in services which creates an inconsistent offer across our localities but would also drive improved system performance and outcomes for our service users.

As outlined previously, we know that our localities have a high degree of mental health, learning disability and autism service needs and we will strive to attract investment based on the needs of our localities. We aim to shift the benchmarking to attract mental health investment above the

national average to allow us to work with partners to deliver the best services for our communities. We recognise that there are competing demands for funding across the health and social care system but will continue to seek a fair share for our service users. With enhanced investment we will be able to accelerate the stated changes and ensure:

- Each locality is properly resourced for its need;
- A fully extended community offer to include maximising potential of VCSE and primary care;
- A consistent and robust crisis and out of hospital provision;
- Enhanced performance across all key operating standards and performance indicators;
- Delivery of our big ambitions at a faster pace;
- More ability to invest in more research and innovation; clinical leadership; skills, career development etc;
- Improved staff recruitment and retention.

A detailed launch and implementation / delivery plan will be developed to support strategy implementation. The service line view of this is described at a high level in appendix a. This will be further expanded, and some of the cross-cutting programmes of work articulated to allow us to hold ourselves to account for delivery.

The delivery plan will include a consideration of the resource requirements to fully deliver the ambitions of the strategy.

The clinical strategy will be monitored through existing governance processes within the organisation. This will include the benefits realisation processes associated with our complex change service transformation programme and business plans at both an organisational and network level (via quarterly quality and performance assurance review/reports).

The clinical strategy underpins everything that we do and will be cross-referenced in both existing and new organisation strategies / plans that are being developed across the Trust, as outlined above.

15.Summary

This strategy sets out our ambition for our services over the next five years. This represents a significant change in our service delivery model and is an exciting development which we believe will deliver significantly improved care to our communities.

Clinical Strategy

Developing a clinically led strategy together

NHS
Pennine Care
NHS Foundation Trust

Appendix a: Our Services

	Service Descriptor	Development Plan
Primary Care		
Talking Therapies	Deliver evidence-based psychological therapy, with the therapy delivered by trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimize outcomes.	We will continue to work with the integrated care system to address the disparity in terms of investment to ensure that we are able to offer services capable of meeting ambitious national and local quality standards.
Living Well (see also CMHT, community services)	Across our localities we are engaged in design work with our partners to develop new models of care for integrated community services. The LTP sets out ambitious targets for transforming community mental health services, developing multi-disciplinary and multi-agency services wrapped around Primary Care Networks (PCNs) – bridging the traditional gap between traditional primary and specialist mental health services. We have already seen investment in primary care through the development of dedicated mental health practitioners working in general practice.	As the Living Well models develop, these practitioners will form the foundation for these services, together with skills and expertise from the local authority and VCSE. These developments will fundamentally change the traditional demarcations between primary and secondary care as we work to integrate and develop more seamless pathways where care and intervention can be stepped up and down as appropriate. Many of our current teams and services will fall within the scope of this work, including our access teams, our psychological medicine in primary care services and community liaison teams.
Memory Assessment Services	Memory Assessment Services are specialised multidisciplinary team services focusing on dementia care. Their main priorities are to: • accurately diagnose dementia and mild cognitive impairment • initiate and monitor appropriate treatment • provide post diagnostic support • provide treatment and support for behavioural and psychological symptoms of dementia • provide end-of-life support for patients and their carers.	Our short-term priority is to achieve this waiting time target, as services struggle with the backlog in assessments due to the Covid-19 pandemic. We need to ensure timely access to assessment and diagnosis so that people can achieve the best outcomes possible. The future developments for Memory Assessment Services will include facilitating patient independence and happiness, standardising services across boroughs and working with the volunteer sector to use evidence based tools to provide timely and responsive care for patients with behavioural and psychological symptoms of dementia.

	Our memory assessment services work towards the national target of 6 weeks from referral to initial assessment and 12 week diagnosis.	
Care Home Liaison Team	Provide mental health input for people in care homes. The teams provide specialist assessments and treatment for people presenting with advanced dementia and complex mental health needs. They also provide training and support for family members and carers. They link with GPs, voluntary sector organisations and local authorities to support patients and family members sustain care placements.	The future goals for the care home liaison teams will include supporting discharge for patients on older adult wards, supporting patients in intermediate care units and working with family members and carers to prevent patients from being admitted to hospital. Links will be forged with our living well teams to ensure equity of access
Psychological Medicine Service (PMS)	Provide specialist expertise for adults with complex physical and psychological difficulties, including long term conditions such as pain, epilepsy, diabetes and long Covid including targeted care for people with atypically high healthcare utilisation. There are 3 aspects to the service clinical care, training and service development. In Pennine Care these services have been developing in line with national and regional strategy and have achieved national awards and recognition. PMS exist in the following areas: • Bury- Integrated Pain Service, Neuropsychology (rehabilitation), Palliative Care; • Oldham- Neuropsychology (stroke), Pain, Oldham PMS (with assertive outreach for people with atypical healthcare use in 3/ 5 Primary Care Networks); • Stockport- Psychological Medicine in Primary Care (with assertive outreach for people with atypical healthcare use); • Pennine Care footprint - Psychological therapies in Physical Health service (via contracts with Northern Care Alliance) and the Psychological Medicine Post Covid Service.	We would seek to secure a Trust-wide approach to PMS to provide a coherent strategy and equity of provision in line with the Long-Term Plan and Pennine Care values including targeting care to reduce health inequalities in a group of patients with multi-morbidities. The transformation plan will be codeveloped with people (patients and staff) who use these services and have strategic fit with the Greater Manchester ICS. This will include: <u>Year 1</u> - mapping of service provision, development of a PMS Trust wide Strategy ensuring effective clinical leadership support, development of a clinical learning network for colleagues and ongoing discussions regarding equitable investment and provision. <u>Year 2</u> - Liaison with CAMHS re support for CYP with physical health problems; development of pathways with liaison mental health services and Talking Therapies; development of core specialist hub (c.f. Perinatal/ Early Attachment services) with a focus on consultation <u>Years 3-5</u> - Implement and evaluate the above
Community Services		

Early Intervention in Psychosis	Psychosis and psychotic disorders can be extremely debilitating. A long duration of untreated psychosis is associated with poorer personal recovery, increased service use and poorer economic outcomes in both the short and long-term. The PCFT Early Intervention Service comprises five multi-disciplinary teams, offering evidenced based interventions for people with suspected psychosis or experiencing their First Episode of Psychosis (FEP), for up to three years. Early Intervention Teams aim to assess and treat within two weeks of referral for people with At-Risk Mental States (ARMS) or FEP, to reduce duration of untreated psychosis and improve outcomes. Teams promote recovery by preventing transition to FEP or reducing the probability of relapse following a first episode of psychosis. Early Intervention Service priorities are to ensure we are appropriately resourced, with the right skill mix, whilst retaining fidelity to the EI model. This will strengthen our ability to consistently meet the referral to treatment targets for FEP and ARMS by offering the full range of quality standard interventions, which form part of NCAP (National Clinical Audit of Psychosis).	Key priorities are to: • Achieve level 3 National Clinical Audit of Psychosis rating by 2023/24 • Level up investment across the 5 boroughs to address variance in FEP pathway • Secure additional investment to be able to offer evidence-based interventions for ARMS in each locality • Upskill workforce to support retention and address gaps in service delivery • Expand workforce to include Mental Health Wellbeing Practitioners, Trainee Assistant Psychologists and Clinical Associates in Psychology • Develop a stepped care approach for psychological interventions for people with SMI • Increase involvement with people with 'lived experience' for service evaluation, development and research • Building stronger partnerships with key stakeholders • Expand ARMS offer to meet 'gold standard'
CMHT (see also Living Well, Primary Care – above)	The transformation of community mental health services is central to the delivery of the Long-Term Plan (LTP) and the national community framework. The framework sets out ambitious plans for community services, which retains a specialist team working with people with severe and enduring mental illness, but as part of an enhanced and integrated community pathway (Living Well). As the requirements of the Care Programme Approach (CPA) come to an end, there is a desire to move away from traditional care co-ordination and an approach where the focus has been on review, monitor and maintenance, to an approach which promotes goal orientation, outcomes, individualised care with an emphasis on recovery, empowerment and integration into local communities.	National benchmarking data demonstrates that our adult CMHTs benchmark in the bottom quartile nationally with regards to investment, resulting in a smaller workforce provision and high caseloads. One of our key priorities is to shift this benchmarking position and ensure that our core teams are appropriately resourced. Our redesigned offer will: • Focus on an MDT approach enhancing the skill mix of the teams to include allied health professionals and psychology, with members working within their professional capacity rather than as a generic care co-ordinators • Delivery of a range of psychical, psychological and social interventions

	Our older adult community offer varies greatly across our localities and we are working to understand this variation and achieve a more consistent approach. Whilst our older adult CMHTs don't benchmark in the same way as our adult teams, we do recognise that there are gaps with regards to skill mix, and a desire to improve the MDT with increased allied health professional and psychology provision. We are also looking at how we embrace new roles across the teams, such as through the introduction of Mental Health Wellbeing Practitioners.	• Development of a modular group offer – psycho-educative approach supported by peer workers and people with lived experience • Development of specialist clinical pathways to support people with personality disorder and physical health needs • Introduce evidence-based reporting and outcome measures
Community CAMHS Service	A service for children, young people, parents/carers, and families experiencing significant difficulties with emotions, relationships, neurodiversity, psychological and or psychiatric difficulties which are significantly impacting on mental health of Children, Young People, and their families. We have been working towards the Thrive framework to develop our core offers and pathways and consolidate and expand services to meet increased demand. This has helped us to understand the need for engagement across all partners and that we need to deliver services in new and innovative ways with a diverse workforce. The need to provide advice, consultation and training support is key to developing a place based thrive offer where young people and their families can make the most of the community assets to both prevent the need for formal mental health intervention or to provide on-going support following a period of treatment from our services	There are several important issues to develop including • Reducing current levels of variation in the offer • Building stronger partnerships • Scaling of our early intervention offers increasing our creative and innovative approaches in partnership with peer mentors and care navigators through a discovery college. • Providing accessible high level clinical expertise in new ways to promote increased risk formulation support and consultation to our community partners via team around the worker approach. • Developing our offer to parents and carers to promote whole family recovery and well-being. Additionally we will: • Increase our integration with paediatric and children's social care services to ensure children and young people access the right care at the right time and in the right place • Develop robust diagnostic pathways for neurodevelopmental conditions

		• Develop all CAMHS services up to 18 years and work in partnership to ensure young adult services are developmentally appropriate, beginning with the most vulnerable populations.
CAMHS Thrive in Education Services (Mental Health Support Teams)	These exciting new teams are run in partnership with a variety of place based VCSE partners with PCFT taking a lead provider role. The services goal is to help young people, from four to 18 years, to thrive in education by providing early support and evidenced based intervention within education settings. The service's main role is to support children and young people who are experiencing mild to moderate mental health difficulties. The service provides a range of support including behaviour activation for low mood (the relationship between activity and mood), managing anxiety and behaviour difficulties, improving low self-esteem and building confidence. They also work closely with parents and provide training, consultation and advice to school staff**.**	The service has a total of 10 teams across the footprint, with a growth plan to 14 in 23/24 and a national target that 35% of all schools will have access to a team. A further focus is to work with education and wider stakeholders to develop and enhance whole school approaches to positive mental health, supporting the implementation of the GM standards. Our focus over the coming years will be to create career development pathways for these entry level roles and develop the Thrive in Education offer to vulnerable groups of young people, including those with Neurodiversity, Special Educational Needs & Disabilities (SEND) and Cared for Children
Community Eating Disorder Service (CEDS)	The service delivers evidence based intensive eating disorders assessment and intervention to young people (up to 18 years old) across the PCFT footprint. The service is currently delivered by two teams, across two estates hubs, one in the North and one in the South. The service's vision is to deliver the best possible care to young people and families in our local communities by intervening at as early a stage as possible and working effectively with local partners to help people to live well and stay well. The multi-disciplinary teams also offer advice and support to families, carers, and those who work with, or support, a child or young person.	The following are the key development priorities of the service: • Review the skill mix and staffing establishment to reflect the growth in activity and to ensure compliance with evidenced based treatments and a family based approach. • Enable compliance with national routine and urgent access and waiting time standards (AWT). • Development of a daily intensive treatment pathway (DIT) to support young people on the edge of hospital care and minimise where possible the need for inpatient care, both into acute and mental health hospitals.
Outpatient services	Each year, hundreds of patients will be seen within outpatient clinics for a review of their mental health by a Consultant Psychiatrist or member of their team.	As the community mental health offer grows and we strive to develop a continuum of care rather than the traditional primary/secondary services, we need to consider the best use of the outpatient model, whilst recognising some of the system challenges associated with shared care arrangements.

	The majority of these patients will not be routinely seen by other practitioners within the specialist teams or necessarily in the care of the CMHT.	
Learning Disability Services	Our Learning Disability services provide specialist assessment and support for people with complex and challenging needs. The teams work with people to reduce and overcome the health inequalities faced by people with a learning disability, supporting people to access a range of services and support to keep them healthy and well.	In 2020 our services co-produced an LD strategy and plan for how services will be developed and transformation over 5 years. Our strategy sets out our pledge – to create change together – around 10 key areas and is aligned with the 10 priorities of the Greater Manchester LD strategy.
The Military Veterans' Service (MVS) for Greater Manchester & Lancashire & Op Courage- Integrated Veterans Mental Health Service North West (Op Courage).	Both services are hosted in this region by the Trust. **Op Courage** The Op Courage Integrated Veterans Mental Service (IVMHS) is a new service commissioned by NHS England (NHSE) aimed at unifying the mental health services currently offered to veterans through the Transition, Intervention & Liaison Service (TILS), Complex Treatment Service (CTS) and High Intensity Service (HIS). The service is to be delivered by a collaboration of partners including NHS trusts and third sector veterans' organisations to deliver the IVMHS across the North-East & Yorkshire and North-West Regions which will be fully operational by April 2022. The service will ensure that a veteran and their family/carers can access a wider holistic service that brings together mental health, physical health and wellbeing provisions to meet the veteran's individual need. Op Courage provides interventions for serving armed forces personnel in their last 6 months of military service (*with a discharge date); current serving reservists; early service leavers; ex service personnel; veterans' and their families/carers. **The Military Veterans' Service (MVS)**	This is currently being developed as part of the new IVMHS service role out and the redevelopment of existing local NHS Veteran mental health services. We work alongside a large number of local armed forces community third sector services as well as the NHS Veterans Trauma network (VTN); the Veterans People, Pathways and Places programme (VPPP) and the Veterans Covenant Healthcare Alliance (VCHA) to ensure equity of access across all healthcare and charitable provision for members of the armed forces community. A key requirement is for an integrated Northern region wide approach to NHS Armed forces Mental Healthcare to provide a coherent strategy, secure investment and address the current inequity of provision across the UK, in line with the NHS Long-Term Plan and the Office of Veterans' Affairs "Veterans' Strategy Action Plan 2022-2024.

	Specialist psychological therapies service for British armed forces veterans across Greater Manchester and Lancashire, delivered by a specialist MDT including people who have been veterans themselves or have family members in the forces. We offer a range of evidence-based treatments, for a number of difficulties that may have arisen from serving in the armed forces. We work closely with a large number of statutory services, charities, voluntary and social enterprise organisations both locally and nationally. We are in partnership with Service charity **Walking with the Wounded** and employ individual placement support workers and support case coordinators who are integrated within our core MVS team.	
Crisis Services and developing alternatives to admission		
Crisis Resolution Home Treatment Teams	Provide short-term mental health support and intervention at home to help avoid people being admitted to hospital. The teams work to deliver intensive support where there has been a deterioration in the person's mental health that requires greater input than a CMHT can deliver. The teams are crucial in ensuring that only those people who absolutely need inpatient care are admitted and want to uphold our principle of 'community first', recognising that people do best when they have their networks of friends and family around them.	We continue to work with the ICS to ensure our teams are commissioned to nationally agreed levels and delivering against the core fidelity standards. We have some work to do with regards the delivery of consistency and standardisation across our pathways, and with developing our skill mix. Gatekeeping processes will be strengthened by delivering robust training packages to all staff to ensure assessments are trusted and conducted only once.
Home Intervention Teams	Our Home Intervention Teams offer short-term mental health support and intervention for older adult patents experiencing a deterioration or crisis in their mental health. Admission to an inpatient ward must be the last resort for our older adult patients, as the evidence highlights that inpatient care can be associated with an increased risk of hospital acquired infections and decline in everyday skills, independence and functioning, increasing the chance of longer-term care needs on discharge.	We have a significant amount of work to address differences in provision across our localities and to standardise our approach to delivery. Our priority will be to work with patients, their families and local authority and volunteer sector partners to ensure we have robust community support to deliver the best outcomes for our patients.

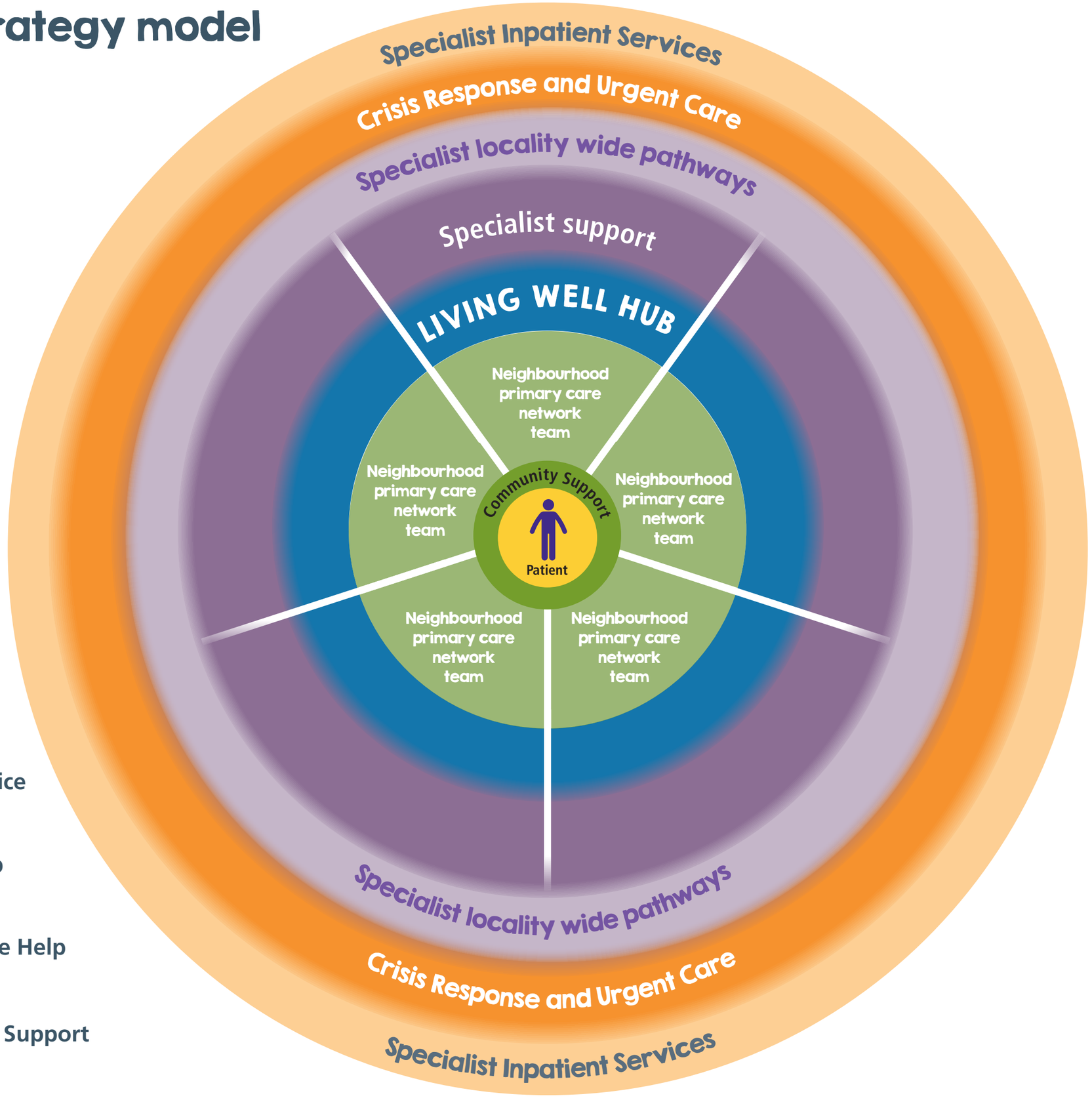
Liaison Mental Health Services	Provide mental health expertise in Acute Trust settings. With three components: clinical work, training and pathway development. LMHS have been developing to 'Core 24' standard, in line with national and regional strategy and NICE guidance from 2016. In some areas an 'all age' offer is provided, linking in with CAMHS services. The clinical focus of LMHS involve mental health presentations in A&E and on the wards.	1. All boroughs to have liaison MH services funded to the 'Core 24' specification and also funded for the delivery of 'liaison services for all ages' 2. Meeting the Psychiatric Liaison Accreditation Network (PLAN) quality assurance standards. 3. Supporting Acute Trust partners to meet AMSAT CQC recommendations 4. Finalisation of SOPs for each borough, which align with PLAN and the Trust wide strategy The transformation plan will be codeveloped with people (patients and staff) who use these services and have strategic fit with the Greater Manchester ICS. This would include the development of a Trust wide LMH strategy, development of a clinical learning network, development of pathways with Primary Care Networks, Psychological Medicine Services, IAPT and other partners.
24/7 helpline and urgent response	An all-age service for people who are experiencing increased mental health need. It is delivered by experienced mental health professionals who can support people to work through immediate problems, work collaboratively to find ways to move forward, and to provide information about other services that may be helpful.	One of the ambitions within the Long-Term Plan is to develop a single point of contact for those experiencing mental health crisis, but also to provide 24/7 crisis response in the community with a 2-hour response time. Working in partnership across the system, we have further work to do with regards to embedding our helpline within service pathways, and in terms of developing the capacity to deliver timely and universal mental health crisis care for everyone, accessible via NHS 111.
Section 136	The Trust has a Section 136 suite in each of its five localities. The police can use a Section 136 of the Mental Health Act if they think someone in the community or a public place has a mental disorder. Under the section they can take emergency action to take the person to a place of safety where their mental health can be assessed. Historically, our Section 136 suites haven't had a dedicated staffing resource, with staff being deployed from our inpatient wards or liaison teams in the event of a presentation. This is unsafe, and places considerable pressure on already busy services.	Our vision for the future is to develop one suite for our footprint – a purpose-built facility with a dedicated staffing resource. We will work in partnership over the coming year to drive forward this exciting development, to deliver improvements to safety, quality, and the patient experience.
CAMHS Home Intensive Treatment Team	A child and family focused service delivering a whole systems approach in alignment with the i-THRIVE framework. The aim of the service is to work with children and young people to reduce	The GM intention is to mobilise HIT across all GM providers during 2022/23 working to a broadly similar service specification. Future implementation plans for the Home Intensive Treatment Team involve:

	the likelihood of a relapse in their mental state, avoid hospital admission when possible, and to support discharge from hospital. Referrals are currently accepted for young people up to 16 years. Referrals are accepted for young people aged 16 years with a diagnosis of Autism or ADHD. A full assessment of the young person's needs is carried out, which is regularly reviewed, and a plan devised with support for family/carers. The service is designed to deliver brief psychosocial interventions within a timeframe of up to 6 weeks The team includes Youth Support Workers who actively engage young people in community activities to promote social inclusion.	• The team expanding to include a part-time Consultant Psychiatrist and part-time Consultant Psychologist • Working hours will be extending to 10pm at night • The referral age will increase to include young people aged 16 and 17 years who will not necessarily have an existing care team • Pathways will be developed to extend referral routes from a wider range of services, including Mental Health Liaison.
CAMHS Rapid Response Teams RRT	A multi-disciplinary team of mental health professionals providing an assertive outreach model to support children and young people up to the age of 18 in crisis. With the primary aim to prevent further escalation and avoid hospital and/or Accident & Emergency (A&E) Department admission, the RRT ambition is to attend the crisis location within 4 hours of the initial referral being raised. As an integral service within the Greater Manchester CYP Crisis Pathway RRT work from 4 geographical bases, covering all 10 boroughs of GM. The teams work together to support any child who presents in crisis in GM, including children who reside in GM and those who present in crisis whilst visiting GM. Providing intensive support for up to 72 hours, the team support and accept referrals from a range of agencies and provide consultation and advice, in real-time, when dealing with a developing crisis.	Further evaluation at a GM level will give further consideration to service developments that may include: • Fully integrating the CYP crisis offer into the out of hours/ 24/7 models of care • Evaluation of the CYP pilot for the Mental Health Joint Response vehicle (in Bury) • Extending referral pathways to wider agencies that could include GPs, social workers and emergency services • Development of targeted parent/carer intervention to be delivered initially within the pathway. • Peer support workers
CAMHS Greater Manchester Assessment Centre (GMAIC)	The centre forms part of a large scale transformation of crisis care delivered to children and young people (CYP) across Greater Manchester. GMAIC encompasses all existing inpatient providers, inclusive of Independent and NHS providers and is led by the Trust. Its function supports the devolved responsibility	The priorities within the service mirror those of the LPC and will see the service develop a single point of access over a 24-hour period for referral management and access assessment for all young people referred into inpatient care.

	to GM Integrated Care Board from NHS England of general adolescent and eating disorder inpatient provision. This service remains integral to the CAMHS inpatient Lead Provider Collaborative (LPC) in ensuring young people receive the right level of care suitable to their needs, in the least restrictive means and as close to home as possible. GMAIC ensure that beds are understood as part of a locally managed network extending across the north west.	
Inpatient Services		
Adult and older people inpatient units	As outlined earlier, the cost per bed continues to be significantly lower than the national average and overall bed numbers are higher than the national average. Bed occupancy and length of stay are also higher than the national average, and therefore higher than we would like. We have inpatient facilities across all localities and during 2022-23 we were pleased to confirm them all as single gender, meeting a key quality indicator for our service users and carers. The estate is also challenged with some wards having limited access to outdoor space and some bedrooms not being en-suite. We are currently heavily invested in the development of our inpatient standards, further to the getting it right first time (GIRFT) review.	Our vision is for every patient to recover in the least-restrictive and most therapeutic environment that meets self-defined recovery needs and outcomes. We will adopt our inpatient standards and the productive mental health ward methodology across all inpatient services All inpatient staff will receive training in Trauma Informed Care and Reducing Restrictive Practices. Implementation of the reformed Mental Health Act will improve choice and autonomy, ensure least restriction, support therapeutic benefit, and promote the rights of the individual.
Tier 4 CAMHS	Hope and Horizon are our child and adolescent mental health (CAMHS) inpatient facilities. A skilled multi disciplinary team provides treatment and support to young people aged between 13 and 18 years, who are suffering from a range of mental health difficulties. Education is provided on site for young people. A 4-6 week pathway is embedded for our general adolescent wards with a treatment pathway identified for young people who may require ongoing inpatient care. We are accredited to meet the standards of the Quality Network for Inpatient CAMHS (QNIC) and have an Outstanding CQC rating. We place a strong	The inpatient team are involved in a number of ambitious workstreams within the LPC for development over the next few years which includes bed modelling; pathways development for PICU; LSU; Day Care; Eating Disorders; Learning Disability and Autism and workforce to name a few. A key priority for the service is to develop a successful bid for a new purpose built unit.

	emphasis on service user and parental involvement and participation both in individualised care planning and around service improvement and development.	
Rehab and High Support Services	We currently operate two Low Secure Units (LSU), Prospect Place (45 male beds) and Tatton Unit (16 beds for males with longer term secure needs). Prospect Place is a purpose-built unit with single rooms, all with en-suite facilities. Pennine Care offers a comprehensive rehabilitation pathway, with 80 inpatient community rehabilitation beds for males and females, as well as a new Community Rehabilitation Team.	Our LSUs continue to improve our offer in alignment the Quality Network for Forensic Mental Health Services (RCPsych). In addition, • We will adopt the productive mental health ward methodology across all inpatient services • All inpatient staff will receive training in Trauma Informed Care and Reducing Restrictive Practices. • Implementation of the reformed Mental Health Act will improve choice and autonomy, ensure least restriction, support therapeutic benefit, and promote the rights of the individual.
PICU	Walkerwood is a purpose built 12 bedded unit providing Psychiatric Intensive Care for males from across the PCFT footprint. In development is a 10 bedded female PICU to reduce the number of females in out-of-area placements	Both units are assessed in line with the National Association for Psychiatric intensive care standards (Quality Network for PICU, QNPICU). In addition: • All inpatient staff will receive training in trauma informed care and reducing restrictive practices • All staff will be RAID (Reinforce Appropriate, Implode Destructive) trained • Continue to embed a trauma informed model of care which is underpinned by RAID principles We will seek ongoing development and alignment through QNPICU and regular peer review

Clinical strategy model



- Thriving
- Getting Advice
- Getting Help
- Getting More Help
- Getting Risk Support

Early Intervention Team, Community CAMHS, Community Learning Disability, Outpatients, Specialist Community Teams (adult and older adult CMHT).

Complex emotional and relational needs (CERN) pathway (formerly the personality disorder pathway) Structured clinical management 24 months, **Physical health team, Military Veterans, Secondary care psychology, Memory Assessment Services**

Crisis Resolution Home Treatment/ Home Intervention Team, Mental Health Liaison, Helpline, Rapid Response, Health Based Place of Safety (136 Suites), Mental Health Urgent Triage,Crisis Cafes, Safe Haven, Children and Young People Crisis service

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Pennine Care
NHS Foundation Trust

Draft 2022/23 Annual Accounts – Including an overview of the submission	
Paper prepared by	Deborah Andrews, Assistant Director of Finance
Executive sponsor	Nicola Tamanis, Executive Director of Finance
Date of report	26th April 2023
Purpose of the report and action required	The Audit Committee approved the 2022/23 draft accounts for submission at their meeting on the 26th April 2023, in accordance with the delegated authority provided by the Board. The purpose of the report is to provide an overview of the 2022/23 draft annual accounts submission and circulate the draft accounts to Board members for information.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The 2022/23 draft annual accounts were submitted on the 27th April 2023 in line with the national deadline. The final audited accounts are due for submission on Friday 30th June. Key highlights from the draft accounts: • Year end surplus of £5.3m (excluding technical items) contributing to Greater Manchester Integrated Care System break-even position • Cash balances of £55.5m ~ £6.4m higher than 2021/22 • Capital spend of £3.6m on internally funded schemes ~ 62% of plan; £2.6m on PDC funded schemes, and £3.3m leases which includes £3.2m relating to impact on new leases accounted for under IFRS 16 • Delivery of £12.8m of efficiencies, of which £3.6m recurrent efficiencies
Recommendation	The Board are asked to receive the 2022/23 draft accounts for information.
Where else has this	The 2022/23 draft accounts were considered and

report been considered and when?	approved through delegated authority from the Board at the Audit Committee on the 26th April 2023

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	X
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	

If option three is selected, please complete the table on page 2

	Please indicate (X) which areas(s) of focus and describe the impact	
Area of focus		**Impact**
	1. Services: we will develop outstanding services that are safe, compassionate, fair, consistent in quality and sustainable; using digital technology to advance our improvements	
	2. People: we will nurture the development of a capable, motivated and engaged workforce which realises the potential and talent of everyone; and that values experts by experience	
	3. Culture: we will create the right conditions for people to flourish by developing a just culture that is fair and inclusive; transparent, curious and outward facing, and that aims high, recognises success and creates pride and belonging	
	4. Partnerships: we will make a full and meaningful contribution to our communities through our partnerships with service users and their carers, third sector, local communities and other organisations	

NHS
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2022/23 Annual Accounts Overview

Deborah Andrews
26th April 2023

Maximising potential

NHS
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Key Dates

- Thursday 27th April – submit draft accounts
- Friday 12th May – AoB resubmission
- Friday 30th June – final audited accounts

Overview

Pennine Care
NHS Foundation Trust

1. Performance Overview
2. Financial Statements – key movements
    1. Statement of Comprehensive Income (SOCI)
    2. Statement of Financial Position (SOFP)
    3. Statement of Changes in Equity (SOCIE)
    4. Statement of Cash Flows (SOCF)

1. Performance Overview

Pennine Care NHS Foundation Trust

- Performance overview
  - Year end surplus of £5.3m (excluding technical items) contributing to Greater Manchester Integrated Care System break-even
  - Cash balances of £55.5m ~ £6.4m higher than 2021/22
  - Capital spend of £3.6m on internally funded schemes ~ 62% of plan; £2.6m on PDC funded schemes , and £3.3m leases which includes £3.2m relating to impact on new leases accounted for under IFRS 16
  - Delivery of £12.8m of efficiencies, of which £3.6m recurrent efficiencies

	2022/23 £000	2021/22 £000
Surplus / (deficit) for the year	**6,786**	**2,744**
Adjusted financial performance		
I&E impairment	-6,079	-2,356
Loss on transfer by absorption	4,628	0
Adjusted financial performance surplus	**5,335**	**388**

Cash Balances	**55,503**	**49,075**

Capital Spend :	**9,532**	**12,989**
Internal Resources	3,607	6,370
Public Dividend Capital	2,623	6,500
Lease Costs (incl PFI)	3,302	119

Efficiencies	**12,813**	**11,276**
Recurrent	3,596	4,971
Non Recurrent	9,217	6,305

Pennine Care
NHS Foundation Trust

1. Performance Overview

- During 2022/23 we transferred the remaining assets relating to the Community Services Transfer to NHS Property Services.

Counterparty	Asset category	NBC at transfer date £000
NHS Property Services	PPE: Land	978
	PPE: Buildings	3,650
	Total	4,628

Pennine Care
NHS Foundation Trust

2.1 Statement of Comprehensive Income (SOCI)

Statement of Comprehensive Income	Note	2022/23 £000	2021/22 £000
Operating income from patient care activities	3	264,405	231,929
Other operating income	4	9,899	8,874
Operating expenses	7, 9	(260,836)	(234,824)
Operating surplus / (deficit) from continuing operations		**13,468**	**5,979**
Finance income	11	1,041	23
Finance expenses	12	(927)	(1,143)
PDC dividends payable		(2,168)	(2,115)
Net finance costs		**(2,054)**	**(3,235)**
Gains/(losses) from transfers by absorption	28	(4,628)	0
Surplus/(deficit) for the year		**6,786**	**2,744**
Will not be reclassified to income and expenditure:			
Revaluations	15	4,132	1,990
Total comprehensive income / (expense) for the period		**10,918**	**4,734**

Patient Care Activities ↑ £32,476k (14%)
Other Operating Income ↑ £1,025k (12%)
Other Operating Costs ↑ £350k (1%)
Gross Staff Costs ↑ £25,663k (14%)

2.2 Statement of Financial Position (SOFP)

Pennine Care
NHS Foundation Trust

Statement of Financial Position	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Intangible assets	13	1,472	1,303
Property, plant and equipment	14	84,921	115,624
Right of use assets	16	46,983	
Receivables	17	2,980	3,475
Total non-current assets		**136,356**	**120,402**
Current assets			
Receivables	17	12,738	6,752
Cash and cash equivalents	18	55,503	49,023
Total current assets		**68,241**	**55,775**
Current Liabilities			
Trade and other payables	19	(41,727)	(38,582)
Borrowings	21	(3,425)	(428)
Provisions	22	(3,490)	(4,224)
Other liabilities	20	(8,463)	(8,005)
Total current liabilities		**(57,105)**	**(51,239)**
Total assets less current liabilities		**147,492**	**124,938**
Non-current liabilities			
Borrowings	21	(21,366)	(13,562)
Provisions	22	(2,103)	(1,983)
Total non-current liabilities		**(23,469)**	**(15,545)**
Total assets employed		**124,023**	**109,393**
Financed by			
Public dividend capital		94,285	90,573
Revaluation reserve		10,456	8,577
Income and expenditure reserve		19,282	10,243
Total taxpayers' and others' equity		**124,023**	**109,393**

Addition of the 'Right of Use' assets follows the implementation of IFRS16

2.3 Statement of Changes in Equity (SOCIE)

Pennine Care
NHS Foundation Trust

Statement of changes in equity for the year ended 31 March 2023	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**90,573**	**8,577**	**10,243**	**109,393**
Surplus / (deficit) for the year			6,786	6,786
Transfer by absorption: transfer between reserves		(2,253)	2,253	0
Revaluations		4,132		4,132
Public dividend capital received	3,712			3,712
Taxpayers' and others' equity at 31 March 2023	**94,285**	**10,456**	**19,282**	**124,023**

Statement of changes in equity for the year ended 31 March 2022	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**84,073**	**6,587**	**7,499**	**98,159**
Surplus / (deficit) for the year			2,744	2,744
Revaluations		1,990		1,990
Public dividend capital received	6,500			6,500
Taxpayers' and others' equity at 31 March 2022	**90,573**	**8,577**	**10,243**	**109,393**

2.4 Statement of Cashflow (SOCF)

Pennine Care NHS Foundation Trust

Statement of Cash Flows	Note	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus / (deficit)		13,468	5,979
Non-cash income and expense:			
Depreciation and amortisation	7.1	8,968	6,658
Impairments and reversals	8	(6,079)	(2,356)
(Increase) / decrease in receivables		(6,026)	685
Increase / (decrease) in payables and other liabilities		10,690	12,588
Increase / (decrease) in provisions		(3,386)	3,480
Net cash flows from / (used in) operating activities		**17,635**	**27,034**
Cash flows from investing activities			
Interest received		1,041	23
Purchase of intangible assets		(619)	(607)
Purchase of PPE and investment property		(9,884)	(9,482)
Net cash flows from / (used in) investing activities		**(9,462)**	**(10,066)**
Cash flows from financing activities			
Public dividend capital received		3,712	6,500
Capital element of finance lease rental payments		(2,158)	
Capital element of PFI, LIFT and other service concession payments		(428)	(396)
Interest element of PFI, LIFT and other service concession obligations		(1,110)	(1,142)
PDC dividend (paid) / refunded		(1,761)	(1,916)
Net cash flows from / (used in) financing activities		**(1,745)**	**3,046**
Increase / (decrease) in cash and cash equivalents		**6,428**	**20,014**
Cash and cash equivalents at 1 April - brought forward		**49,075**	**29,061**
Cash and cash equivalents at 31 March	**18.1**	**55,503**	**49,075**

Increase in cash balances primarily driven by the surplus

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NHS Foundation Trust

Final page

Maximising potential

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Report to the Board of Directors
3rd May 2023

Pennine Care
NHS Foundation Trust

Integrated Performance Report	
Paper prepared by	Rachel Clayton - Head of Strategic Planning and Performance
Executive sponsor	Gaynor Mullins – Director of Strategy
Date of report	26th April 2023
Purpose of the report and action required	The main purpose of this report is to provide Board with the latest performance against each Key Operating Standard in line with our published data, identifying any key issues, risks and achievements.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	**Overall Performance** Overall quality and safety standards continue to be monitored with key focus on seclusion and use of restraints. Pressures remain in our inpatient services with high demand for beds and high occupancy levels continuing to impact on the number of out of area placements. Pressures remain in CAMHS services with referrals continuing to rise and waiting lists growing particularly within the neuro development pathway. Waiting times for allocation in our community mental health team has also been escalated with the main pressures being seen in Bury and Oldham care hub. Pressures in our Memory Assessment Services have also been escalated due to waiting times for assessment and diagnosis. Agency Spend also remains a key risk. Overall demand and staffing pressures continue to be the main reason causes along with the underlying investment in core services. **Key Operating Standards** Out of 32 indicators, 28 were available to be reported this month, Of these : • **9** have been achieved or are on target to be

	achieved. • 12 have not been achieved or are not on target to to be achieved. • 7 do not currently have an agreed target. Overall performance against our key operating standards during March 2023 shows little or no change with no significant improvement or deterioration in overall achievement of 43% of standards achieved in month. In month there has been minimal variation in performance against individual metrics, except for out of area placements which has continued to deteriorate. Overall achievement of standards during 2022/23 has remained consistent with an average of 43% of standards achieved each month indicating no change in the overall level of performance during 2022/23. Key standards that remain a risk include: ○ Out of area placements ○ IAPT access and recovery ○ My Yearly Conversation ○ Turnover ○ Data Quality Maturity Index Score
Recommendation	The Board are asked to note the contents of the report
Where else has this report been considered and when?	The report has been circulated to Trust Management Board members for comments prior to submission to Board.

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	X

If option three is selected, please complete the table on page 2

	Please indicate (X) which areas(s) of focus and describe the impact	
Area of focus		**Impact**
X	**1. Services: we will develop outstanding services that are safe, compassionate, fair, consistent in quality and sustainable; using digital technology to advance our improvements**	This Intergrated performance report aims to provide assurance against key operating standards aligned to our service area of focus
X	**2. People: we will nurture the development of a capable, motivated and engaged workforce which realises the potential and talent of everyone; and that values experts by experience**	This Intergrated performance report aims to provide assurance against key operating standards aligned to our people area of focus
X	**3. Culture: we will create the right conditions for people to flourish by developing a just culture that is fair and inclusive; transparent, curious and outward facing, and that aims high, recognises success and creates pride and belonging**	This Intergrated performance report aims to provide assurance against key operating standards aligned to our culture area of focus
	4. Partnerships: we will make a full and meaningful contribution to our communities through our partnerships with service users and their carers, third sector, local communities and other organisations	

Integrated Performance Report
Period ending 31st March 2023

Section 1: Purpose of the Report

The Integrated Performance Report (IPR) is a Board Level report aimed at providing assurance on performance against the Trusts key operating standards. The report forms part of the Strategic Performance Reporting framework aligned to the Trust ambitions and strategic objectives (Appendix 1).

The main purpose of this report is to provide Board with the latest performance against each key operating standard in line with our published data, identifying any key issues, risks, and achievements.

The key operating standards within this report have been compiled from the key metrics monitored by NHSI/E in the System Oversight Framework, the national contract provider operating standards and quality requirements, the National Mental Health Activity Planning metrics, and our key internal operating standards. These have then been aligned to the Trusts key area of focus within our Trust Strategy.

Each key operating standard has also been allocated to a sub-committee with performance reported into the nominated committees as part of the wider reporting suite ,ensuring triangulation with the broader performance management framework. Details of the key operating standards and provided in Appendix 2.

1.1 Update on reporting of Key Operating standards

As part of the wider improvement plan for our Board Performance report a full review of all metrics is currently being carried out with a new set of Key Operating Standards and timeline for reporting due to be agreed by the Executive Team by 30th April 2023.

Section 2: Executive Summary

2.1 Overall Performance Headlines and Key exceptions

Overall quality and safety standards continue to be monitored as part of the weekly safety huddles in place across all care hubs, with a monthly focus on quality and safety as part of the executive performance huddle. Use of seclusion continues to be a key focus with weekly review meetings in the care hubs to review episodes of seclusion. Use of restraints and prone restraints are also monitored closely.

Overall patient experience feedback from our friends and family survey remains above the national average for Mental Health Trusts.

Inpatient services continue to experience high demand for beds and high occupancy levels, with pressures in the social care and housing system continuing to impact on the number of patients who are clinically ready for discharge and overall delayed discharges. The overall delay rate in March reported at 9.24% with the adult delay rate reported at 8.18%. This ongoing pressure has resulted in a further increase in the number of out of area placement days during March 2023.

Pressures also continue to be seen in our CAMHS services with referrals continuing to increase we received 1503 referrals into core CAMHS during March 2023, which was an increase of 3% on the February 2023 figure of 1462, and the highest levels seen all year. The overall number of young people awaiting an assessment or intervention has increased again during March, with a total of 4962 young people on waiting lists at end of March. Performance against the Greater Manchester 12 and 18-week access standards also remain below target at 79.51% against the 95% 12-week assessment standard and 75.32% against the 98% 18-week treatment standard. The main challenge remains within the neuro development pathway which accounts for 80% of current waiters.

As expected, the number of patients waiting for this pathway also increased due to:

1. 750 young people being transferred from Stockport Borough Council following the end of a pilot relating to the neurodevelopment pathway.
2. A data recording error which occurred in Tameside for young people awaiting the neuro development pathway and resulting incident response team corrections.
3. The cessation of a private provider across the footprint of the Trust which has led to increased caseloads as young people are not able to transition at 16/18 and therefore remain under the care and treatment of Pennine Care CAMHS services whilst an alternative offer is determined. A commissioning solution has been sourced for Oldham; however this currently remains a pressure in Bury and HMR.

Additional Investment has been agreed for 23/24, the impact of which is being worked through and Community CAMHs services are also implementing new capacity and demand management processes, which are evidence based and use lean methodology. This is anticipated to bring improvement in achievement of the 12- and 18-week performance following implementation in June. A specific update on the CAMHS waiting times has been requested and will be presented to the Performance and Finance committee within the next Quarter.

Pressures with Community Mental Health Teams continue to pose a significant challenge within the mental health system and continue to impact on waiting times, particularly in relation to waiting for allocation to a case load. As at 14.04.23, there were 343 total waiters across CMHTs, with over 60% of referrals waiting 28 days for an assessment. This includes those who are waiting reallocation to a care coordinator and those who are awaiting transfer from the Early Intervention Team. The current number of patents waiting allocation is reported at 174, with particular pressures reported in Bury at 75 and Oldham at 84. Vacancies remains the main cause along with underlying levels of investment. A piece of work is underway lead by the Network Directors for Quality to develop a detailed understanding of patients waiting for assessment and the impact on patient care and service delivery. This will include a root cause assessment and improvement plan.

Challenges also remain across Memory Assessment Services with waiting times for assessment and Diagnosis currently reporting significantly below the Greater Manchester Standards of 80% and high numbers of patients waiting for diagnosis across the Trust . During March 53% of patients received an assessment within timescale however only 4.5% received a diagnosis within timescale. Staffing Pressures and variation in service models are reported as the main causes with work taking place in individual care hubs to identify the specific locality issues , identity any investment requirements and develop improvement plans.

Our overall headcount has increased in year however vacancies and turnover levels remain high with a key risk arising in relation to more competitive salaries in other Trusts and introduction of Golden Handshake and retention payments, particularly across nursing and social workers. The resulting staffing pressures continue to impact on our bank and agency use (which remains high) and overall workforce standards for training and my yearly conversations compliance. Focus remains on reducing agency spend through the Executive led agency group and Network Operational and Performance Executive scrutiny. The current distance from agency plan has further increased to c.144%. The 2023/24 planning guidance advises agency expenditure should be no greater than 3.7% of total pay costs. This will be challenging as currently agency is c7% of total pay costs.

Month 12 has seen a further improvement in the financial position (+£1.5m) relating to the continued review of prior year provisions and accruals as well as the over achievement of non-recurrent efficiency savings from general budget underspends. The position remains subject to audit however the draft accounts are reporting a surplus, before technical adjustments, of £5.4m. The surplus position is expected to contribute to an overall break-even position for the ICB.

There has been no material movement in the release of recurrent savings; the projected shortfalls of £1.6m will be carried forward as an additional savings target into the 23/24 financial plan.

The challenges highlighted within our performance reporting correlate with our strategic risks within the Board Assurance Framework of overwhelming demand and competition for staff both of which are currently rated as 20 (significant).

2.2 Key Operating Standards – Key headlines and exceptions

Overall performance against our key operating standards during March 2023 shows little or no change with no significant improvement or deterioration in overall achievement.

In month there has been minimal variation in performance against individual metrics, except for out of area placements which continues to deteriorate.

An assessment of performance against individual metrics over the past 12 months indicates 9 standards were we have a good level of confidence that performance will be achieved, and 12 metrics where there is an ongoing risk to achievement.

- **Out of Area Placements (OAPs):** There has been a further increase in the number of nationally reportable out of area days during March 2023 taking the Qrt.4 position to 2559 days the highest levels seen for over 4 years . The main challenges continue to be both an increase in demand and pressures with delayed discharges resulting in consistently high occupancy levels .The acute care delivery group continues to oversee workstreams which aim to support improved patient flow. At system level, recovery plans are being developed to address the challenges with a commitment to working together as a system to reduce OAPs during 2023/24.

- **Talking Therapies (formerly IAPT) – access and recovery:** Our overall access numbers for 2022/23 are reported at 18162 a 22% increase on 2021/22 however 2779 below the planned trajectory for the year. Our overall 6 weeks waiting times standard continues to be just below the 75% standard at 74.60% for Qtr. 4 with Oldham and Bury localities remaining our key pressure points. Our monthly recovery standard was not achieved in March 2023, and monthly performance continues to fluctuate with inconsistent achievement seen since

April 2022. Pressures in the wider pathways also continue with the average waits for second appointments 11 weeks from 1st appointment with the % seen within 90 days at around 35% against a less than 10% standard. Funding has been secured as part of the 23/24 planning process and business cases for the allocation of the investment will be developed as part of this work. The Talking Therapies Leadership group continues to oversee our improvement plans and implementation of the recommendations from the system maturity toolkits , however given the significant improvement work required it is unlikely that significant and sustained improvement will be seen for a least 6 -12 months.

- **Waiting time for routine access to Children and Young Peoples community eating disorders:** As previously reported achievement of the 4-week access standard for routine cases continues to be a challenge due to low numbers in the data set. Overall performance has improved in the last 6 months of 22/23 with the average increasing from 86% to 91% . Additionally breach numbers remain very low and continue to be related to patient/carer choice, with overall performance well above the national average for these services and performance against the 1-week urgent referrals remaining at 100%.

- **Time to recruit:** Performance in March 23 is reported at 72 days against the 70-day standard with significant improvement seen during the last 5 months of 22/23 with the average reducing from 81 to 73 days. Whilst we are still above the 70-day standard significant work continues to improve the experience of managers and service users and feedback is collected on a monthly basis and remains overwhelmingly positive. Over the next 3-6 months focus will be on how we can streamline recruitment and sideways moves for internal candidates which will impact overall timeframes. It is expected that this improvement will continue with performance during 23/24 predicted to be in line with the 70-day standard.

- **Staff attendance:** Attendance levels improved further during March 2023 and are reported at 94.4% against our 95% standard. In addition to the ongoing internal support programmes the new toolkit developed by NHSE will be launched in May 23 .The tool requires a range of information including absence reasons, workforce demographic, staff survey results etc, analyses the data and makes recommendations on key areas of focus. The toolkit will also allow for better benchmarking and sharing good practice case studies which will inform our priorities for improvement. As a result of ongoing improvement work our workforce plan for 23/24 indicates an increase in expected attendance levels during 2023/24, in line with the 95% standard.

- **Turnover:** Turnover remains higher than the internal 10% target at 12.62% which is consistent with the average seen throughout 22/23. .Retention of staff will be a major focus in 2023/24 and as such our workforce plan indicates a reduction in overall turnover by quarter 4 2023/24 to 9%. Our internal retention group continues to meet and have developed some potential proposals to support retention of staff which will be worked up and shared with the Executive Directors for consideration.

- **My Yearly Conversation:** Overall compliance against my yearly conversation standard remains below the 85% target at 81% with no change seen in overall compliance over the last 4 months of reporting. Compliance levels continue to be a key focus of improvement within care hub, network and executive level performance meetings with additional support

is being provided by Human Resources Business Partners and improvement trajectories being developed.

- **Core and Essential skills Training:** Compliance for March 2023 has improved further to reported at 89.6% against an overall 90% standard. Work is continuing to take place to review data flows from the Learning Management System into tableau and it is predicted that once completed this will slightly improve our current reported compliance. Local monitoring of individual compliance continues to be managed through the care hub and network operational performance meetings with executive oversight at the weekly Executive Performance Huddle.

- **Mental Health Services Data Set (MHSDS) Data Quality Maturity Index (DQM**I): Our latest performance shows 85.00%, a slight deterioration from last month against the 90% standard**.** An assessment of issues has been completed and an action plan is being developed to drive forward improvements during 23/24.

- **Flu Vaccination:** Uptake of the flu vaccination is reported at 48.4% against the national 80% standard. Our final position as at the 28th February 2023 yet to be published.

Section 3 : Key Operating Standards

Integrated Performance Dashboard 31st March 2023.

Key Operating Standard	Target(22/23)	Last reported Performance	Last reporting period	Current Performance	Reporting Period	Direction from last reporting period	Monthly Trend
Duty of Candor Breaches	Zero	Zero	Feb-23	Zero	Mar-23	⟷	
Staff vaccination for COVID rates	no target	46.60%	w/c 20/2/23	43.80%	as at 14/4/23	↓	
Number of people working in the NHS who have had a 'flu vaccination (annual with monthly seasonal reporting)	90% (70%- 90% range)	46.50%	w/c 20/2/23	48.40%	as at 14/4/23	↑	
Proportion of patient safety incidents reported as resulting in harm (%)	Av 40%	38.85%	Jan-23	36.93%	Feb-23	↓	
Potential under-reporting of patient safety incidents	av. 0.2	N/A		N/A			
National Patient Safety Alerts not declared complete by deadline (Cental Alerting System (CAS))	0	Zero	Feb-23	Zero	Mar-23	⟷	
Staff recommending Care	TBC	63.80%	Qrt 3 Annual Staff survey	Not due		↑	
Friends and Family Survey- Overall Satisfaction with services	Av 86%	93%	Feb-23	95%	Mar-23	↑	
Children and young people (ages 0-17) mental health services access (number with 1+ contact)	Annual increase	15560	rolling 12 month (Feb 22 - Jan 23)	15720	rolling 12 month (Feb 22 - Jan 23)	↑	
Eating Disorders urgent seen within 1 week	95%	100.0%	rolling 12 month (Mar 22 - Feb 23)	100.0%	rolling 12 month (April 22 - Mar 23)	⟷	
Eating Disorders Routine seen within 4 weeks	95%	89.57%	rolling 12 month (Mar 22 - Feb 23)	89.18%	rolling 12 month (April 22 - Mar 23)	↓	
Number of adults and older Adults receiving 2+ contacts with core community mental health teams	Annual increase	6070	rolling 12 month (Feb 22 - Jan 23)	6050	rolling 12 month (Mar 22 - Feb 23)	↓	
Talking Therapies access (total numbers accessing services)	20941 annual	17879	rolling 12 month (Mar 22 - Feb 23)	18162	rolling 12 month (Mar 22 - Feb 23)	↑	
Talking Therapies recovery rate (%) (S082a)	50% per month	50.1%	Feb-23	49.1%	Mar-23	↓	
Talking Therapies 6 weeks access Standard	75% per qrt	73.93%	Jan - Feb 23 QRT 4	74.60%	Jan - March 23 QRT 4 primary	↑	
Talking Therapies 18 weeks Access Standard	95% per qrt	99.6%	Jan - Feb 23 QRT 4	99.3%	Jan - March 23 QRT 4 primary	⟷	
EIP - Access within 2 weeks	60% per qrt	84.6%	Jan - Feb 23 QRT 4	86.5%	Jan - March 23 QRT 4 primary	↑	
Mixed Sex accommodation breaches	0	0	Feb-23	0	Mar-23	⟷	
Inappropriate Adult acute mental Health placements - out of area placement bed days (OAPS nationally reportable)	< 300 days in qrt	1667	Jan - Feb 23 QRT 4	2559	Jan - March 23 QRT 4 primary	↑	
Adult acute mental health beds with a length of stay over 60 days - ***number of discharges in period with hospital spell of over 60 days***	TBC	31	Feb-23	35	Mar-23	↑	
Older adult acute mental health care with a length of stay over 90 days -***number of discharges in period with hospital spell of over 90 days***	TBC	13	Feb-23	17	Mar-23	↑	
Proportion discharges from hospital followed up within 72 hours	80%	81.9%	Jan - Feb 23 QRT 4	80.4%	Jan - March 23 QRT 4 primary	↓	
MHSDS Data Quality Maturity Index score	90.00%	87.40%	Nov-22	85.00%	Dec-22	↓	
Time to recruit (average number of days from authorisation on Trac to Start date in post)	70 days	71 days	Feb-23	72 days	Mar-23	↓	
WTE Vacancy rate in month	< 9.5%	14.91%	Feb 23 metric in testing	14.34%	March 3 metric in testing	↓	
% Increase in Headcount in last 12 months	TBC	10.00%	Nov 22 Metric in Testing	8.00%	March 22 Metric in Testing	↓	
Staff attendance	95%	93.4%	Feb-23	94.4%	Mar-23	↑	
Core Training Compliance	90%	88.6%	Feb-23	89.6%	Mar-23	↑	
My yearly conversation (IPDR)	85%	81.9%	Feb-23	81.0%	Mar-23	⟷	
Turnover (Rolling 12m excluding employee transfer)	< 10%	12.85%	rolling 12 month (Mar 22 - Feb 23)	12.62%	rolling 12 month (April 22 - Mar23)	↑	
Staff recommending place to work	TBC	66.00%	Qrt 3 Annual Staff survey	not due		↑	
Overall Engagment score from Pulse Survey / NHS staff survey (out of 10 , 10 being high)	TBC	7.1	Qrt3 Annual Staff Survey	not due		↑	

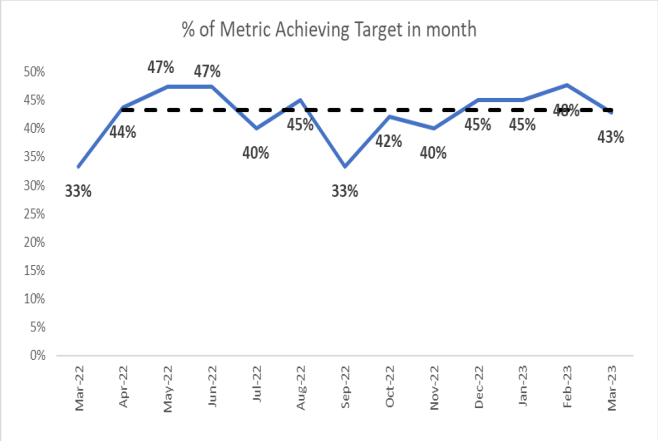
	Standard has been achieved
	Standard is on track to be achieved
	Standard has not be achieved
	Standard is not on track to be achieved
	Standard has no target or is unable to be reported

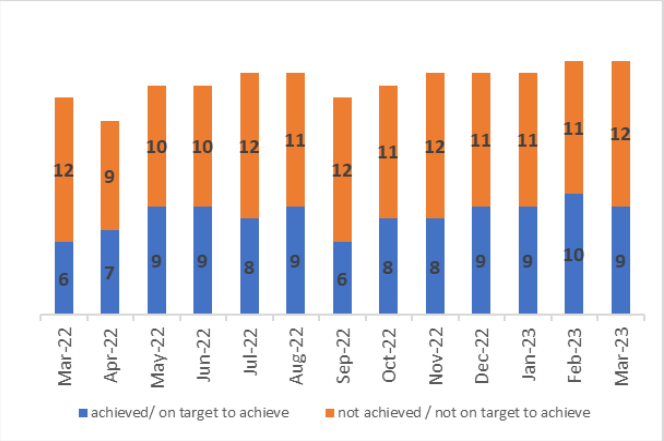
NB : The Trust uses Blue and Orange to indicate if a target has been achieved or not rather than the traditional Red and Green colour scheme. This is in line with recommendation regarding colour schemes for people who are colour blind

3.1 Key Operating standards analysis and exception reporting

Out of 32 metrics within the Integrated Performance dashboard, 28 have been reported this month with 1 under review and 3 not due this month. Of the 28 metrics reported, 7 do not currently have a specified target.

Of the 21 standards reported against a target, 9 (43%) have achieved the required target and 12 (57%) have not achieved the required standard. This takes the average in year to 43% achievement.





Overall performance against our key operating standards during March 2023 shows little or no change with no significant improvement or deterioration in overall achievement, indicating a consistent level of performance during 2022/23.

In month there has been minimal variation in performance against individual metrics, except for out of area placements which continues to deteriorate.

An assessment of performance over the past 12 months indicates:

- 9 standards where we have a good level of confidence that performance will continue to be achieved.
- 3 indicators where we are seeing fluctuating performance, however, it is still expected that the standard will be achieved within the next 3-6 months.
- 3 indicators where whilst the position has improved but it is unlikely the target will be consistently achieved in the next 3 – 6 months.
- 5 standards where the position continues to fluctuate and/or remain below standard with no improvements and therefore it remains unlikely that the standard will be achieved consistently in the next 3 – 6 months.
- 1 metric where the position continues to deteriorate with significant ongoing risks to achievement.

The following table shows the outcome of the assessment for each standard:

Consistent Achievement of Standard with achievement predicted to continue	Improving position		Fluctuating/ no improvement		Deteriorating position / significant ongoing risk to achievement
	Further improvement expected with consistent achievement predicted within the next 3-6 months	Improving position however still unlikely / unclear meet standard in next 3- 6 months	Improvement expected in next 3 – 6 months	unlikely /unclear that this standard will be consistently achieved in next 3-6 months	
9		3	3	5	1
• Eating Disorders Urgent 1 week access • Early Intervention 2-week access • Talking Therapies 18-week access • Overall Experience of care results • Duty of Candour Breaches • Central Alert System responses. • Mixed Sex accommodation breaches • 72 Hour follow up • Proportion of harm		• Talking Therapies access numbers • Talking Therapies 6-week Access • Eating Disorders routine 4-week access	• Time to Recruit • Staff attendance • Core and Essential training	• Talking Therapies recovery • My Yearly Conversation • Flu Vaccination • Turnover • Data Quality Maturity Index score	• Out of Area Placements

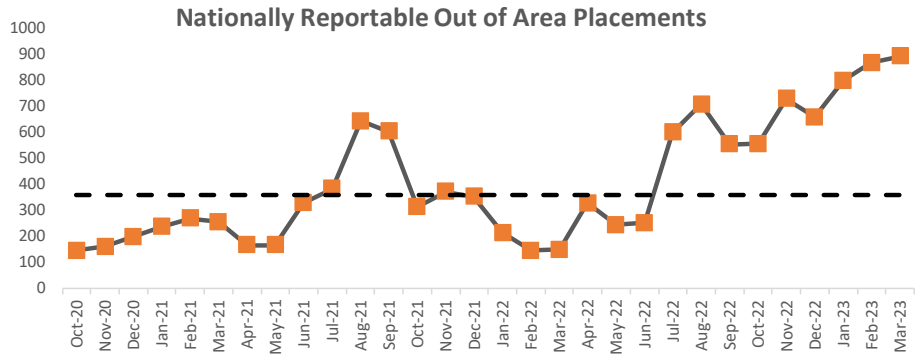
An update against the key operating standards where performance is not currently meeting the required standard is provided below.

Nationally Reportable Out of Area Placements (OAPs):
Out of Area Placements (OAPs) are associated with poor patient experience, poor clinical outcomes and high financial cost. The practice can lead to people being separated from their friends, families and support networks, disrupting the continuity of their care and potentially impeding recovery.

A nationally reportable out of area placement occurs when there are no appropriate beds available within the Trust footprint or within the Greater Manchester including beds commissioned as part of the bed bureau independent sector contracts.

The aim of the Long-Term Plan is to eliminate Inappropriate adult acute mental health Out of Area Placements whilst this still remains the overall ambition recognition of the current pressures have been acknowledged with systems now asked to work to reduce Out of Area placements and plan to eliminate as soon as possible. In line with this a revised trajectory for 23/24 is currently being developed as part of the operational plan submission.

Performance: What the chart is telling us?
The number of OAP bed days increased further in March 2023 taking the Qtr. 4 position to 2559 the highest levels seen in over 4 years This issue is reflected Nationally and across the Northwest .The national average days reports for October - December 2022 was 971 with the Trust reporting above this at 1835 moving us into the top quartile for this period. However the national picture overall showed also an increase in this period with over half of the trusts who submitted data reporting an increase in days

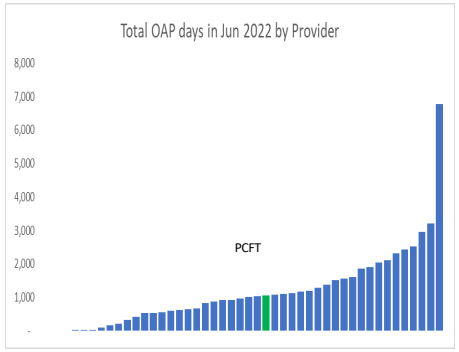


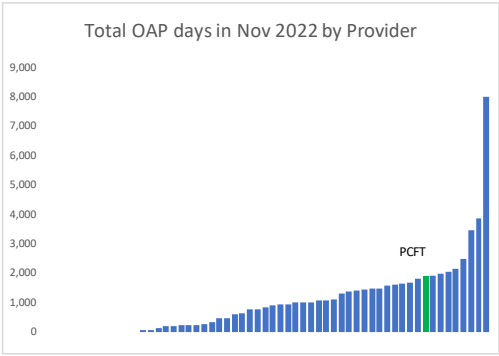
Root causes behind current performance:
There are high levels of unmet mental health need in the community, which has grown during the pandemic.
There are also significant pressures on beds in general hospitals, and delays in discharging patients from mental health inpatient settings due to a lack of social care support.
Occupancy levels have a direct link to length of stay and delayed transfers of care with the Trust running at over 100% occupancy (including leave) for several months.
The average lengths of stay over the last 12 months have also remained high, with an increase seen in recent months.
Delayed transfer of care have remained high in adult services with the main reason for delay linked to Social care/ housing and accommodation. The shortage of beds and the lack of mental health services available in the community, alongside the insufficient number of crisis mental health services are the main drivers behind There is also currently significant inequity of access to available Independent sector beds across the region.

Qtr. 3 20/21	Qtr. 4 20/21	Qtr. 1 21/22	Qtr. 2 21/22	Qtr. 3 21/222	Qtr. 4 21/22	Qtr. 1 22/23	Qtr. 2 22/23	Qtr.3 22/23	Qtr.4 22/23	Ortley Trend
504	762	663	1630	1035	509	822	1862	1944	2559	

Intervention and Planned Impact:
Internally, the improvement work around OAPs and associated factors is managed by the Acute Care Delivery group (ACDG) who oversee delivery of the acute care transformation programme. Key workstreams are in place to improve patient flow including alternatives to admission, reducing length of stays over 90 days and sustaining successful discharge schemes which aim to address the pressures as well as the additional PICU bed capacity. Recovery also ties into the Trust wide transformational change across secondary care mental health services, including core services, Primary Care Networks, urgent and emergency care

As the above workstreams begin to embed it is expected that some improvement will start to be seen during 2023/24 . A System recovery plan is also being developed as part of the operational planning process with a Integrated Care Board commitment to work with system partners and place based leads to support a reduction delayed discharges and Out of Area Placements during 23/24. Following this commitment a trajectory for reduction is currently being developed.





Talking Therapies (formerly IAPT) - Access and Recovery Standards

These standard focuses on improved access to psychological therapies, in order to address enduring unmet need. Around one in six adults in England have a common mental health disorder, such as depression or anxiety. The NHS Long Term Plan requirement for Talking Therapies (IAPT) is to increase the number of people receiving recognised support (access rates) and maintain achievement of the 6- and 18-week waiting time standards and the recovery standards.

Greater Manchester has submitted plans to achieve the 21/22 target of 98,475 people receiving IAPT recognised support ra+B15:W16ther than the 22/23 target of 101,240. The national waiting time standards states that 75% of people who have been referred to Talking Therapies service should start their treatment within 6 weeks of referral, and 95% within 18 weeks. The national recovery rate standard is that a minimum of 50% of eligible referrals should move to recovery

Our internal performance trajectories indicate PCFT contribution towards this target would be 20,941. This translates to 1,745 per month for PCFT which, based on activity during 21/22, would mean an average increase of 504 per month during 22/23.

In recognition of current pressures the national access rates have been reduced and re profiled across integrated care board for 23/24. A revised trajectory for PCFT contribution is currently being established as part of the operational plan submission.

Performance: What the chart is telling us?

Overall access levels during 22/23 are 22% higher than in 21/22 at 18162 however 2779 below the planned trajectory for the year .Our overall 6 weeks waiting times standard continues to be reported just below the 75% standard at 74.60% for Qtr. 4 with Oldham and Bury localities remaining our key pressure points. Our monthly recovery standard was not achieved in March 2023, and monthly performance continues to fluctuate with inconsistent achievement seen since April 2022. Pressures in the wider pathways also continue with the average waits for second appointments 11 weeks from 1st appointment with the % seen within 90 days at around 35% against a less than 10% standard.

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Root causes behind current performance:

Historical under investment into Talking Therapy services has led to pressures with maintaining access levels and waiting times.

Across the trust there are a number of vacant posts within the teams which is impacting on both the prevalence targets and those awaiting treatment. The services also reports high sickness levels

Workforce challenges are recognised nationally across Talking Therapy services, and a national trainee programme has been in place for a number of years. Regionally this was not fully embedded due to historic funding complexities and the ability to offer trainees permanent position due to under commissioned services.

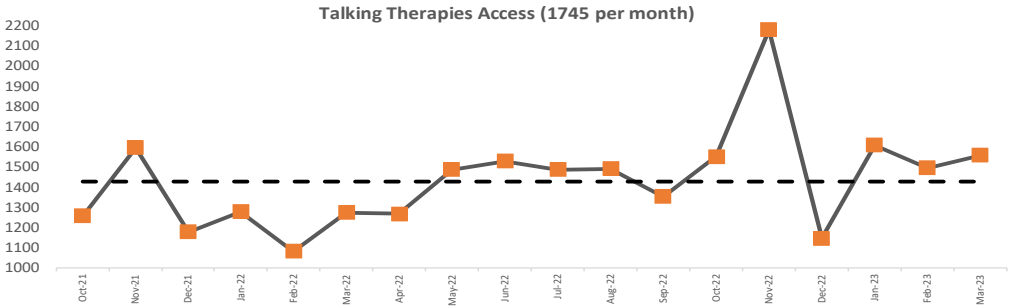
Intervention and Planned Impact:

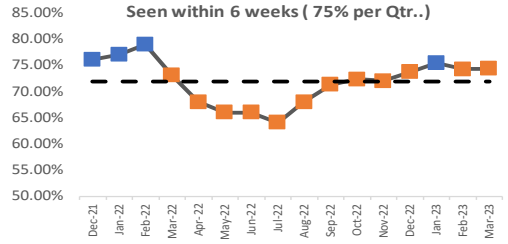
The Talking Therapies Leadership group continues to oversee the action plan

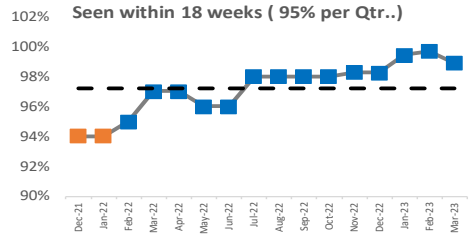
The new Clinical Lead for Talking Therapies is now in post and will be reviewing the recommendations from the recently completed System Maturity Tool with individual borough leads; this will be to enable adherence to standards, drive standardisation and equity in service delivery across the footprint, as well as identify any gaps and resources required.

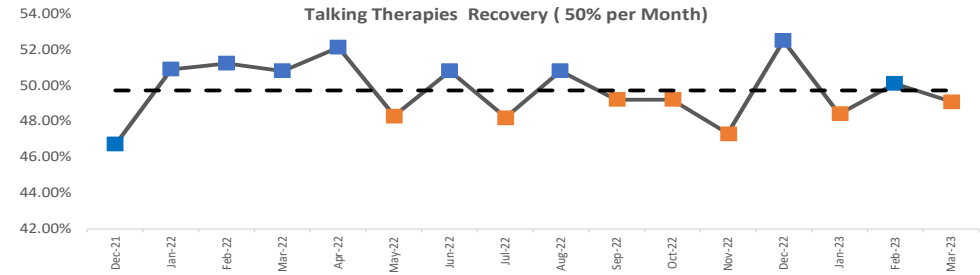
Funding has been secured as part of the 23/24 planning process and business cases for the allocation of the investment will be developed as part of this work.

Given the significant improvement work required it is unlikely that significant and sustained improvement will be seen for a least 6 months , which given the nature of the performance standard reporting will not be seen in the published performance for a least 12 - 18 months.









Staff Attendance

By monitoring the Trust attendance at work, we can review whether the Trust is supporting our workforce appropriately and where there may be areas of concerns in terms of staffing and any local issues. Higher attendance levels have been shown to suggest better staff engagement and better patient outcomes as a result. Our NHS People Plan also reflects on the need to support an inclusive and supportive culture across the NHS and Care system, to ensure that staff are retained and we identify any areas which may need any additional support in terms of staff welfare and wellbeing. Across other NHS Trusts in the North West there is an acceptance of the figure of 95% staff attendance to be reflective of achievable target for attendance level**s.**

Performance: What the chart is telling us?

Attendance levels have further improved to 94.40% against our 95% standards a slight with the overall average over the last 6 months reported at 93%.

Root causes behind current performance:

The three top causes for absence in terms of sickness are; anxiety/depression, cold/cough/flu (includes COVID) and 'other unknown causes'. with Anxiety/Stress/Depression the highest reason for sickness absence across the Trust and the number of days lost is significant.

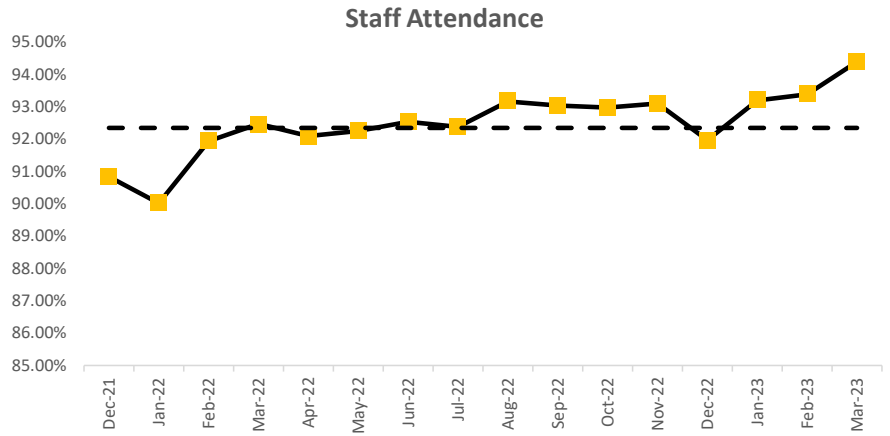
Intervention and Planned Impact:

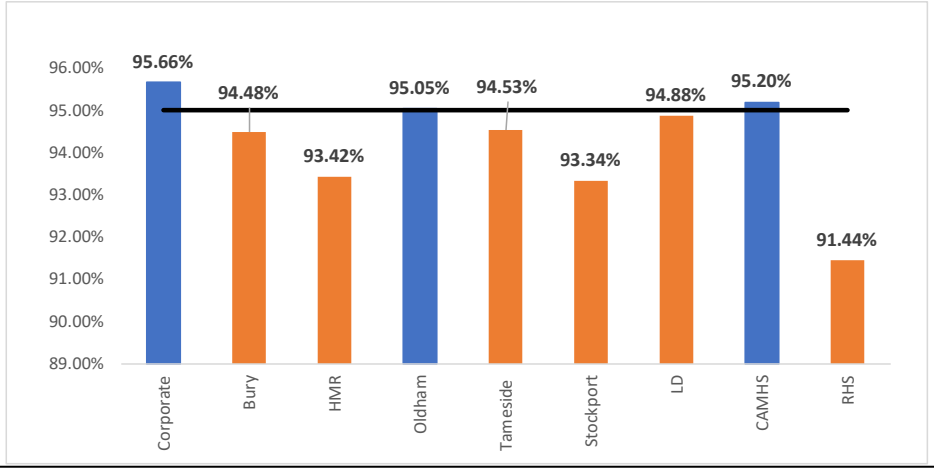
Targeted support is being provided into the Networks by the HR business partners to support improvement with staff attendance including improvement the return-to-work discussion compliance and recording of sickness absence reasons.

Whilst there is already a range of support and interventions for Anxiety/Stress/Depression available to staff and managers, there will be much greater focus on this over the next 12 months. The Deputy Director Workforce is establishing a task and finish group to review absence generally with a focus on how to address the high levels of absence due to sickness with a greater focus on spotting early signs and preventing staff going off ill.

A new toolkit developed by NHSEI will be launched in May 2023l. The tool requires a range of information including absence reasons, workforce demographic, staff survey results etc., analyses the data and makes recommendations on key areas of focus. The toolkit will also allow for better benchmarking and sharing good practice case studies.

As a result of ongoing improvement work our workforce plan for 23/24 indicates an increase in expected attendance levels during 2023/24





Core Mandatory Training Compliance : Ensuring our Staff are trained on core skills and competences is essential for providing safe services and protecting staff from harm. The UK core skills framework outlines the statutory and mandatory subjects which need to be completed as a national minimum standard. In addition to these subjects the Trust has identified 2 further subjects it wishes to monitor. Whilst individual courses have specific compliance levels set overall the Trust aims to ensure 90% compliance of all staff to be up to date with all relevant training.

Performance: What the chart is telling us?
Performance improved significantly over a number of months however since July 2022 overall compliance levels have remained around 88%.
Key areas of challenge remain Intermediate Life Support , Basic Life Support, Information Governance and Fire safety.

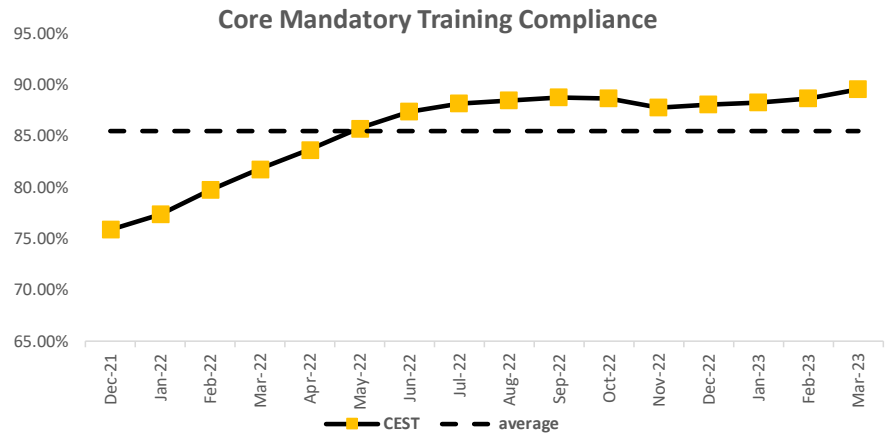
Root causes behind current performance:
key pressures in services related to both capacity and demand an impacting on time for staff to complete/ attend courses.

A review of data flows from the Learning Management System into tableau has identified a small data quality issue which is predicted will slightly improve our current reported compliance levels .

Intervention and Planned Impact:
Compliance is closely monitored both at the operational performance and finance meetings and the weekly Executive Performance huddle with a key focus on Information Governance Training and Basic Life Support training.

A range of improvement plans with targeted support are in place to support specific pressures points including national courses and or alternative options for completing online course for staff with limited access to systems

Work is taking place to update the data flows from the Learning Management System into tableau with work expected to be completed in the next 3-4 months .



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A new toolkit has been developed by NHSEI which all GM trusts are going to trial in April. The tool requires a range of information including absence reasons, workforce demographic, staff survey results etc, analyses the data and makes recommendations on key areas of focus. The toolkit will also allow for better benchmarking and sharing good practice case studies.

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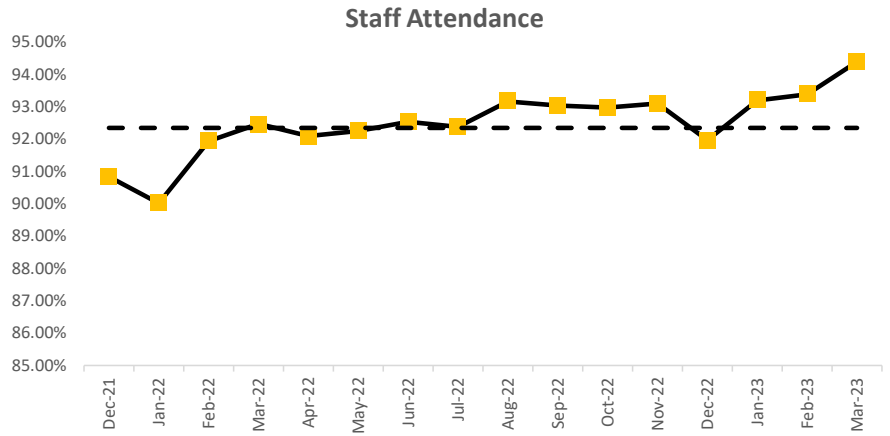
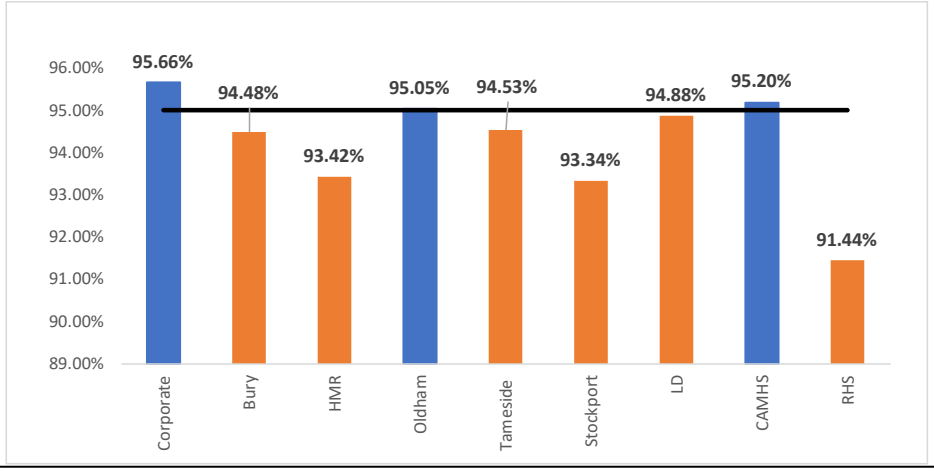




Mental Health Services Data Set : Data Quality Maturity Index (MHSDS - DQMI)

The NHS Mental Health Implementation Plan sets out the importance of improved data quality, with the Mental Health Services Data Set – Data Quality Maturity Index(MHSDS – DQMI) being a key measure of progress. It Is expected that the coverage, consistency, quality, and breadth of data submitted nationally should be on a par with physical health to accurately reflect local service activity. This will enable comprehensive analysis and monitoring to support improvements in patient care and choice.

The Data Quality Maturity Index(DQMI) is a monthly publication intended to raise the profile and significance of data quality in the NHS. The DQMI score is a data quality value index based on the completeness, validity, default values and coverage, based on a list of key data items within the Mental Health Services Data Set (MHSDS). These include NHS number, date of birth, gender, postcode, specialty, and consultant. The MHSDS DQMI score is defined as the mean of all the data item scores (for percentage valid and complete), multiplied by a coverage score for the MHSDS. The score is calculated and published monthly by NHS Digital.

All providers are expected to be achieving scores of or above 90% by 2022/23 and 95% by 2023/24 . The target is monitored monthly with performance taken as position reported in the last month of each quarter. As part of the 22/23 operational plan GM have set a target of 90% by Qtr. 4 2022/23. Our aim is to achieve the 90% target by the end of Qtr. 4 and improve further to achieve the 95% standard by the Qtr. 3 2023/24

Performance: What the chart is telling us?

Performance remains below the 90% target and whilst some improvment has been seen in year with a small step change from 84% to 87% a slight drop was seen in Dec 22, . The Trust position is above the overall national NHS Trust score of 83%.

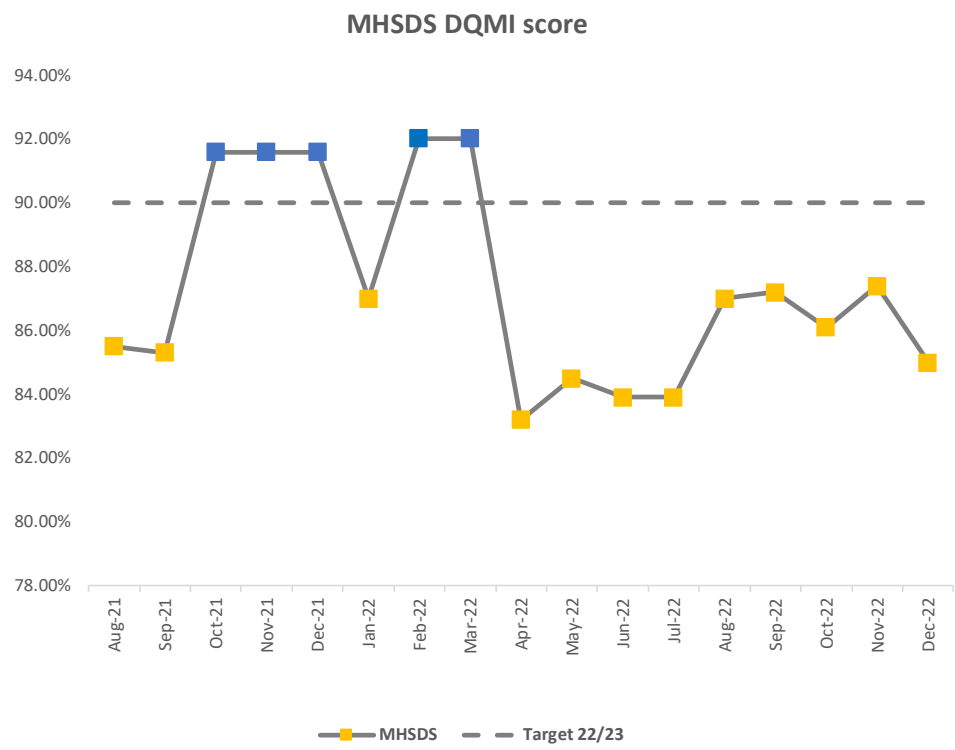
Root causes behind current performance:

An assessment has been undertaken by the Business Intelligence team to identify the issues .This as been shared at the information and data qulaity assurace group and further analsyis is now being carried out to fully understand the root causes.

Based on previous assessments it is expected that improvement will require a range of actions including development and implementation of additional specific data fields in Paris and improved recording of key data fields in Paris.

Intervention and Planned Impact:

Once the full assessment is complete a detailed action plan will be developed. This will set out clear actions and lead responsibilities and will outline a trajectory for improvement . Whilst it is now unlikely that the 90% standard will be achieved this year the overall aim will be to reach 95% by Qtr. 3 23/24.



Eating Disorders - Routine Assessment within 4 weeks

More than 1.6 million people in the UK are estimated to be directly affected by eating disorders, with Anorexia Nervosa having the highest mortality amongst psychiatric disorders. Research shows that areas with dedicated community eating disorder services (CEDS) had better identification from primary care; lower rates of admissions with non-ED generic CAMHS admitting 2.5 times those from the community ED service.

The national expectation was to deliver the referral to treatment standard by March 2021 and for the standard to be maintained throughout the NHS Long Term Plan, so that 95% of under 19s, referred with a suspected eating disorder, start treatment within:

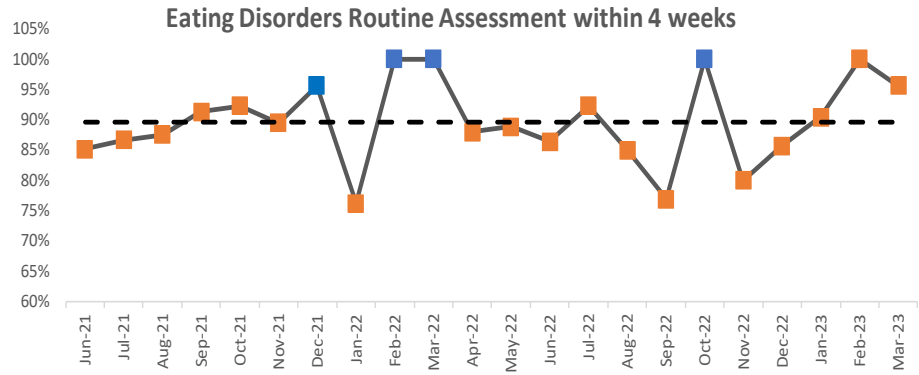
• one week for urgent cases; and

• four weeks for routine cases.

Across GM there is commitment to meet both targets of 95% with discussions taking place around current challenges to meeting the targets. The target is monitored quarterly using a 12-month rolling position.

Performance: What the chart is telling us?

Monthly performance shows an average achievement of 89% with the overall Qrtly standard of 95% not being achieved since before Qrt1 21/22. Improvement has been seen in the last 5 months and our Trust Performance remains well above the national average for this service of 68.5% (as at Qtr.2 22/23)



Root causes behind current performance:

In month Performance fluctuates due to the low numbers captured in the standard (average of 19 cases reported each month with an average of 2 breaches per month) .

Based on current average monthly demand the service would need less than 12 breaches per year in order to achieve the 95% standard. It is therefore unlikely that the 95% standard can be achieved consistently.

Breach reasons are mainly attributed to patient/ carers changing the appointments date with only 1 breach in the last 12 months reported due to service pressures/ issues.

Intervention and Planned Impact:

The service will continue to monitor breach reasons to ensure every effort is made to achieve the 4 week standard wherever possible and that waiting lists remain low.

Qtr. 2 21/22	Qtr. 3 21/222	Qtr. 4 21/22	Qtr. 1 22/23	Qtr. 2 22/23	Qtr. 3 22/23	Qtr. 4 22/23	Qrtly Trend
91.20%	90.75%	90.04%	90.48%	89.75%	88.80%	89.18%	

3.2 Executive Finance Dashboard 2021/22 – period ending 31st March 2023 (Subject to Audit)

Key Financial Indicators	FY Plan £'000	FY Actual £000	FY Var £000
Financial Performance:			
Trading (Surplus)/ Deficit before system support	11,183	4,397	(6,786)
Overall (Surplus)/ Deficit – inc. technical adjustments	0	(6,786)	(6,786)
Overall (Surplus)/ Deficit – exc. technical adjustments	0	(5,335)	(5,335)
Lead Provider Collaborative Tier 4 CAMHS	0	0	0
Cash:			
Closing cash balance	22,261	55,503	33,242
Capital:			
Capital plan (excluding IFRS 16 right of use assets)	9,569	6,230	(3,339)
Efficiency:			
Recurrent Savings	4,971	3,596	(1.375)
Non recurrent Savings	6,305	9,217	2,912
Total	**11,276**	**12,813**	**1,537**
Temporary staffing:			
Agency	5,751	14,014	8,263
Bank	11,304	14,366	3,062
Total Temporary Staff	**17,055**	**28,380**	**11,325**
Total Gross Staff costs	**191,038**	**207,240**	**16,202**
Agency as a % of gross staff costs	**3.01%**	**6.76%**	-

2023/24 Financial Planning Update:

The GM system plan was rejected by the national team and therefore a further revised plan will be submitted early May.

SUMMARY POSITION

Financial Performance: At the March year end the overall position (subject to audit) is a surplus of £6.8m, this includes a technical adjustment relating to impairments of £1.5m, resulting in a financial performance of £5.3m surplus. During quarter 4 the system recovery planning process updated the forecast outturn position to reflect a £3.9m surplus, at month 12 the actual outturn has increased to a £5.4m surplus. The increase is driven by the release of provisions following recalculation at year end, further assessment of expenditure accruals and over achievement of non-recurrent efficiency. The surplus position is expected to contribute to the overall breakeven position for the Greater Manchester Integrated Care Board.

Financial performance in relation to the Lead Provider Collaborative (LPC) for tier 4 CAMHS is reported as a separate operating segment within the accounts, the position is break-even at the end of March 2023

Cash: at the end of March cash balances are £55.5m, a reduction of £0.9m from the end of February. There has been no material movement on performance against the Better Payments Practice Code (BPPC)

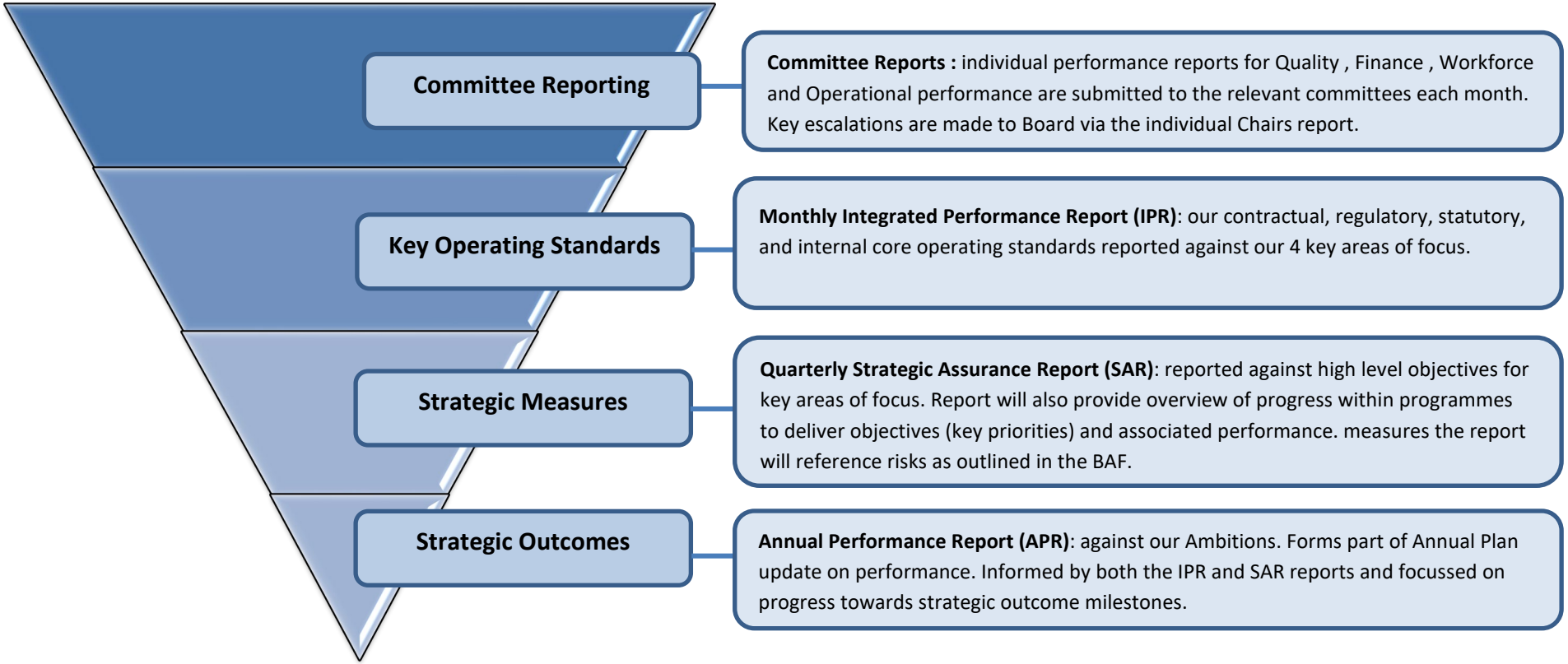
Capital: At the end of March capital expenditure is £6.2m c.65% of plan.

The full year plan includes additional PDC for: Frontline Digitisation; Health Based Place of Safety; and cyber. The outturn includes an underspend of £1.1m on PDC relating to the Health Based Place of Safety scheme. This underspend of £2.3m on internal funding has been agreed to support the GM system.

Efficiency: There has been no material movement in the release of recurrent savings. At month 12 the full £11.3m target for 2022/23 has been exceeded due to the continued achievement of non-recurrent schemes, increasing the outturn to £12.8m. The in-year recurrent figure is £3.6m, £1.4m under plan. The recurrent underachievement of c£1.6m will need to be carried forward on to the 23/24 target.

Temporary Staffing: The distance from agency plan is c144%. The rate of spend has seen no material change in the level of service provision, winter pressures or strike action. When comparing temporary staffing costs against the 2021/22 position bank has remained at a consistent level, however agency has increased by c£4m. Focus remains on reducing agency spend through the Executive led agency group and Network Operational and Performance Executive scrutiny. The 23/24 planning guidance advises agency expenditure should be no greater than 3.7% of total pay costs. This will be challenging as currently agency is c7% of total pay costs.

Appendix 1 : Strategic Performance Framework



Committee Reports : individual performance reports for Quality , Finance , Workforce and Operational performance are submitted to the relevant committees each month. Key escalations are made to Board via the individual Chairs report.

Monthly Integrated Performance Report (IPR): our contractual, regulatory, statutory, and internal core operating standards reported against our 4 key areas of focus.

Quarterly Strategic Assurance Report (SAR): reported against high level objectives for key areas of focus. Report will also provide overview of progress within programmes to deliver objectives (key priorities) and associated performance. measures the report will reference risks as outlined in the BAF.

Annual Performance Report (APR): against our Ambitions. Forms part of Annual Plan update on performance. Informed by both the IPR and SAR reports and focussed on progress towards strategic outcome milestones.

Appendix 2: Key operating Standards Directory

Ref	Area of Focus	Routine Monthly Key Operating Standard	TARGET	Target frequency	Definition	Numerator	Denominator
1	Services	Duty of Candor Breaches	0	Monthly	Number of duty of candor breaches in month	no of breaches	
2		Staff vaccination for COVID rates	TBA	Seasonal	% of staff who have had their autumn booster covid vaccination	Of the denominator, those who receive their covid vaccination.	total number of staff
3		Staff vaccination for Flu rates	90%	Seasonal	% of frontline healthcare workers (HCWs) between 1 September 2022 and 28 February 2023, *in line with the widened definition of frontline HCWs used during the 2021/22 flu season,* which includes non-clinical staff who have contact with patients. Who have received their flu vaccination in the period.	Of the denominator, those who receive their flu vaccination.	Total number of frontline healthcare workers (HCWs) between 1 September 2022 and 28 February 2023, in line with the widened definition of frontline HCWs used during the 2021/22 flu season, which includes non-clinical staff who have contact with patients.
4		Proportion of patient safety incidents reported as resulting in harm	Av 40%	Monthly	% of incidents reported which resulted in Harm	Total number of indicants reported as resulting in harm	total number of incidents reported in period
5		Potential under-reporting of patient safety incidents	Av0.2	TBC	Number of months in which data reported to NRLS or LFPSE within the most recent published six-month period based on reported dates	Number of months in which data reported to NRLS or LFPSE within the most recent published six-month period based on reported dates	Six (the most recent published six-month period based on reported dates)
6		National Patient Safety Alerts not declared complete by deadline (Central Alerting System - CAS)	0	Monthly	National Patient Safety Alerts not declared complete by deadline	Number of National Patient Safety Alerts not declared complete by deadline	N/A
7		Staff Recommending Care	TBA	Quarterly			
8		Friends and Family Survey- Overall Satisfaction with services	Av 86%	Monthly	Overall experience of service reported as good or very good in month as part of friends and family survey	Overall number of responses received	number of responses reported at good or very good.

Ref	Area of Focus	Routine Monthly Key Operating Standard	TARGET	Target frequency	Definition	Numerator	Denominator
9	services	Children and young people (ages 0-17) mental health services access (number with 1+ contact)	5% Annual Increase	Annual	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact.*(contact can include a direct contact with a patient, parent or carer (as a patient proxy) or between professionals (as indirect activity), as long as they are clinically meaningful.*	Number of CYP aged under 18 supported through NHS funded mental health with at least one contact	N/A
10		Eating Disorders urgent seen within 1 week	95%	QRTLY	The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months).	The number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within one week of referral in the reporting period (rolling 12 months).	The number of CYP with a suspected ED (urgent cases) that start treatment in the reporting period (rolling 12 months).
11		Eating Disorders Routine seen within 4 weeks	95%	QRTLY	The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months).	The number of CYP with ED (routine cases) referred with a suspected ED that start treatment within four weeks of referral in the reporting period (rolling 12 months).	The number of CYP with a suspected ED (routine cases) that start treatment in the reporting period (rolling 12 months).
12		Number of adults and older Adults receiving 2+ contacts with core community mental health teams	5% Annual Increase	Annual	Number of adults and older adults receiving at least two contacts with core community mental health services (transformed or non-transformed PCNs.)The indicator covers activity delivered through all core community mental health services as well as the new service models, where they exist. excludes IAPT and EIT activity	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses	
13		IAPT access (total numbers accessing services)	20941	Annual	Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period (count of the number of people who first attend an IAPT appointment recorded as either 'assessment and treatment' or 'treatment' in the reporting period.)	count of the number of people who first attend an IAPT appointment recorded as either 'assessment and treatment' or 'treatment' in the reporting period.	N/A
14		IAPT recovery rate	50%	QRTLY	The number of people who are moving to recovery	The number of people who are moving to recovery	Number of people who have completed treatment *minus the number of people who have completed treatment that were not at caseness at initial assessment*
15		IAPT 6 weeks	75%	QRTLY	The percentage of service users referred to an IAPT programme who wait six weeks or less from referral to entering a course of IAPT treatment*	Number of patients who complete treatment who started within 6 weeks of referral	Number of people completing treatment
16		IAPT 18 weeks	95%	QRTLY	The percentage of service users referred to an IAPT programme who wait 18 weeks or less from referral to entering a course of IAPT treatment are treated within 18 weeks of referral*	Number of patients who complete treatment who started within 18 weeks of referral	Number of people completing treatment
17		EIP - Access within 2 weeks	60%	QRTLY	The proportion of people experiencing first episode psychosis or with an ARMS (at risk mental state) with a maximum wait of two weeks from referral to the start of treatment.	The number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	The number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period.
18		Mixed Sex accommodation breaches	0	monthly	Total number of mixed sex accommodation admission breaches in period	Total number of mixed sex accommodation admission breaches in period	
19		Inappropriate Adult acute mental Health placements - out of area placement bed days (OAPS nationally reportable)	0	QRTLY	Total number of out of area bed days used in period	Total number of out of area bed days used in period	
20		Number of discharges in period with hospital spell over 60 days *(Rate per 100,000 population of people in adult acute mental health beds with a length of stay over 60 days)*	TBC	monthly	Total number of discharges from Adult acute wards in period who had a hospital spell over 60 days on discharge	Total number of discharges from Adult acute wards in period who had a hospital spell over 60 days on discharge	
21		Number of discharges in period with hospital spell over 90 days *(Rate per 100,000 population of people in older adult acute mental health care with a length of stay over 90 days)*	TBC	monthly	Total number of discharges from older people wards in period who had a hospital spell over 90 days on discharge	Total number of discharges from older people wards in period who had a hospital spell over 90 days on discharge	
22		Proportion discharges from hospital followed up within 72 hours	80%	QRTLY	Assesses compliance with the National Standard Contract: 80% of adults discharged from ICB-commissioned mental health inpatient services receive a follow-up within 72 hours.	Of the denominator number, those who have been followed up within 72 hours (commencing at 12am the day after discharge).	Number of people discharged from an ICB-commissioned adult mental health inpatient setting
23		MHSDS Data Quality Maturity Index score	90%	monthly	The DQMI score is a data quality value index based on the completeness, validity, default values and coverage, based on a list of key data items within the MHSDS. These include NHS number, date of birth, gender, postcode, specialty and consultant. The MHSDS DQMI score is defined as the mean of all the data item scores (for percentage valid and complete), multiplied by a coverage score for the MHSDS	Mental Health Services Dataset DQMI score achieved in the relevant time period	

Ref	Area of Focus	Routine Monthly Key Operating Standard	TARGET	Target frequency	Definition	Numerator	Denominator
24		Time to recruit (days from Approval to Start)	70 days	monthly	Average number of days from Approval of post to Start date for Agenda for Change staff	Average number of days from Approval of post to Start date for Agenda for Change staff	
25		WTE Vacancy rate in month	<9.5%	monthly	**current month overall staff WTE vacancies***(Current month Budget WTEs less current month contracted WTEs on General Ledger adjusted for staff employed by other organisations)* / ***Total WTE worked in month*** *(Current month worked WTEs for staff on Payroll feed into General Ledger adjusted for staff employed by other organisation*	current month overall staff WTE vacancies	Total WTE worked in month (Current month worked WTEs for staff on Payroll feed into General Ledger adjusted for staff employed by other organisation
26		WTE substantive staff in month % of all WTE staff in month	>91%	monthly	**Current month worked WTEs for substantive staff on Payro**ll *feed into General Ledger adjusted for staff employed by other organisations* **as a % of total WTE worked in month** *(total substantive/bank and agency)*	Current month worked WTEs for substantive staff on Payroll feed into General Ledger adjusted for staff employed by other organisations	Total WTE worked in month (Current month worked WTEs for staff on Payroll feed into General Ledger adjusted for staff employed by other organisation
27		Staff attendance	95%	monthly	Of the total number of staff available to work each day, number reporting sickness absence	Of the total days, the total number of days recorded on ESR as sickness absence	Total number of available staff work days on ESR in the period excluding leave
28		Core and Essential Skills Training (CEST)	90%	monthly	Total number of mandatory courses per staff and total number of staff having completed all mandatory course compliance	Total number of mandatory courses per staff that are up to date	Total number of mandatory courses per staff
29	**People**	My yearly conversation Trust wide	85%	monthly	Total number of staff and total number of staff having an in date My yearly Conversation	Of the total number of staff, the number of staff with an MYC recorded on ESR that is <= 12 months	Total number of staff - headcount excluding bank and agency staff
30		Turnover (Rolling 12m)	<10%	monthly	The 12 month rolling turnover rate of staff leaving (excluding employee transfers)	Total leavers throughout period (headcount)	Staff in post(headcount) at start of period+ staff in post at end of period / 2
31		Staff recommending place to work	QRTLY	monthly			
32	**Culture**	Overall Engagement Score	QRTLY	monthly			

Glossary of Acronyms

BLS	Basic Life Support	ILS	Intermediate Life Support
CCG	Clinical Commissioning Group	LTP	Long Term Plan
CEST	Core and Essential Skills Training	MHSDS	Mental Health Services Data Submission
CQUIN	Commissioning for Quality and Innovation	MFT	Manchester Foundation Trust
EIP	Early Intervention in Psychosis	MYC	My Yearly Conversation
EIT	Early Intervention Team	NHSI/E	NHS Improvement/England
FFT	Friends and Family Test	OAP	Out of Area Placement
FVFV	Five Year Forward View	TNA	Trainee Nurse Associates
IAPT	Improving Access to Psychological Therapies		

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Pennine Care
NHS Foundation Trust

Chair's report from a meeting of the Audit Committee held on 15 March 2023	
Paper prepared by	John Starkey, Assistant Trust Secretary
Non-Executive sponsor	Edward Vitalis, Non-Executive Director / Chair of Audit Committee
Date of report	19 April 2023
Purpose of the report and action required	The report provides a summary of the key messages arising from a meeting of the Audit Committee held on 15 March 2023.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Committee: • Received reports from Internal Audit: MIAA - Internal Audit Progress Report including update on outstanding audit recommendations. - Draft Internal Audit Plan 2023/24 Received Reports from Anti-Fraud: MIAA - Anti-fraud progress report • Received reports from External Audit: Grant Thornton - External Audit Plan for year ending 31/3/2023 • Other activities - Received updates on the accounts and preparation for the year end. - Received a key financial controls update, including waivers - Discussed Quality Accounts governance process. • Risk management governance arrangements are believed by management to be weak and immature. The Committee recommends implementing training on this area to address the leadership and cultural change required in respect of the risk management position. • Audit Committee recommends that the Trust Board considers the accounts on a going concern basis. •
Recommendation	• Board to note the report.
Where else has this report been considered and when?	N/A

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	**X**
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus	

Audit Committee: 15 March 2023
Chair's report

Pennine Care
NHS Foundation Trust

The following is a summary of the key matters discussed at Audit Committee on 15 March 2023.

Item	Highlight	Comment / action / key risks

Internal Audit (IA)	Progress report including update on outstanding audit recommendations	• Four final audit reports had been finalised, two of which were limited assurance.
		  ◦ Risk management – Core controls: The Trust's Risk management framework was going through changes at the time of the audit
		  ◦ The Ulysses system is not used consistently across the Trust and is not used to its full capability.
		  ◦ There was a lack of evidence of risk management training
		• Health and Safety
		  ◦ There were no recent examples of H&S risk assessments within Service areas as the Trust temporarily suspended completion of these during the COVID period
		  ◦ There was no independent management forum for review of the risk management data managed by the teams to ensure they were consistent and comply with the Trust framework requirements.
		  ◦ The Health & Safety Committee meetings did not consistently meet quorum requirements, there was inconsistent reporting of significant risks at the time of the audit and inadequate review and update of the Health & Safety audit programme to the Committee.
		
		The report included a breakdown of outstanding/partially implemented internal audit recommendations: -
		▪ 12 actions previously raised had been closed since the previous meeting.
		▪ next follow-up would be in June, to allow a new action management process to embed

	Internal Audit Plan 2023/2024 (Draft)	• The Committee received the draft plan which highlighted the risks that had been assessed in formulating the plan and detailed the proposed reviews and scope and how they linked to the Board Assurance Framework risks • Committee members noted safer staffing was an area of concern that may need to be considered as this posed a higher risk.

Item	Highlight	Comment / action / key risks
Anti-fraud (AF)	Anti-fraud progress report Dec 2022 – Mar 2023	• The Committee received a report outlining one referral query received during the reporting period which concerned time sheets and this was returned to HR for further information. One case was closed due to CPS advising not in the public interest to prosecute and an interview under caution was due to take place on 13/03/23. • Committee sought assurance that the level of fraud prevention checks within PCFT were at a level that could be expected this was confirmed to be the case.
Annual report and accounts	Accounts and preparation for year end	• The Committee were informed of changes in accounting policies, including the long-expected updated provisions for leases following the transition to IFRS 16 on 01/04/2022. • The Audit Committee, on behalf of the Trust Board, considered any specific events, conditions or factors that individually or collectively, might cast significant doubt on the going concern assumption and received and discussed the report and confirmed they were happy to proceed on that basis.
External Audit	External audit plan	• The Committee received the plan for the year ending 31/03/2023, highlighting the levels determined for materiality and triviality. • There was no change in audit fees for the year. • Value for Money work would be conducted by Grant Thornton's specialist value for money team and reporting was planned on this before the end of July 2023.
Other activities	Key financial controls update including waivers	• The Committee received a report providing assurance on key financial processes impacting financial management and control. • One avoidable waiver was raised during the period and 5 special losses/compensation payments were made in 2022/23
	Quality Account governance process	• The Committee discussed process noting progress made ensuring governance processes were in place to meet deadlines
Items for escalation to Board		• Risk management governance arrangements are believed by management to be weak and immature. The Committee recommends implementing training on this area to address the leadership and cultural change required in respect of the risk management position • The Audit Committee recommends that the Trust Board considers the accounts on a going concern basis.

Edward Vitalis, Non-Executive Director / Chair of Audit Committee 19 April 2023

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Pennine Care
NHS Foundation Trust

Chair's report from a meeting of the Audit Committee held on 26 April 2023	
Paper prepared by	John Starkey, Assistant Trust Secretary
Non-Executive sponsor	Edward Vitalis, Non-Executive Director / Chair of Audit Committee
Date of report	26 April 2023
Purpose of the report and action required	The report provides a summary of the key messages arising from a meeting of the Audit Committee held on 26 April 2023.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Committee: • Received reports from Internal Audit: MIAA - Internal Audit Progress Report including update on outstanding audit recommendations. - Final Internal Audit Plan 2023/24 Received Reports from Anti-Fraud: MIAA - Anti-fraud plan 2023/24 - Anti-fraud Annual Report 2022/23 • Received an update on external Audit progress: Grant Thornton • Other activities - Reviewed the draft unaudited accounts - Received a report from the External auditor on informing the audit risk assessment management responses - Received information needed to make the going concern assessment • Audit Committee recommends that the Trust Board considers the accounts on a going concern basis. • Committee noted some of the areas reflected in the internal audit reports were discussed in depth at Quality Committee 25 April 2023
Recommendation	• Board to note; - Internal audit opinion of "moderate" - Results of quality spot check and cyber controls audits - Audit Committee approval of draft accounts
Where else has this report been considered and when?	N/A

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	**X**
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus	

Audit Committee: 26 April 2023
Chair's report

Pennine Care
NHS Foundation Trust

The following is a summary of the key matters discussed at Audit Committee on 26 April 2023.

Item	Highlight	Comment / action / key risks
Annual report and accounts 2022/23	Accounts and preparation for year end	• The Committee reviewed the draft unaudited accounts, praised the work done by the Finance team to meet timescales and approved the draft for submission. • Committee received the informing the risk assessment management responses report • Audit Committee, on behalf of the Trust Board, approved the assessment of the accounts as meeting going concern requirements
External Audit (Grant Thornton)	External audit progress	• The Committee noted progress on statutory external audit and the Value for Money assessment
Internal Audit (MIAA)	Progress report including update on outstanding audit recommendations	• Two final audit reports had been finalised, both of which were limited assurance. ○ Quality spot checks ○ Ligature – Management of ligature knives did not meet ligature policy requirements ○ Seclusion - Interviews with staff at Arden and Norbury wards revealed potential non-compliance with the Mental health code of practice in relation to Seclusion ○ Violence & aggression - Interviews with staff across the wards highlighted improvements were needed in the recording of incidents ○ Cyber organisational controls ○ Third party contract management policies required updating ○ A number of governance policies required updating ○ Cyber incident management plan required updating and approval ○ A number of documented procedures required updating The Committee recommended that findings were shared with other Board sub-committees to alert them to findings relevant to their areas of scope
Internal Audit (MIAA)	Internal Audit Plan 2023/2024 (Final)	Audit Committee approved the plan

Item	Highlight	Comment / action / key risks
Internal Audit (MIAA)	Head of Internal Audit opinion	• A Moderate assurance opinion was provided, based on 11 final reports. Committee viewed this as a fair assessment, given the proactive use of internal audit to focus on those areas where the Executive team felt there was scope for improvement.
Anti-fraud (AF)	Anti-fraud plan 2023/24	• The Committee received and approved the plan for 2023/24
Anti-fraud (AF)	Anti-fraud Annual report 2022/23	• Committee received the annual report
Other activities	Board Assurance Framework	• The Committee received a report covering the Board Assurance Framework 'BAF', the Risk Management Policy and planned training
Items for escalation to Board		• The Head of Internal Audit provided a "Moderate" assurance opinion which was felt by the Committee to be a fair assessment. • Results of recent internal audit reports covering quality spot checks and cyber controls to be referred to the Quality Committee and Performance and Finance Committee • The Audit Committee approved the draft accounts for submission to NHSE on a going concern basis.

Edward Vitalis, Non-Executive Director / Chair of Audit Committee 26 April 2023

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Pennine Care
NHS Foundation Trust

Chair's report from a meeting of the Performance and Finance Committee held on 29 March 2023	
Paper prepared by	John Starkey, Assistant Trust Secretary
Non-Executive sponsor	Daniel Benjamin, Non-Executive Director / Chair of Performance & Finance Committee
Date of report	11 April 2023
Purpose of the report and action required	The report provides a summary of the key messages arising from a meeting of the Performance and Finance Committee held on 29 March 2023.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Committee received reports and updates on the following areas: • Board Assurance Framework risks: - Well-led recommendations and actions (Deloitte) - Finance, Operational and Partnerships risks and mitigations • Performance reporting, including: - Operational performance report: February 2023 - Finance report: M11 February 2023 - Estates report • Strategy - Annual planning – annual plan process including Finance • Other reports - Financial systems - replacement - Health and Safety report – priorities Key issues: • Trust Board should note the financial position faced by the Trust for the year 2023-2024 • There is a risk to Pennine Care around what will be assessed as being permitted expenditure under the money provided under the Mental Health Investment Standard • There is pressure on the Trust's capital plan • Trust Board is asked to note the position re: The Meadows and also any potential financial impact the various outcomes could have.
Recommendation	To note the report and key issues
Where else has this report been considered and when?	N/A

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	**X**
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus	**X**

Performance and Finance Committee: 29 March 2023
Chair's report

Pennine Care
NHS Foundation Trust

The following is a summary of key matters discussed at the Performance and Finance Committee ("P&FC") meeting on 29 March 2023. I was assured that within the matters discussed, there was work ongoing or planned in each area. The minutes will be produced in due course.

Item	Highlight	Comment / action / key risks
Finance	• Presentation of Finance report – M11 February 2023	• The Committee received a report providing an update on the financial performance for the month ending 28th February 2023. • Key points were: - The financial performance has continued to improve in month 11, with a year to date surplus of £4.0m against a forecast out-turn of £3.9m - The in-month position was higher than expected largely due to finalisation of income with ICB's and over-achievement of non-recurrent efficiency savings - Capital was forecast to be underspent by £1.5m, with the underspend supporting delivery of the CDEL target at system level - Year to date expenditure on agency staff was 7.07% of total staffing, with national planning guidance expecting overall system plans to be no greater than 3.7%
Board Assurance Framework	• Finance, Operational and Partnerships risks and mitigations.	• The Committee received an update on the progress made in mitigating BAF Risks 2, 3, 5 and 6 • Members received and reviewed an update on progress made in actioning the agreed recommendations of the autumn 2022 Well Led review by Deloitte LLP. Target completion date is end April 202
Performance reporting	• Presentation of February 2023 operational performance report.	• The Committee received and discussed the report. Key points were: **IAPT:** waiting times decreased in February from referral to first appointment. There was sustained good performance against the 18-week standard **72-hour follow-up** standard was being met consistently **Memory Assessment Services:** There were continued challenges in performance across both standards, with diagnostic and trajectory plans continuing to understand pressures and support improvements **Clinically Ready for Discharge Definitions** were implemented for adult acute / older people's wards **CAMHS:** February saw the highest number of referrals over the last 12 months, with an increase of more than 200 on January figures **Learning Disability targets**: There was an improvement in the number of people seen within the LD internal 8-week 'waited' target **Core and Essential Training:** continued increase in overall compliance during Februar
	• Estates report	• The Committee received and discussed the report. Key points being: - Overview of actions on key recommendations from a recent ligature survey across Trust wards - Meetings with Northern Care Alliance to develop land to "grow your own" and install wind turbines - Implementation of National Standards of Cleaning and a review of Trust-wide taxi management - An update on sustainability and Net Zero governance and training, including an upcoming forensic audit of all utility bills from previous years.

Item	Highlight	Comment / action / key risks
		- Updates on recent changes in leases and capital developments, including an update on the latest position with The Meadows
Strategy	• Annual plan process and content including Finance	• The Committee received a presentation on the Annual Plan timetable and process. Highlights included: - 2023/24 Draft Financial Plan at March 2023 - Data showing the underlying system deficit movement across GM annually, since 2019 - Commentary on the 2023/24 indicative final plan - Continuing recurrent efficiency - The 2023/24 cross-GM system Capital plan, noting that, currently, the CDEL envelope does not cover the depreciation generated by all the provider organisations - PCFT's proposed 5-year capital programme - An update on the Operational plan that was submitted to GM on 16th March 2023, highlighting that the OAPs trajectory had been revised to reflect the continued increase in OAPS seen over past 2 months. - Improvement in forecast full year recurrent efficiency for 22/23 =-£0.8m - Forecast higher levels of inflationary costs in 23/24 = +£1.4m - Ongoing work with ICS in relation to full year impact of investment decisions = +£5.9m - Indicative Integrated Care Board position – deficit of c£700m - There is a risk that GM is unable to balance its books, which could threaten the amount of capital available to Pennine Care next year. - There is a risk to Pennine Care around what will be assessed as being permitted expenditure under the money provided under the Mental Health Investment Standard - Final financial plan submission date to NHSE/I is 30th March 2023 but the plan will need to be presented to GM prior to this date. The Board will be asked to delegate authority to the Chair, Chief Executive, Director of Finance and Chair of P&FC for the Trust's submission.
Other reports/ discussions	• Financial systems	• The Committee received the high-level plan for the replacement of the finance system which is due to expire in September 2024. The team has engaged the support of UHY Consultancy to support the procurement. • The Committee noted the plan and the intention to bring a business case for approval to PFC in May 2023.
	• Health and Safety report	• The Committee received a report highlighting work continued to triangulate reporting across the Trust and priorities were; Training, creating a single framework for monitoring compliance with required actions, a dashboard and an annual report.
	• Terms of Reference	- The Committee reviewed the Terms of Reference

Thanks were conveyed to all attendees for their contributions in meeting and work associated with preparation for the meeting.

Daniel Benjamin, Non-Executive Director/Chair of Performance & Finance Committee 21 April 2023

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Pennine Care
NHS Foundation Trust

Chair's report from a meeting of the Performance and Finance Committee held on 26 April	
Paper prepared by	John Starkey, Assistant Trust Secretary
Non-Executive sponsor	Daniel Benjamin, Non-Executive Director / Chair of Performance & Finance Committee
Date of report	26 April 2023
Purpose of the report and action required	The report provides a summary of the key messages arising from a meeting of the Performance and Finance Committee held on 26 April 2023.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Committee received reports and updates on the following areas: • Board Assurance Framework risks: - Well-led recommendations and actions (Deloitte) - Overwhelming demand, Major incident, Loss of stakeholder support and Lack of financial sustainability risks and mitigations • Performance reporting, including: - Operational performance report: March 2023 - Out of Area placement report - Finance report: M12 March 2023 • Strategy - Annual planning – annual plan process including Finance • Other reports - Review of delivery of digital strategy milestones - Information Governance and DPO update - Health and Safety vs NHS workplace standards report Key issues: • Trust Board should note the financial position faced by the Trust for the year 2023-2024
Recommendation	To note the report and key issues
Where else has this report been considered and when?	N/A

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	**X**
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus	**X**

Performance and Finance Committee: 26 April 2023
Chair's report

Pennine Care
NHS Foundation Trust

The following is a summary of key matters discussed at the Performance and Finance Committee ("P&FC") meeting on 26 April 2023. I was assured that within the matters discussed, there was work ongoing or planned in each area. The minutes will be produced in due course.

Item	Highlight	Comment / action / key risks
Finance	• Presentation of Finance report – M12 March 2023	• The Committee received a report providing an update on the financial performance for the month ending 31st March 2023. • Key points were: - The financial performance has continued to improve in month 12, with a year to date surplus of £5.4m against a forecast out-turn of £3.9m - The increase is driven by the release of provisions following recalculation at year end, further assessment of expenditure accruals and over achievement of non-recurrent efficiency. The surplus position is expected to contribute to the overall breakeven position for the Greater Manchester Integrated Care Board - at the end of March cash balances are £55.5m, this is an increase of £6.4m since April 2022. The movement is primarily due to capital spend being lower than planned (£3.3m) along with the surplus - generated - Capital expenditure (excluding other schemes – IFRS 16 leases and PFI capital charges) to the end of March is £3.6m, £2.25m (46%) below the plan - Temporary Staffing: The distance from agency plan is c144%
Board Assurance Framework	• Finance, Operational and Partnerships risks and mitigations.	• The Committee received an update on the progress made in mitigating BAF Risks 2, 3, 5 and 6 • Members received and reviewed an update on progress made in actioning the agreed recommendations of the autumn 2022 Well Led review by Deloitte LLP.
Performance reporting	• Presentation of March 2023 operational performance report and out of area placements - position update	• The Committee received and discussed the report. Key points were: **IAPT:** system maturity toolkit has now been completed for all areas **CMHT:** pressures continue to cause a significant challenge **Memory Assessment Services:** There were continued challenges in performance **Bed occupancy:** remains high within inpatient settings **OAPS:** increased during March **CAMHS:** Referrals into core CAMHS have increased and numbers waiting over 18 weeks have increased The Committee discussed recent press coverage of whistleblowing at The Priory and noted some of PCFT's patients receive care from The Priory Committee requested more information to be brought to Committee in July; - a deep-dive into CAMHS waiting times to establish geographical variations - more information around the cohort of potentially untriaged patients with autism

Item	Highlight	Comment / action / key risks
	• Review of delivery of Digital Strategy milestones	• The Committee received and discussed the report. Key points being: - challenges with the recruitment of suitably skilled staff - risks arising from the increased cyber threat from phishing - ongoing challenge of securing funding to deliver the strategy
Strategy	• Annual plan process and content including Finance	• The Committee received an update on the Annual Plan timetable and process. Highlights included: - following rejection of the final submission by NHSE on 30 March this revised paper provided the detail of the resubmission due on 4 May 2023. - negotiations were continuing on a final 'accepted' position for the Greater Manchester ICS - Committee approved the resubmission of the 2023/24 Financial Plan with a deficit position of £1.8m
Other reports/ discussions	• Information Governance and Data Protection Officer update	• The Committee received a summary of the status of the Trust's Data Security and Protection Toolkit, and assurance / risk escalation from the latest IGAG meeting. - Committee requested risks highlighted in the report and also recent internal audit findings within these areas were incorporated into the BAF
	• Health and Safety Self assessment vs NHS workplace standards	• The Committee received a report highlighting the current staffing model and those areas of work being prioritised; training, creating a single framework for monitoring compliance with required actions, a dashboard and an annual report.
	• Board Assurance Framework	- The Committee received an update on the progress made in mitigating BAFs associated with the committee - Members received and reviewed an update on progress made in actioning the agreed recommendations of the Autumn 2022 Well Led review by Deloitte LLP

Thanks were conveyed to all attendees for their contributions in meeting and work associated with preparation for the meeting.

Daniel Benjamin, Non-Executive Director/Chair of Performance & Finance Committee 26 April 2023

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Pennine Care
NHS Foundation Trust

Chair's report from a meeting of the People and Workforce Committee held on 28 March 2023	
Paper prepared by	John Starkey, Assistant Trust Secretary
Non-Executive sponsor	Liz Allen, Non-Executive Director/Chair of People and Workforce Committee
Date of report	24 April 2023
Purpose of the report and action required	The purpose of this report is to provide an overview of the main items of business conducted at a meeting of the People and Workforce Committee held on 28 March 2023.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Committee held discussions on the following areas: • **Well Led** - Board Assurance Framework update (People & Culture) - Well-led recommendations and actions (Deloittes) • **People and Workforce Strategy** - People Plan and strategy action plan update • **People and Workforce reporting** - Workforce dashboard: February 2023 - Employee relations / Gender pay gap / Staff survey 2022 / Guardian of safe working • **Equality, diversity and inclusion (EDI)** - Programme Report • Overview of current workstreams: ➢ **Effective and sustainable workforce** - Programme report ➢ **Capable and skilled staff** - Programme Report ➢ **Effective leadership** - Programme Report ➢ **Staff health, wellbeing, and engagement** - Programme Report and Quarterly focus on staff wellbeing • Industrial action planning update
Recommendation	The Board is asked to note the contents of the report.
Where else has this report been considered and when?	N/A

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	X
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus	

People and Workforce Committee (P&WC): 28 March 2023
Chair's report
Summary of the key matters discussed at the People and Workforce Committee held on 28 March 2023.

Pennine Care
NHS Foundation Trust

Item	Highlight	Comment / action / key risks
People and Workforce Strategy		
Board Assurance Framework	People and Culture risks update Deloitte LP Well led review	• The December 2022 Board meeting assigned a responsibility to this Committee for scrutinising assurance over controls to mitigate this risk. A paper was presented that provided the latest position and the Committee scrutinised the assurance provided. • Members received and discussed at some depth an update on progress made in actioning the agreed recommendations of the autumn 2022 Well Led review by Deloitte LLP.
People and Workforce Strategy		
People Plan and strategy	Update on progress/ key achievements	• The Committee noted that good progress had been made against the People Plan delivery plan. It was on track to meet our ambitions and notable achievements set out against the four domains of the strategy were highlighted. A small number of actions were delayed due to resource/capacity issues, and some had a financial risk due to non-recurrent funding expiring.
People and Workforce Reporting		
Integrated Performance report / Workforce dashboard: February 2023	Overview of key workforce metrics.	▪ The Committee noted a reduction in time to recruitment and an increase in management and candidate satisfaction with the process. ▪ Absence has fallen slightly since last month and over the next 12 months there will be greater focus on prevention. ▪ Turnover remains at 12% ▪ My yearly conversation is below the 85% target and work is underway to address this.
Staff Survey results 2022	Key highlights	• Survey responses of 47% are 11% increase compared to previous 12 months. Highest response rate for NW MH/LDA trusts. • 5 key themes above peer average, 3 average and 1 below peer average • Most improved MH Trust on question `I would recommend the Trust as a place to work' with 7% increase - 79% agree that patients / service users are our top priority – an increase of 6% and above average - 66% would recommend us as a place to work – an increase of 7% and above average - 60% of colleagues say we act fairly in respect of career progression against a number of protected characteristics – an increase of 5% and just below average • 76% agree that we respect individual differences – an increase of 6.5% and above average - Improvements in colleagues feeling safe to speak up and confident that something would be done - both above average
Employee relations dashboard	Overview of activity	The report highlighted; • Disciplinary cases main causes are staff falling asleep on duty and verbal/physical abuse of patients

Item	Highlight	Comment / action / key risks
		• There remains a disproportionality of black, Asian and minority ethnic staff being taken through the disciplinary process, which continues to be explored. • There has been significant reduction in the time it is taking to complete disciplinary cases. • There are no particular themes across Early Resolution or Dignity at Work cases. • There is a higher than expected number of Employment Tribunals and greater governance is being put in place to address this.
Gender pay gap	Overview of activity	Headline figures March 2022: • 79% women and 21% men • Mean gender pay gap of 11.55% (compared to 11.32% in 2021 • Median gender pay gap of 2.39% (compared to 2.77% in 2021).
Equality, diversity and inclusion (EDI)		
EDI programme report	Progress update on workstreams	• **Oldham Community Group Project:** There is a follow up to previous sessions with the women's group run by the Chair on 29th April and there is an engagement session planned to engage the community on the EDI strategy in May which will be supported by the Workforce team. • **Military Vets:** Dedicated project team in place. Recruitment is underway to the paid involvement post. Design workshop planned in April with NCCMH and PCFT women's project to help plan our focused listening groups Since sharing the work of the project with key stakeholders we have seen an increase in women Veterans in treatment with the service from 5% to 12% – the service will continue to monitor to ensure reach is maintained/increased • **Trans**: The project lead has engaged with a number of stakeholders including the parent of a child who went through CAMHS, a young adult who chose to go down a private route and a former service user. Key themes to date: Delays in appropriate referrals, using incorrect pronouns and dead names – linked to issues with PARIS, difficulty accessing services or how to navigate the system. It has also been recognised there is a real lack of understanding of trans issues within CAMHS teams, an initial training session has been delivered and a training plan now needs to be developed • **Staff Networks:** • a staff networks awareness week is being planned for May • a survey is going out to all current network members to understand their experience • we have now appointed to the Band 3 administrator and Band 6 Project Officer (both starting in April) and the interviews for the Head of EDI post are currently underway • planning is now underway for the year 2 roll out of the anti racist survey which is likely to be late May
Delivery plan outcome one: effective and sustainable workforce		
Programme report	Progress update	• **Key achievements** •An assessment centre for trainee healthcare support workers (THCSWs) was held in January and included verbal reasoning and computer skills assessment. This aided decision-making regarding which candidates were successful. 21 candidates attended, 11 were successful and are going through employment checks. • First cohort of THCSWs commenced their apprenticeship programme

Item	Highlight	Comment / action / key risks
		• Penultimate session with service users and carers held to finalise the induction programme for future THCSW cohorts. Extremely positive and productive session. Final session to be held in Sept/Oct when first evaluation of whole programme is undertaken • Internal recruitment and external events supported by the education & workforce development team. Lots of interest in the support worker roles • Working with GM Integrated Care System on the care leaver pathfinder project • Currently there are 302 supervisors and 426 assessors for pre-registration learners across the trust • In February 2023 we supported a total of 205 learners in practice for a total of 7,687.5 hours • Widening Participation Facilitator supported apprenticeship week and careers week • Increased tariff funding received for increased learner hours supported has enabled recruitment of additional practice education facilitator time • Successful recruitment events for targeted services such as CAMHS and IAPT, as well as general roles targeting local communities • **Progress due but not achieved** • Identified that the level 2 clinical support worker apprenticeship standard is for staff working in adult services only. This is impacting the trainee HCSWs we have who are deployed within CAMHS. We have contacted IFATE to see if the apprentice standard can be made more generic to include children's support workers as well as adult support workers as the underlying knowledge skills and behaviours required are common to both. We are in discussion with Health Education England and other GM organisations to determine if there is sufficient interest to run a GM cohort for children's support workers • Fulfilment of vacancies in key areas and reduction of establishment gap in substantive workers. Work is ongoing with FBPs and HRBPs on a weekly basis to understand picture for each Care Hub and reconcile • Retention strategy refresh is being moved with operational support via OMT meeting in terms of quick wins and benchmarking work against other Trusts • **Live issues/ escalations/ hot spot areas** • Continued requests from universities to take additional learners and to increase our capacity further • Need to ensure that trainee HCSWs within CAMHS can progress to a Band 3 in-line with their adult support worker counterparts • Turnover of staffing is currently at 13.48% in last rolling 12 month period. 16.9% of leavers within our clinical staff groups are voluntary resignations • **Recommendation** • When new Practice Education Facilitators in post facilitate additional long arm assessment to increase Capacity

Item	Highlight	Comment / action / key risks
Delivery plan outcome two: capable and skilled staff		
Programme report	Overview of current workstreams	• **Key achievements** • Physical health matrix disseminated to operational managers to determine numbers of staff requiring each level of physical health training. • 13 staff enrolled in functional skills this month (9 on L2 Maths and 4 on L2 English) • 10 apprentice starts in February 2023 with a total of 122 apprentices currently on programme • Two nursing associate facilitators were recruited using funding from Health Education England (HEE) to support trainee nursing associates • 12 preceptees completed their preceptorship programme in February and a further 7 were enrolled on programme. There are currently 108 preceptees on programme and we have 216 preceptors to support them across the Trust. • In February 2023, 18 people commenced their care certificate (CC) training and 22 completed it. There are currently 162 staff undertaking their CC and of those 53 are outside the expected 12-week completion timeframe. The trust currently has 302 staff able to assess the CC • April 2022 to end Feb 2023 there were 1463 attendees at in-house and externally commissioned training and 275 did not attends • Current spend to date from HEE funding of 370K is 362KS • **Progress due but not achieved** • Mental Health demand scoping for training needs underway. Deadline for return to HEE is 18 March. No returns received from managers as yet. Chaser email sent • **Potential risks to delivery** • Unable to meet requirements of preceptorship quality mark at present until new CPD Manager in post and policy refreshed to ensure it meets national requirements • Unclear yet what HEE funding will be available for workforce upskilling in coming financial year. • **Live issues/ escalations/ hot spot areas** • On the third round of interviews, a new Continuing Professional Development (CPD) Manager has been offered the post. Awaiting pre-employment checks • Currently no preceptorship lead as the CPD manager post is vacant • Meeting organised to understand requirements of self-assessment to gain national preceptorship quality mark
Delivery plan outcome three: effective leadership		
Programme report	Progress update	• **Key achievements** • Expectations of line manager document being developed to highlight roles & responsibilities, signpost to further support and to be used as part of supervision for managers • Trust values and expected behaviours integrated into new management induction • Proposal for compassionate leadership mandatory programme due to start in April • Resources on the Managers area of the intranet to support Mangers and leaders with links and guidance • Supporting with bespoke band 5 & 6 development programme for clinical staff • Staff survey data for themes linked to leadership show positive progress, however, also identifies some areas for growth with bank staff • **Progress due but not achieved** • Overall attendance on certain managers and leadership training is low, with high level of no shows

Item	Highlight	Comment / action / key risks
		• **Potential risks to delivery** • Transactional videos on systems have been identified by managers as something that would be valued and useful. Identifying subject experts to create these has been challenging
Delivery plan outcome four: staff health, wellbeing and engagement		
Programme report	Progress update	• **Key achievements** • Schwartz rounds steering group being re-launched • Staff survey data indicates positive movement from last year on all people promise themes • Work is underway with the Resilience Hub to improve the support to staff post incidents • Proposal for options for additional funding for staff hardship funds being developed • Digital support team are now attending trust welcome to promote their service (including digital hubs) • Training for mediators taking place at the end of the month, recruitment for mediators has targeted under-represented groups • Career management bite sized sessions launched for all staff to attend, targeting under-represented groups • Monthly wellbeing events scheduled include neurodiversity awareness & session for mental health awareness week • Over 50 leaders trained in use of TED tool - engagement plan developed • Project underway refreshing & updating new starter induction & onboarding process • **Progress due but not achieved** • TED tool - those actively involved in delivering TED surveys and using the toolkit is minimal. As a result, drop-in support sessions and catch-ups have been arranged • My Yearly Conversation paperwork has been updated but awaiting sign off • **Potential risks to delivery** • People pulse response rate January 2023 = 141 - needs to increase to help inform engagement metrics • Menopause accreditation – Lack of buy in from Health & Wellbeing group to review accreditation standards • **Live issues/ escalations/ hot spot areas** • Cost of living • Overall retention
Guardian of safe working report	Quarterly report	• There are no major concerns to report to the Board and the GoSW provided continued assurance that the systems and processes to ensure doctors are rostered and working safe hours are in place and effective. Zero exception reports also indicate that their training needs are not compromised by service provision needs.
Other business		
Industrial action planning assessment	Update on planning	• Briefing on recent ballot results for Pennine Care was provided and details of proposed strike were provided.

Liz Allen, Non-Executive Director, 24 April 2023

Pennine Care
NHS Foundation Trust

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Chair's report from a meeting of the Quality Committee held on 28 March 2023	
Paper prepared by	John Starkey, Assistant Trust Secretary
Non-Executive sponsor	Claudette Elliott, Non-Executive Director/Chair of Quality Committee
Date of report	18 April 2023
Purpose of the report and action required	The purpose of this report is to provide an overview of the main items of business conducted at a meeting of the Quality Committee held on 23 March 2023
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Committee held discussions in the following areas: • Quality report: March 2023 and live quality issues • Quality Group - Chair's summary February 2023 • Network reports • Inpatient nursing retention survey feedback • Infection Prevention and Control Bi-Annual IPC BAF • Well-led recommendations and actions (Deloitte) • Board Assurance Framework: Quality Risks update
Recommendation	The Board is asked to note the contents of the report.
Where else has this report been considered and when?	N/A

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	**X**
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus	

Quality Committee: 28 March 2023 - Chair's report

Pennine Care NHS Foundation Trust

Summary of the key matters discussed at the Quality Committee held on 28 March 2023.

Item	Highlight	• Comment / action / key risks
Board Assurance Framework	Risk associated with Quality	• The Committee received an update on the progress made in mitigating BAF Risk 1 – Safe Care and reviewed the risks after considering agenda items from this meeting • Members received and reviewed an update on progress made in actioning the agreed recommendations of the Autumn 2022 Well Led review by Deloitte LLP
Well-led		
Quality report: February 2023 and live quality issues	Key reporting highlights and live quality issues	**Live issues** • Covid was still being managed by colleagues continuing to wear face masks in clinical areas. **Quality Dashboard** - The Committee received information around the following items; - An increase in incidents notified to the CQC, due to improvements in IPC and physical health coding on the Ulysses system. - An increase in patient-to-patient assaults, due to the move to single sex wards - Collaboration across the ICB to support falls work - An increase in complaint levels across CAMHS and in respect of waiting times for autism and ADHD due to cessation of LANCuk services. • The Committee noted the report, updates on live issues and assurances provided and requested further data on physical violence on Rosewood and Hague wards.
Quality Group Chair's summary: February 2023	Overview of items discussed	• The Committee received and noted the content of the report. Key highlights were: - Discussions around triangulation of the risk register
Patient Safety		
Briefings and learning for Pennine Care NHS Foundation Trust	Internal reports received	• The Committee received and noted a quarterly update from South Network highlighting partnership work with Stockport Foundation Trust, progress against quality metrics and continued pressures around staffing of acute in-patient areas. Presentations were received on the results of a recent nursing retention survey and information on the Infection Prevention and Control Bi-Annual IPC BAF, where IPC Team staffing remaining a key risk.

Claudette Elliott, Non-Executive Director / Chair of Quality Committee 31 March 2023

Pennine Care
NHS Foundation Trust

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Chair's report from a meeting of the Quality Committee held on 25 April 2023	
Paper prepared by	John Starkey, Assistant Trust Secretary
Non-Executive sponsor	Claudette Elliott, Non-Executive Director/Chair of Quality Committee
Date of report	26 April 2023
Purpose of the report and action required	The purpose of this report is to provide an overview of the main items of business conducted at a meeting of the Quality Committee held on 25 April 2023
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Committee held discussions in the following areas: • Quality report: April 2023 and live quality issues • Quality Group - Chair's summary April 2023 • North Network report • Safeguarding Annual report • Reducing restrictive practice presentation • Clinical and ethics summary • Freedom to Speak Up Annual Report • Seclusion Task and Finish group report • Well-led recommendations and actions (Deloitte) • Board Assurance Framework: Quality Risks update
Recommendation	The Board is asked to note the contents of the report.
Where else has this report been considered and when?	N/A

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	**X**
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus	

Quality Committee: 25 April 2023 - Chair's report

Pennine Care NHS Foundation Trust

Summary of the key matters discussed at the Quality Committee held on 25 April 2023.

Item	Highlight	• Comment / action / key risks
Board Assurance Framework	Risk associated with Quality	• The Committee received an update on the progress made in mitigating BAF Risk 1 – Safe Care and reviewed the risks after considering agenda items from this meeting • Members received and reviewed an update on progress made in actioning the agreed recommendations of the Autumn 2022 Well Led review by Deloitte LLP • Additional controls were identified that could be added to the BAF. • Risks exist on respect of lack of training in Mental Capacity Act, basic life support and immediate life support training BLS and ILS training • Health and Safety risk management governance is still immature and needs embedding further within the Trust.
Well-led		
Quality report: April 2023 and live quality issues	Key reporting highlights and live quality issues	**Live issues** • Compulsory wearing of masks to prevent Covid spread had been relaxed. Commentary was provided on the impact of recent strike action. • Quality Account report for 2021/22 will be presented to Committee in May and the 2022/23 in May or June. **Quality Dashboard** - The Committee noted the following points; - A detailed breakdown of patient incidents - Data provided split by network - Trust safer staffing position
Quality Group Chair's summary: April 2023	Overview of items discussed	• The Committee received and noted the content of the report. Key risks were: - An increase in waiting lists across CAMHS and CMHT services - Declining compliance in BLS and ILS training training
Patient Safety		
Briefings and learning for Pennine Care NHS Foundation Trust	Internal reports received	• The Committee received and noted a presentation on Reducing Restrictive Practice, delivered by Louise Bond, Programme Development Lead at Health Innovation Manchester. The Trust had achieved a 50% reduction in some areas, against a 25% national target. • A quarterly update from North Network highlighting increasing waiting lists but a low level of complaints. • The safeguarding annual report, which highlighted a 22% increase in demand and assurance that key areas were being addressed. • A clinical and ethics update detailing a Spring Covid booster, flu vaccines had been ordered and Oxehealth • A summary of the Freedom to Speak Up annual report showing good results against national averages. The Committee discussed triangulation of minority staff group data and the need to continue to monitor this. • An update from the Seclusion task and finish group The Committee received updates and presentations on the agenda items listed for discussion and assurances. The joint work that Pennine Care is undertaking with Health Innovation Manchester provided good assurance that, as an organisation, we are reviewing and addressing the issues and challenges associated with reducing restrictive practice.

Item	Highlight	• Comment / action / key risks
		We have a few wards and services actively taking part in the programme, that is already beginning to show some improvements. • The Safeguarding Annual report provided detail updates on the range of interventions and work underway within Pennine Care. We have seen significant increase in demand, that the Committee discussed in detail. The Committee received assurances on the mitigations in place to address the issues related to Mental Capacity Act Training

Claudette Elliott, Non-Executive Director / Chair of Quality Committee 26 April 2023

Greater Manchester Children and Young People's Mental Health Provider Collaborative

Report to the Board of Directors
29th March 2023

Greater Manchester Child & Adolescent Mental Health Services (CAMHS) Lead Provider Subcommittee	
Paper prepared by:	Edward Vitalis, Non-Executive Director/Chair
Executive sponsor:	Edward Vitalis, Non-Executive Director/Chair
Date of report:	6 April 2023
Purpose of the report and action required:	To provide an overview of the main items of business conducted at the Greater Manchester CAMHS Lead Provider Subcommittee on 29th March 2023.
Executive summary / key issues for Board's attention (and links to other strategies etc.):	The Committee held discussions covering: Overview of the LPC work January – March 2023 Commissioning and Quality Assurance report Finance and Contract report and updates, including plans for reinvestment of savings Commissioning and Transformation plans for 2023-2024
Recommendation:	To note the report.
Where else has this report been considered and when?	N/A

Impact on our five-year plan areas of focus - select one of the following options	Mark with 'X'
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	X
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	

Greater Manchester Child & Adolescent Mental Health Services Lead Provider Subcommittee (GM CAMHs LPC)
Chair's Report

NHS
Pennine Care
NHS Foundation Trust

The following is a summary of the key items discussed at the GM CAMHs LPC subcommittee on the 29 March 2023. Minutes from the meeting will be presented at the next meeting in June.

Item	Highlight	Comment/action/key risks
Minutes of last meeting/actions	Approval of draft minutes and action log review.	• The Committee requested two minor amendments to the Minutes (to reflect AO's attendance and correct GM's job title), otherwise they were happy to approve the minutes from the December subcommittee. • The action log was reviewed; action 1, 4 & 8 to carry forward to the next; action 2 noted as complete, action 3, 5, 6 &7 to be covered in the presentation/report, as such, can be marked as complete.
Commissioning and Quality Assurance report	Overview of the LPC work Jan to March 2023	The Commissioning and Quality Assurance reports have been amalgamated for this quarter but these will be split out for future meetings. • The GM CAMHS LPC Transformation Plan has been reviewed and revised with priorities agreed for 2023/24 • Phase 2 service planning and quality assurance continues to be discussed with NHSE as regards to FCAMHS. Further meetings have been arranged to commence Due Diligence and confirmation has been received that the national specification for FCAMHS has been drafted. • The GM CAMHS LPC held a North West CAMHS LPC Leadership Quality Assurance event on 9th March 2023. A number of task and finish workstreams were agreed to support a more collaborative approach to quality assurance. • All five Quarter 3 contract review meetings have successfully taken place in recent weeks. Key points to note are: ➢ Reduced number of beds at GMMH due to consultant capacity ➢ 5 beds have now been re-opened on Horizon at PCFT with plans in place for the remainder to be re-opened in the coming months. ➢ The spotlight session for Quarter 3 was on restrictive practice; from this a new working group has been formed with representatives from all providers involved. • The GAU 4-6 week pathway continues to work well with Stage 2 of its evaluation now underway. • The delayed discharge process has been successfully implemented with delayed discharges now minimal. • Led by a psychologist at GMMH, scoping is underway in to how to ensure inpatient services can deliver outstanding trauma informed care. This piece of work will have a wider reach than the EUPD work programme it replaces. • Cat Mullett is now in post as Head of Quality and Compliance for the LPC.

Item	Highlight	Comment/action/key risks
		• Routine quality assurance visits are taking place (every 6 weeks), as well as 6-monthly in depth Environmental and Quality reviews. Ad hoc quality visits are also taking place in response to any concerns raised by GM case managers or placing case managers. • Quality concerns at Priory's Orchard Ward had prompted additional quality assurance measures to be undertaken by the case managers and Head of Quality. These concerns were relayed to CQC who undertook a planned, unannounced visit to Priory Cheadle. The CQC report has not yet been published but it is likely to result in a downgrade of their current rating. • The focus for next quarter will be on: ➢ transformation programmes, including weight management of YP in inpatient settings, reducing restrictive practice and trauma informed services; ➢ working with other LPCs to progress the development of the Quality Assurance Framework; ➢ consideration of utilising the CNEST assessment tool across GMAIC and HIT. ➢ maintain increased surveillance of those units with reduced staffing, increased incidents and high patient acuity ➢ agree the approach to the acquisition of Phase Two services with NHSE and commence a Due Diligence process ➢ continue to work in collaboration with the emerging ICS to align governance, connect quality assurance and joint transformation planning for 2023 onwards ➢ engagement and collaboration with providers on the developments and roll out of PSIRF which is a new patient safety framework to replace StEIS. • Admissions for the quarter continue on a downward trend. There are two admissions outside of Greater Manchester – one YP is admitted to a specialist LDA unit, the other YP is admitted to an LSU in St Andrew's (after discussion and agreement from the LSU network); this placement is going well and as a result the YP no longer needs an EPC. • Risks and Issues relate to: ➢ delay in issuing of subcontracts. ➢ limited information communicated by NHSE regarding mitigation in relation to progressing to Phase 2 of services (acquisition of FCAMHS) ➢ levels of acuity remain high and length of stay has increased on some pathways. An update on the Quality Maturity Framework will be shared at the next Subcommittee; this framework provides assurance regarding the maturity of the LPC.

Item	Highlight	Comment/action/key risks
		The committee felt assured by the information provided. It was queried why two young people were placed outside of GM but, after hearing the rationale for this, all were assured that these admissions were appropriate. Regarding whether Phase 2 of the development of the LPC only involved the acquisition of FCAMHS, it was advised that NHSE have signalled they have no plans to bring under-13s and medium secure into the LPC; however, there is the possibility of more specialised provision being brought under the ICB in future years and so this position may change. The subcommittee is asked to **note** the report.
Finance and Contract Assurance Report	Updates on financial position and forecasted financial position	• The head agreement has been signed by both NHSE and the LPC. Contract variations for 22-23 have been signed by Pennine Care but are awaiting signing by NHSE at which point subcontracts can be issued to GM tier 4 CAMHS LPC partner providers and other out of area LPCs where GM young people are placed. • Revised guidance from NHSE states that Lead Provider (LP) to LP sub-contracts are no longer required for out of area placements into the Manchester Priory and Cygnet sites; LPs from other areas will sub-contract directly with Priory and Cygnet for this activity. The LPC still has quality assurance (QA) responsibility for all of the activity in The Priory's and Cygnet's Manchester Tier 4 CAMHS units and a meeting has been requested with NHSE to get clarity on how the QA will be provided outside of a contract framework. • The latest year end forecast expenditure for EPCs is £3,042k, this could result in a year end underspend of £3,417k. The GM CAMHS LPC's share of this gain is £259k. • The NW LPCs groups have decided to continue collaborative management of the EPCs; the success of this has been a contributing factor to the reduced spending on EPCs this year. Next year, the finance risk / gain share will only include the pooling of each LPCs recurrent funding, whereas in 2022/23 there was additional non-recurrent EPC funding from NHSE. This means there is a possibility of there being a risk share, so the LPCs have agreed for there to be a tolerance of 5% above the pooled funding, after which point the LPC would request additional support from NHSE. • NW group have agreed to move to cost per case payment arrangements, based on actual activity, from 1st April 2023. Due to current activity, this results in a favourable position of £274K for the year, however, this picture could change depending on activity.

Item	Highlight	Comment/action/key risks
		• Discussions between GM NHS Provider organisations in relation to the benefits of a risk / gain share arrangement across the GM LPCs are ongoing but no agreement has been reached to progress this any further in 2022/23. • The LPC is reporting a breakeven financial position for Month 11 (February 2022/23) and continues to forecast a breakeven position for the full year. Within this breakeven position is funding to be carried forward into 2023/24, which will be in the range of £1.5m to £2.0m. Working papers providing the detail of the proposals and transformation plans behind this funding, which will be reinvested in services, have been prepared for external audit. CC noted that the point of LPCs was to make savings and reinvest those savings into CAMHS services that impact on the Tier 4 CAMHS provision at a system level. The LPC will take the investment plans through the Partnership Board governance in early 2023/24, however, partners will be unable to vote on this as they have not entered into a risk / gain share agreement. • NHSE have advised that once the current contract expires on 31st March 2024, they will enter into a new contract with the LPC for a further 2 years. • CC noted that ways the LPC can manage its financial position are for partners to continue to manage activity at a system level, maximising use of NHS beds and reducing EPC spend. The subcommittee queried the risk around the 5% tolerance above pooled funding for EPCs. The LPC noted that even if this did exceed 5% there was still no guarantee that NHSE would flow any additional money, however, the LPC's share of an additional 5% risk on EPCs might be approximately £15k-£30k so felt tolerable. The LPC responded to queries regarding reinvestment of savings to advise that proposals cover both reinvestment into new services, as well as to fund the continuation of the LPC to implement some of the transformation plans, with a plan to get these proposals agreed at the next Partnership Board in April. The subcommittee is asked to **note** the report and any actions taken.
Commissioning and Transformation Plans 23-24		The LPC shared an overview of the key aims of the original business case for the LPC. • The GM CAMHS LPC is one of the biggest LPCs in the country, it holds all pathways within its footprint. Admissions from outside of the North West make up the majority of admissions into the independent sector providers, which in turns results in most admissions into the GM footprint being from out of area.

Item	Highlight	Comment/action/key risks
		• There has been a general downward trend for CAMHS Tier 4 services nationally, and in GM there has been a sharp decline in admissions. However, there has been a change to the pattern of admissions; acuity of GAU admissions has increased and the length of stay of LSU admissions has increased slightly. • An ambition of the LPC was to support the Crisis Care pathway to embed and expand its services. A data review is planned to try to correlate the reduction in demand for Tier 4 services with the impact the Crisis Care programs have had. There are plans to reinvest funds from Tier 4 savings to support the Crisis workstream, particularly around looked after children. In terms of the high level work plan previously agreed for 22-23: • GAU stepped care approach has been delivered and is business as usual, with evaluations under way. • Expansion of the GMAIC Single Point of Access (SPOA) is progressing. • It has been deemed unfeasible to enable nasogastric tube feeding for eating disorders on all GAU wards – limited demand means it is not possible to maintain the skills competence and confidence of staff to deliver this. It will be necessary to consolidate the demand into one or more units to allow for the 'critical mass' of demand to be reached. • The decision not to develop an NHS PICU unit will be reassessed as part of the upcoming bed planning work. • The plan to develop a pathway around EUPD has evolved into developing a model of trauma informed care across all inpatient services. • A review of education provision and advocacy services for all partners is still to be undertaken; currently this is monitored via the quarterly KPI submissions and contract reviews, as well as on the ground by the case managers. Commissioning intentions for 2023-2024 were discussed: • Maintain steady state • Take on the commissioning of NW FCAMHS • Reduce block contract for GMMH back to original 15 beds • Develop proposals for reinvestment (in collaboration with the GM CYPMH Crisis Care review recommendations)

Item	Highlight	Comment/action/key risks
		• Achieve Level 1 Quality Maturity Framework – Established and Optimised (Steady State) • Revisit bed planning in collaboration with NW LPCs (inc. reconsideration of NHS PICU) • Develop Co-Production Strategy for the collaborative • Development of a Quality SOP in partnership with NW LPCs The transformation programme for 2023-2024 was shared: • Establishment of GMAIC 24/7 SPOA model • Establish the scope, model and implementation of a trauma informed model of care. • Continue to develop services and pathways for the learning disability and autism cohort • Progress eating disorder services with the use of virtual wards and consolidate bed utilisation. • Launch a program of work around reducing restrictive practice and use of seclusion. • Expand the family ambassador model to link in with the co-production strategy. • Further scope possible transformation around workforce The subcommittee are asked to **note** the plans for 2023-2024.
Reflections		The subcommittee felt it had been a useful meeting and wished to thank the team for their fantastic work in managing the LPC. The quality of the papers was again commended.

Edward Vitalis,
Non-Executive Director / Chair of GM CAMHs LPC
6 April 2023

Report to the Board of Directors
3rd May 2023

Pennine Care
NHS Foundation Trust

Terms of Reference review	
Paper prepared by	John Starkey – Assistant Trust Secretary
Executive sponsor	Andy Chittenden - Director of Corporate Affairs
Date of report	27th April 2023
Purpose of the report and action required	The Board is asked to review and approve the Terms of Reference for the Board and a number of its sub-committees
Executive summary / key issues for Board's attention (and links to other strategies etc.)	Each Board sub-committee has reviewed and updated its own Terms of Reference and updates have been approved at the relevant sub-committee. The Trust Board's own Terms of Reference has not been reviewed since 2018 and is also brought for review.
Recommendation	Board is asked to review and approve the Board sub-committee Terms of Reference and its own Board Terms of Reference
Where else has this report been considered and when?	Each Board sub-committee has reviewed its own Terms of Reference

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	X
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	

Pennine Care
NHS Foundation Trust

BOARD OF DIRECTORS
TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Trust has a Board of Directors, as set out in the Trust's constitution, which exercises all the powers of the Trust on its behalf, but the Board of Directors may delegate any of those powers to a committee of Directors or to an Executive Director.

1.2 The Standing Orders for the Practice and Procedure of the Board of Directors are set out in Annex 7 of the Constitution.

2. MEMBERSHIP

2.1 The Board of Directors consists of:

Chair (who is a Non-Executive Director)
Non-Executive Directors (who include the Deputy Chair)
Chief Executive
Director of Quality, Nursing and Healthcare Professionals / Deputy Chief Executive
Chief Operating Officer
Medical Director
Executive Director of Finance
Executive Director of Strategy
Executive Director of Workforce
Medical Director

2.2 The Chair of the Trust or, in their absence, the Deputy Chair, will chair meetings of the Board.

3. MEETINGS OF THE BOARD

Meetings will be held monthly.

Meetings of the Board will be held in public however matters of a confidential nature will be discussed in a separate closed session that will not be attended by members of the public. In addition, the Board will hold regular informal strategy / development workshops.

4. QUORUM

4.1 In line with the Trust's Constitution a quorum will consist of five Board members, including not less than two Executive Directors, one of whom must be the Chief Executive or another executive director nominated by the Chief Executive to deputise for them; and not less than two Non-Executive

Directors, one of whom must be the Chair of the Trust or the Deputy Chair. A duly convened meeting of the Board at which a quorum is present will be competent to exercise all or any of the authorities, powers or discretions vested in or exercisable by the Trust.

4.1 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

5. SECRETARY

5.1 The Trust Secretary or their nominee will act as secretary to the Board.

6. MINUTES

6.1 The Trust Secretary will ensure that all proceedings and resolutions of meetings of the Board are minuted, including the names of those present and in attendance.

6.2 The Trust Secretary will ensure a separate record is kept of all points of action arising from the meetings and all issues carried forward, and that these are progressed as necessary.

6.3 The Chair will ascertain at the beginning of each meeting, the existence of any conflicts of interest and the Trust Secretary will ensure these are minuted accordingly.

7. ROLE AND FUNCTION

7.1 The Board of Directors leads the Trust by undertaking three core roles:

- Formulating the Trust's strategy to deliver safe, high quality, patient-centred care
- Ensuring accountability by holding the organisation to account for the delivery of the strategy; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and through seeking assurance that systems of control are robust and reliable
- Shaping a healthy culture for the Board and the organisation.

7.2 To support the Board in fulfilling its core roles, the Board will receive reports and recommendations from its formal sub-committees.

7.3 The general responsibilities of the Board are:

<u>To formulate strategy</u>

7.4 To agree and maintain the Trust's strategic vision, aims and objectives.

7.5 To agree and maintain the Trust's Integrated Business Plan and Long Term Financial Model.

7.6 To agree the Trust's strategic plan, ensuring its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.

7.7 To take decisions on significant service changes, investment / disinvestment opportunities and other strategic matters expressly reserved to the Board of Directors, as outlined in the Scheme of Delegation.

<u>To ensure accountability</u>

7.8 To agree and maintain arrangements for the purpose of monitoring and improving the quality of health care provided by the Trust.

7.9 To ensure the Trust operates effectively, efficiently and economically and with probity in the use of resources.

7.10 To ensure the continued financial viability of the organisation.

7.11 To ensure that the Trust achieves the targets and requirements of stakeholders within the available resources.

<u>To shape the Trust's culture and values</u>

7.12 To shape the culture and values of the Trust and promote these in the way that the Board does business and interacts with the rest of the organisation and external stakeholders.

8. REVIEW

These terms of reference will be subject to review in May 2024.

Pennine Care
NHS Foundation Trust

AUDIT COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. MEMBERSHIP

The Committee shall be appointed by the Board from amongst its independent Non-Executive Directors and shall consist of not less than four members. A quorum shall be two members. One of the members will be appointed chair of the Committee by the Board. The chair of the organisation itself shall not be a member of the Committee.

3. ATTENDANCE

The Executive Director of Finance, Executive Director of Nursing, Health Care Professionals and Quality Governance / Deputy Chief Executive, and Medical Director, and the appropriate Internal and External Audit representatives shall attend meetings. At the end of every meeting the Non-Executive Directors should have the opportunity to meet privately with the External and Internal Auditors to establish if there are any issues they wish to raise in the absence of executive directors and senior managers of the Trust. In addition, there will be a scheduled private meeting between the Non-Executive Directors and Auditors at least once per calendar year.

Other directors and heads of department may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

The Chief Executive should be invited to attend annually to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

The Director of Corporate Affairs or nominated deputy shall attend to provide appropriate support to the chair and committee members and will ensure accurate minutes are taken.

4. ACCESS

The Head of Internal Audit, representatives of External Audit, and the Anti-Fraud Specialist have a right of direct access to the Chair of the Committee.

5. FREQUENCY OF MEETINGS

An annual programme of meetings (together with a work programme) will be agreed with the Board based on the requirements of the Board calendar. Meetings shall be held not less than four times a year. The Board, Accounting Officer, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

6. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice (in line with the Trust's guidance on Managing Requests for Legal Advice) and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. DUTIES

The duties of the Committee can be categorised as follows:

7.1 Integrated Governance, Risk Management and Internal Control

The Committee shall review the Trust's establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that support the achievement of the Trust's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

(i) All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or any other independent assurances, the Committee feels appropriate, prior to endorsement by the Board.

(ii) The underlying assurance processes within the Assurance Framework that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks through the Board Assurance Framework, and the appropriateness of the above disclosure statements.

(iii) The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

(iv) The policies and procedures for all work related to fraud, bribery and corruption as required by NHS Counter Fraud Authority (CFA).

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers concerning the overarching systems of integrated governance, risk management

and internal control, together with indicators of their effectiveness. These 'deep dives' will focus on the design and application of controls which contribute to an effective system of internal control.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.

7.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

(i) Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal

(ii) Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring consistency with the assurance needs of the Trust, as identified in the Assurance Framework

(iii) Considering the major findings of internal audit work and management responses

(iv) Ensuring co-ordination between the internal and external auditors to optimise audit resources

(v) Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust

(vi) Monitoring the effectiveness of internal audit and carrying out an annual review

7.3 External Audit

The Committee shall review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

(i) Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit

(ii) Discussion with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan

(iii) Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

(iii) Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to

the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

(iv) Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services. The Committee will report at least annually to the Council of Governors on non-audit services that have been approved for the auditors to provide under the policy and the expected fee for each service.

The Committee will make a report to the Council of Governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable the Council of Governors whether or not to re-appointment them. The Committee will make a recommendation to the Council of Governors about the re-appointment of the External Auditor.

7.4 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust.

These will include, but will not be limited to, any reviews by the Department of Health arm's length bodies or regulators/inspectors (e.g. NHSE/I / Care Quality Commission), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include the arrangements for managing integrated governance and risk.

In reviewing the arrangements for managing integrated governance and risk, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

7.5 Anti-Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for anti-fraud, bribery and corruption that meet NHS CFA's standards through the work of the Anti-Fraud Specialist (LCFS). It shall receive assurance over the coverage of the work of the AFS through receipt of an annual operational counter fraud plan that is compliant with the NHSCFA's Standards for Providers.

The Committee will refer any suspicions of fraud, bribery and corruption to the NHS CFA.

7.6 Management

The Committee shall request and review any reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

The Committee shall use the internal auditors to track progress of outstanding audit recommendations and may require attendance from directors and managers should progress prove to be unsatisfactory.

7.7 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

(i) The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee

(ii) Changes in, and compliance with, accounting policies, practices and estimation techniques

(iii) Unadjusted miss-statements in the financial statements

(iv) Significant judgments in preparation of the financial statements

(vi) Significant adjustments resulting from the audit

(vii) Letters of representation

(viii) Explanations for significant variances

The Committee will review the circumstances associated with instances when the Standing Orders, Standing Financial Instructions, and Reservation and Delegation of Powers are waived.

7.8 Whistleblowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

7.9 Reporting

The Committee shall report to the Board on how it discharges its responsibilities.

The Director of Corporate Affairs, or nominated deputy, shall ensure that minutes of Committee meetings are formally recorded and the chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the Board or require executive action.

The Committee will provide the Board with an annual report on its work in support of the Annual Governance Statement, specifically commenting on:

(i) The fitness for purpose of the Assurance Framework

(ii) The completeness and 'embeddedness' of risk management in the Trust

(iii) The integration of governance arrangements

(iv) The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as functioning business

(v) The robustness of the processes behind the production of the quality accounts.

7.10 Administrative support

The Committee shall be supported by the Director of Corporate Affairs or nominated deputy, whose duties in this respect will include:

(i) Agreement of agendas with the chair and attendees

(ii) Preparation, collation and circulation of papers in good time

(iii) Ensuring that those invited to each meeting attend

(iv) Taking the minutes and helping the chair to prepare reports to the Board

(v) Keeping a record of matters arising and issues to be carried forward

(vi) Arranging meetings for the chair – for example, with the Internal / External Auditors or AFS

(vii) Advising the Committee on pertinent issues / areas of interest / policy developments

(viii) Ensuring that action points are taken forward between meetings

(ix) In conjunction with the chair, ensuring that Committee members receive the development and training they need

8. REVIEW

These terms of reference will be subject to review in May 2024.

Date	Version	Approved by	Main amends
15 Dec 2021	1	Board ratification	
2 Feb 2022	1.1	Board ratification	
15 Dec 2022	1.2	Audit Committee amends	Minor typographical details

Pennine Care
NHS Foundation Trust

PERFORMANCE AND FINANCE COMMITTEE TERMS OF REFERENCE

1. CONSTITUTION

The Board of Directors resolves to establish a Committee of the Board to be known as the Performance and Finance Committee (the Committee).

The Committee has authority delegated to it from the Board of Directors to act in accordance with these terms of reference.

2. PURPOSE

The Committee exists to seek assurance and oversee the performance of the Trust in terms of:

- Finance
- Investment
- Performance

This will also include focus on:

- Capital
- Estates and Facilities
- Digital and Business Intelligence
- Information governance
- Health and Safety / emergency planning
- Procurement
- Green plan

Functions of the Committee can be found under section 7 of the Terms of Reference.

3. MEMBERSHIP

Membership of the Committee will comprise:

- Four Non-Executive Directors (one of whom will be the nominated chair of the Committee)
- Executive Director of Finance
- Chief Operating Officer
- Executive Director of Strategy

4. IN ATTENDANCE

The Committee will co-opt additional members to attend as and when required but this will routinely include:

- Director of Capital, Estates and Facilities
- Deputy Director of Finance
- Chief Digital Information Officer
- Head of Strategic Planning and Performance
- Head of Strategic Procurement
- Assistant Trust Secretary

The Committee may request the attendance of individuals from within and outside the Trust with relevant experience and expertise if it considers this necessary.

The Chief Executive may be invited to attend as required but at least on an annual basis.

5. MEETINGS AND QUORUM

5.1 The Committee will agree a meeting calendar on an annual basis, setting out the main work items to be carried out by the Committee at each meeting to ensure that adequate time is given to the main duties of the Committee.

5.2 Members are expected to attend all meetings. Any member unable to attend a meeting of the Committee will be required to forward their apologies to the Assistant Trust Secretary in advance of the meeting, along with the name of their nominated deputy / representative.

5.3 If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he / she will declare that interest as early as possible and shall not participate in the discussions. The chair will have the power to request that member to withdraw until the Committee's consideration has been completed.

5.4 A quorum shall be three members of the Committee, comprising of not less than two Non-Executive Directors and one Executive Director. If the Committee is not quorate the meeting may be postponed at the discretion of the chair. If the meeting does take place and is not quorate, no decision shall be made at that meeting and such matters must be deferred until the next quorate meeting. In the case of non-agreement or no decision reached by the majority, the issue is to be escalated to the Board for discussion.

5.5 In the absence of the nominated chair, another Non-Executive Director member will deputise as Committee chair.

5.6 The chair of the Committee may agree that members may participate in its meeting via telephone, video or computer link. Participation in this manner will be deemed to constitute presence in person at the meeting.

6. FREQUENCY

An annual programme of meetings (together with a work programme) will be agreed with the chair of the Committee.

7. FUNCTIONS

7.1 Receive and consider the Trust's annual plan / business plan / delivery objectives.

7.2 Satisfy itself that financial, investment and performance decisions are consistent with Trust Strategy.

7.3 Review performance against key goals set out in the strategic and annual plan, plus NHS England's Operating Framework, through receipt of the Operational Performance Report.

7.4 Undertake deep dive assurance activity in relation to the performance of services or networks.

7.5 Seek assurance that organisational systems and processes in relation to performance and finance are robust and well-embedded so that priority is given to identifying and managing risks. Report to the Board on the committee's level of assurance regarding the management of strategic risks to performance and finance.

7.6 Seek assurance that effective actions are being taken and plans are in place to secure successful recovery where the Trust is failing to deliver performance in line with strategic or contractual targets.

7.7 Seek detailed assurance regarding current and projected financial performance against the agreed financial recovery plan, taking into consideration activities at a system-wide level to address financial and clinical sustainability.

7.8 Provide assurance that the Trust is financially solvent as a Foundation Trust by strategically monitoring cash flow, cash levels and liquidity.

7.9 Review current and forecast financial performance and compliance with financial performance standards, as set out by the regulator.

7.10 Scrutinise and challenge investment proposals in line with the Trust's Commercial Strategy, including system-wide business cases / partnership agreements. Authority to approve business cases in the value of £500k - £1m.

7.11 Scrutinise and challenge the Trust's Capital Plan, including consideration of proposals for acquisition and disposal of assets and proposals for property leases and leases which fall under IFRS16.

7.12 Scrutinise the production and implementation of annual cost improvement plans / transformation plans; and seek assurance as to the risks to successful delivery of the annual CIP / transformation programme throughout the year.

7.13 To review the contractual framework relating to any material commercial relationships.

7.14 Seek assurance the Trust is meeting its statutory and regulatory obligations relating to finance, investment, and performance.

7.15 Receive and seek assurance the Trust is assessing and effectively managing current and future Board Assurance Framework risks to performance and finance. Escalate to Board any key risks or areas of concern.

7.16 Seek assurance regarding the delivery of the Trust's Digital Strategy.

7.17 Seek assurance the Trust is assessing and effectively managing its Green Plan and that current and future aims, objectives, and delivery plans are in line with national NHS statutory emissions and environmental targets for carbon reduction.

7.18 Seek assurance regarding the Information Governance agenda across the Trust; and provide oversight, on behalf of the Board, of reports from the Data Protection Officer.

7.19 To act as the assurance and escalation route for Emergency Planning and Health and Safety in the organisation.

7.20 Seek assurance, providing challenge and scrutiny as necessary, regarding the development and implementation of priorities to address health inequalities as they relate to access, experience and outcomes for the people who need our services.

7.21 Refer activities and tasks to appropriate Board level committees as deemed appropriate by the Committee, having due consideration of the remit of those committees and their workplans.

7.22 Receive and accept delegated activities and tasks from the Board of Directors or other Board committees by agreement.

7.23 Review and approve any policies relating to finance, investment, or performance or other documents as necessary on behalf of the Board of Directors.

7.24 Review and approve any policies relating to finance, investment, or performance or other documents as necessary on behalf of the Board of Directors.

8. REPORTING

The Committee reports to the Board of Directors.

The Committee will receive reports/escalations from the following group(s):

- Value and Investment Group
- Digital Strategy and Portfolio Board
- Information Governance Assurance Group
- Health and Safety Committee

The Committee will also receive escalation of issues from Executive Directors or other executive-led groups where there is a financial or performance impact.

9. INPUTS

- Reports and plans as identified in the agreed workplan, including finance and performance reports and forward plans
- Relevant reports / correspondence from regulators and key stakeholders
- Delegated / transferred issues from the Board of Directors and / or Board committees

10. OUTPUTS

- Minutes
- Action log
- Chair's reports to the Board of Directors to provide assurance regarding matters discussed and to highlight / escalate key issues and risks. Chair's reports will also be shared with the Council of Governors.

11. DATE OF REVIEW

These Terms of Reference will be reviewed in February 2024. Following this, an annual review of the Terms of Reference and compliance will take place.

Pennine Care
NHS Foundation Trust

PEOPLE AND WORKFORCE COMMITTEE TERMS OF REFERENCE

1. CONSTITUTION

The Board of Directors hereby resolves to establish a Committee of the Board to be known as the People and Workforce Committee (the Committee).

The Committee has authority delegated to it from the Board of Directors to act in accordance with these terms of reference.

2. PURPOSE

The Committee exists to:

- Seek assurance on behalf of the Board of Directors regarding the development, implementation and effectiveness of people and workforce, OD improvement, and equality, diversity and inclusion strategies that supports the Trust's vision, values and overarching strategic direction, including the ambition to reduce health inequalities.

Functions of the Committee can be found under section 7 of the Terms of Reference.

3. MEMBERSHIP

Membership of the Committee will comprise:

- Four Non-Executive Directors (one of whom will be the nominated chair of the Committee)
- Chief Operating Officer
- Executive Director of Strategy
- Executive Director of Workforce

4. IN ATTENDANCE

The Committee will co-opt additional members to attend as and when required but this will routinely include:

- Head of Workforce
- Head of Workforce (Medical)
- Head of Organisational Development
- Head of Equality, Diversity and Inclusion
- Deputy Director of Nursing, Healthcare Professionals and Quality Governance.
- Assistant Trust Secretary
- Staff side representative

The Committee may request the attendance of individuals from within and outside the Trust with relevant experience and expertise if it considers this necessary.

The Chief Executive may be invited to attend as required but at least on an annual basis.

With prior agreement, the Committee chair may agree to the attendance of observers at meetings.

5. MEETINGS AND QUORUM

5.1 The Committee will agree a meeting calendar on an annual basis, setting out the main work items to be carried out by the Committee at each meeting to ensure that adequate time is given to the main duties of the Committee.

5.2 Members are expected to attend all meetings. Any member unable to attend a meeting of the Committee will be required to forward their apologies to the Assistant Trust Secretary in advance of the meeting, along with the name of their nominated deputy / representative.

5.3 If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he / she will declare that interest as early as possible and shall not participate in the discussions. The chair will have the power to request that member to withdraw until the Committee's consideration has been completed.

5.4 A quorum shall be four members of the Committee, comprising of not less than two Non-Executive Directors and one Executive Director. If the Committee is not quorate the meeting may be postponed at the discretion of the chair. If the meeting does take place and is not quorate, no decision shall be made at that meeting and such matters must be deferred until the next quorate meeting. In the case of none agreement or no decision reached by the majority, the issue is to be escalated to the Board for discussion.

5.5 In the absence of the nominated chair, another Non-Executive Director member will deputise as Committee chair.

5.6 The chair of the Committee may agree that members may participate in its meeting via telephone, video or computer link. Participation in this manner will be deemed to constitute presence in person at the meeting.

6. FREQUENCY

The Committee will meet, as a minimum, on a bi-monthly basis; and may hold additional meetings on specific topics or as required

7. FUNCTIONS

7.1 To provide support and challenge with regards to strategic people, workforce and EDI priorities (including those within the NHS People Plan), and to receive assurance regarding delivery across the following areas aligned to the People Plan:

- Effective and sustainability workforce
- Capable and skilled staff
- Effective leadership
- Staff health, wellbeing and engagement
- Equality, diversity and inclusion

Make recommendations to Board regarding strategic workforce matters as appropriate.

7.2 To seek assurance, providing challenge and scrutiny as necessary, regarding the development and implementation of priorities within the Equality, Diversity and Inclusion Strategy

7.3 To seek assurance, providing challenge and scrutiny as necessary, regarding the development and implementation of priorities to address health inequalities as they relate to people and workforce.

7.3 To provide support and challenge regarding the delivery of the OD improvement plan and actions required to supporting the creation of an inclusive, open and transparent culture.

7.4 To seek assurance in relation to strategic workforce planning to meet the future needs of patients and service users, aligned to Trust and system strategies, and the quality and effectiveness of plans to deliver them.

7.5 Review the performance of key workforce metrics, and seek assurance that action is being taken where sub-standard performance is identified.

7.6 Seek assurance that organisational systems and processes in relation to people and workforce are robust and well-embedded and that priority is given to identifying and managing risks. Report to the Board on the committee's level of assurance regarding the management of strategic risks to people and workforce.

7.6 Receive and seek assurance the Trust is assessing and effectively managing current and future Board Assurance Framework risks (People and Culture). Escalate to Board any key risks or areas of concern.

7.7 As appropriate, inform the Internal Audit programme in relation to key areas of People and Workforce performance and delivery in discussion with the Executive Director of Finance and the Audit Committee chair.

7.8 Seek assurance regarding the Trust's approach to ensuring compliance with relevant legal and regulatory requirements, including equality, diversity and human rights legislation.

7.9 Refer activities and tasks to appropriate Board level committees or Executive Directors as deemed appropriate by the Committee; having due consideration of the remit of those committees and their workplans.

7.10 Receive and accept delegated activities and tasks from the Board of Directors or other Board committees by agreement.

8. REPORTING

The Committee reports to the Board of Directors.

The Committee will receive reports / updates at each meeting from the following group(s):

- People and Workforce Steering Group
- Equality, Diversity and Inclusion Steering Group
- E-roster Project Board
- Future Workforce Group
- Effective and Sustainable Group
- Education Quality Group
- Staff Health, Wellbeing and Engagement Group

The Committee will also receive escalation of issues from Executive Directors or other executive-led groups where there is a workforce impact.

9. INPUTS

- Reports and plans as identified in the agreed workplan
- Highlight / exception reports from sub-groups
- Relevant reports / correspondence from regulators and key stakeholders
- Delegated / transferred issues from the Board of Directors and / or Board committees

10. OUTPUTS

- Minutes
- Action log
- Chair's reports to the Board of Directors to provide assurance regarding matters discussed and to highlight / escalate key issues and risks. Chair's reports will also be shared with the Council of Governors.

11. DATE OF REVIEW

These Terms of Reference will be reviewed in March 2024. Following this, an annual review of the Terms of Reference and compliance will take place.

Pennine Care
NHS Foundation Trust

QUALITY COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Quality Committee (the Committee).

The Committee has authority delegated to it from the Board of Directors to act in accordance with these terms of reference.

2. PURPOSE

The Committee exists on behalf of the Board of Directors to:

- Seek assurance that effective and appropriate systems are in place to drive evidence-based quality improvement
- Seek assurance that service users, patients and carers are receiving outstanding services that are safe, compassionate, fair and consistent in quality.

Functions of the Committee can be found under section 7 of the Terms of Reference.

3. MEMBERSHIP

Membership of the Committee will comprise:

- Four Non-Executive Directors (one of whom will be the nominated chair of the Committee)
- Medical Director
- Executive Director of Nursing, Healthcare Professionals and Quality Governance / Deputy Chief Executive

4. IN ATTENDANCE

The Committee will co-opt additional members to attend as and when required but this will routinely include:

- Chief Operating Officer
- Deputy Director of Nursing, Healthcare Professionals and Quality Governance
- Deputy Medical Director
- Chief Pharmacist
- Chief Psychological Lead

- Person with living experience
- Representation from estates
- Assistant Trust Secretary

The Committee may request the attendance of individuals from within and outside the Trust with relevant experience and expertise if it considers this necessary.

The Chief Executive may be invited to attend as required but at least twice a year.

5. MEETINGS AND QUORUM

5.1 The Committee will agree a meeting calendar on an annual basis, setting out the main work items to be carried out by the Committee at each meeting to ensure that adequate time is given to the main duties of the Committee.

5.2 Members are expected to attend all meetings. Any member unable to attend a meeting of the Committee will be required to forward their apologies to the Assistant Trust Secretary in advance of the meeting, along with the name of their nominated deputy / representative.

5.3 If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he / she will declare that interest as early as possible and shall not participate in the discussions. The chair will have the power to request that member to withdraw until the Committee's consideration has been completed.

5.4 A quorum shall be four members of the Committee, comprising of not less than two Non-Executive Directors and one Executive Director. If the Committee is not quorate the meeting may be postponed at the discretion of the chair. If the meeting does take place and is not quorate, no decision shall be made at that meeting and such matters must be deferred until the next quorate meeting. In the case of none agreement or no decision reached by the majority, the issue is to be escalated to the Board for discussion.

5.5 In the absence of the nominated chair, another Non-Executive Director member will deputise as Committee chair.

5.6 The chair of the Committee may agree that members may participate in its meeting via telephone, video or computer link. Participation in this manner will be deemed to constitute presence in person at the meeting.

6. FREQUENCY

The Committee will meet on a monthly basis.

7. FUNCTIONS

7.1 To provide support and challenge with regards to continuous quality improvement, and to receive assurance of such across the following areas aligned to the Quality Strategy:

- Well-led
- Clinical effectiveness
- Patient safety
- Patient experience and engagement
- Quality Improvement

A cross-cutting focus for assurance and scrutiny includes improvements in arrangements to demonstrate equality, diversity and inclusion in the above areas.

7.2 To seek assurance, providing challenge and scrutiny as necessary, regarding the implementation and delivery of priorities within the Trust's Quality Strategy and Quality Account; along with other priorities / areas of focus as agreed by the Board and the Quality Committee, which will be identified within the Committee's workplan.

7.3 To actively seek assurance the Trust is continuously improving the quality of services for the benefit of patients and carers across the networks.

7.4 Provide scrutiny and challenge that required standards of healthcare are achieved and that action is taken where sub-standard performance is identified. Hold Executive Directors to account for the quality and safety of the Trust's clinical services, patient and carer experience, and clinical risk management outcomes.

7.5 To seek assurance, providing challenge and scrutiny as necessary, regarding the development and implementation of priorities to address health inequalities as they relate to access, experience and outcomes for the people who need our services.

7.6 Seek assurance that the organisational systems and processes in relation to clinical governance (quality, safety, patient experience, and clinical effectiveness) are robust and well-embedded so that priority is given to identifying and managing risks to the quality of care. Report to the Board on the committee's level of assurance regarding the management of strategic risks to the quality of care.

7.7 To receive assurance regarding the Trust's compliance with regulatory requirements and national standards for quality, providing support and challenge; and, if necessary, escalate issues to the Board of Directors.

7.8 To receive information and analysis relating to lessons learned from serious incidents, serious case reviews, regulation 28 letters, homicide reviews, patient complaints etc.; and to seek assurance that learning is embedded and this leads to improvements in the experiences of patients, service users and carers.

7.9 Receive and seek assurance the Trust is assessing and effectively managing current and future Board Assurance Framework risks to quality. Escalate to Board any key risks or areas of concern.

7.10 To receive assurance regarding the robustness of the quality impact of cost improvement plans, and that risks to quality and safety are considered, mitigated and monitored.

7.11 Scrutinise the findings of all Internal Audit reports relating to quality. As appropriate, inform the Internal Audit programme in relation to key areas of quality performance and delivery.

7.12 Refer activities and tasks to appropriate Board level committees or Executive Directors as deemed appropriate by the Committee; having due consideration of the remit of those committees and their workplans.

7.13 Receive and accept delegated activities and tasks from the Board of Directors or other Board committees by agreement.

8. REPORTING

The Committee reports to the Board of Directors.

The Committee will receive regular highlight reports and / or escalated risks / issues from the following group(s):

- Trust-wide Quality Group

The Committee will also receive escalation of issues from Executive Directors or other executive-led groups where there is a quality impact.

9. INPUTS

- Reports and plans as identified in the agreed workplan
- Highlight / exception reports from sub-groups
- Relevant reports / correspondence from regulators and key stakeholders
- Delegated / transferred issues from the Board of Directors and / or Board committees

10. OUTPUTS

- Minutes
- Assurance and action tracker
- Chair's reports to the Board of Directors to provide assurance regarding matters discussed and to highlight / escalate key issues and risks. Chair's reports will also be shared with the Council of Governors.

11. DATE OF REVIEW

These Terms of Reference will be reviewed in April 2024. Following this, an annual review of the Terms of Reference and compliance will take place.

Report to the Board of Directors
Wednesday 3 May 2023
Part I

Pennine Care
NHS Foundation Trust

Risk Management Policy	
Paper prepared by	Alexia Charnley Head of Risk and Compliance
Executive sponsor	Clare Parker, Executive Director of Quality, Nursing and Allied Health Professionals
Date of report	27 April 2023
Purpose of the report and action required	The Risk Management policy has been reviewed and updated to ensure that this is fit for purpose and reflective of the needs, position, values and ambitions of the Trust. This policy is one which requires engagement and ratification by members of the Trust Board.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Risk Management Policy has been updated and amended to reflect current arrangements, roles and responsibilities. It also includes information on the three lines of defence model which incorporates the role of internal audit, as well as some introductory statements relating to risk appetite. This policy should support the Trust in its development and maturity in approach to risk, as well as our ambitions to be Well Led. In review and revision of this policy, the recommendations made by Deloitte have been considered as well as the observations and recommendations made by MIAA.
Recommendation	Members are asked to support the ratification of this policy.
Where else has this report been considered and when?	Risk Management Committee 21 March 2023 Executive Directors Group 17 April 2023 Trust Management Board 19 April 2023

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	x
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	

DOCUMENT CONTROL	
Title:	**Risk Management Policy**
Version:	**1.1**
Reference Number:	**CO129**
Scope:	
This document applies to all staff employed by Pennine Care NHS Foundation Trust, including all staff working within the Trust employed by other agencies, and trainees, students or anyone on a temporary placement.	
Purpose:	
The purpose of this document is to explain to the reader the organisational view on risk management, so that they will be able to actively participate in risk management processes.	
Requirement for Policy:	
Best Practice	
Keywords:	
Risk Register, risk score, likelihood, consequence, treatment, local risk management system	
Supersedes:	
CO022 – Risk Management / Risk Register Policy GL052 – Risk Management Guideline V1 Risk Management Framework	
Description of Amendment(s):	
Inclusion of Glossary of terms Expansion of roles and responsibilities Inclusion of risk appetite, three lines of defence model and risk scoring matrix	
Owner:	
Director of Corporate Affairs	
Accountability:	
Executive Director of Quality, Nursing & Healthcare Professionals/Deputy CEO	

Individual(s) & group(s) involved in the Development:	
This document has been developed in collaboration with the following interested parties: • Executive Team • Risk Management Group • Health & Safety Committee • Trust Management Board • Audit Committee	
Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: **NA**	
Equality Impact Analysis:	
Date approved: **Reference:**	
Freedom of Information Exemption Assessment:	
Date approved: **Reference:**	
Information Governance Assessment:	
Date approved: **Reference:**	
Policy Panel:	
Date Presented to Panel: **Presented by:** **Date Approved by Panel:**	
Policy Management Team tasks:	
Date uploaded to Trust's intranet: **Date uploaded to Trust's internet site:**	
Review:	
Next review date: **Responsibility of:**	31 March 2026 Director of Corporate Affairs
Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
Policy Associated Documents:	

TAD_CO129_01	Guidance on Risk Scoring and Prioritisation
TAD_CO129_02	Risk Management Tools
TAD_CO129_03	Definitions
Other external documentation/resources to which this policy relates:	
CQC Regulations: **This guideline supports the following CQC regulations:**	
17	Good Governance
NICE Products: **This policy has been produced to reflect recommendations published in the following NICE products**	

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1. INTRODUCTION

Risks make the achievement of plans, goals, strategies and ambitions less likely. In order to reduce the likelihood and impact of risks impacting upon anything of value to the Trust, we are proactive in identifying, prioritising and responding to risk. It is everyone's responsibility.

Figure 1 PCFT's *Big Four Ambitions 2022-25.*

For the period 2022 – 2025, PCFT has four Big Ambitions, set out in the Figure 1 above. Our greatest ambition is to provide outstanding care. Anything that could stop us from keeping people safe in our care is a related risk.

The Board has identified six over-arching strategic risks which each pose a threat to the achievement of our ambitions. These form the Board Assurance Framework.

These are:

1 Failure to provide safe care

2 Overwhelming demand

3 Major incident

4 Competition for staff

5 Loss of stakeholder support

6 Lack of financial sustainability

This policy will assist colleagues across the Trust in undertaking proactive risk management activity.

2. PURPOSE

The overall purpose of risk management at PCFT is to:

a. Reduce the level of exposure to harm for patients, colleagues or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable;

b. Promote success and protect everything of value to PCFT, such as high standards of patient care; safe working environments; PCFT's safety record; trusted stakeholder relationships; estate, equipment and supplies; sources of income; reputation.

c. Continuously improve performance by proactively adapting and remaining resilient to changing circumstances and events, such as ever-increasing demand for services; infectious disease; industrial action; cyber-attack; cost inflation or service disruption.

3. GLOSSARY OF TERMS

Term	Definition
Board Assurance Framework	A method for the effective and focused management of the principal risks that rise in meeting the Trust's strategic objectives
Significant Risks	Risks scoring 15, 16, 20, 25 that may adversely impact PCFT objectives.
All Clinical Areas	Any Risk that will affect ALL or more than one Clinical area.
All Trust Wide	Any Risk that will affect ALL or more than one Department, Care Hub, Network or area of the Trust
Departmental Risks	Risks specific to that Department
Consequence	Outcome or impact of an event
Control	The arrangements made or precautions taken to reduce risk at the time that the risk is identified. The current arrangements.
Further actions and mitigation	Actions that underpin the controls in place.
Initial risk	Exposure arising from a specific risk before any action has been taken to manage it
Likelihood	Used as a general description of probability or frequency
Residual Risk	Risk remaining after implementation of risk treatment
Risk	The combination of the probability of an event and its consequence. Risk is considered in terms of the chances of something happening that will have an impact upon objectives.
Risk Appetite	The amount and type of risk that an organisation is prepared to seek, accept or tolerate
Risk Assessment	The overall process of risk identification, analysis and evaluation
Risk Management	The culture, processes and structures that an organisation applies in order to realise potential opportunities, whilst managing adverse effects
Risk Score	Magnitude of a risk expressed in terms of the combination of consequences/ severity and their likelihood
Significant Risk Register	All risk assessments scoring 15+ are brought together to form the risk register

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

Chief Executive – Has overall accountability to the Board for effective risk management. The Chief Executive is responsible for ensuring priorities are determined and communicated; risk is identified and managed in accordance with the Board's appetite for taking risk. Risk appetite is defined in numerous ways, including the degree of delegation to officers and groups set out in the Scheme of Reservation and Delegation; the Trust's suite of policies and guidelines and the target risk score set out for each of the six over-arching risks described within the Board assurance framework.

Non-Executive Directors and Non-Executive Chair – Responsibility to scrutinise and, where necessary, challenge the robustness of systems and processes in place for the management of risk.

Executive Director of Quality, Nursing and Healthcare Professionals – The designated Executive Director with responsibility for oversight of risk management system and processes. Chairs the Risk Management Group.

Medical Director, Executive Director of Quality, Nursing and Healthcare Professionals & Chief Operating Officer – Collective responsibility for the coordination of risk activities across the Medical, Nursing and the Healthcare Professionals workforce, and across operational services to implement and comply with clinical policy and practice in relation to managing risks. Collective responsibility for patient safety and patient experience.

All Executive Directors – To ensure the Risk Management Framework and policy are embedded within their service areas. To take shared responsibility for all risks. To act as Executive lead for organisational risks and maintain oversight and assurance of that risk. To ensure effective management and oversight of scores, controls and key assurances of the risks within the Board Assurance Framework.

Director of Corporate Affairs / Assistant Trust Secretary – The Director of Corporate Affairs is responsible for risk management policy development, coordinating Board assurance within the Board Assurance Framework (BAF); developing and communicating the Board's appetite for taking risk, establishing mechanisms for scanning the horizon for emergent threats and keeping the Board sighted on these, and monitoring the management of risk across corporate departments, Networks and Care Hubs. In the event of unsatisfactory compliance with the risk management process or unacceptable risk exposure, the Director of Corporate Affairs shall escalate the matter to the relevant Executive Director for their immediate attention and action.

Head of Risk and Compliance – Has day to day responsibility for risk management process and health and safety. They shall report to the Director of Corporate Affairs for the development of risk management policy; administration of risk management systems; oversight of risk exposures facing PCFT; provision of risk management training and support to Networks and Care Hubs; and the maintenance of an action plan to improve risk management and health and safety at work.

They shall be responsible for the reporting of relevant data subsets of the risk register to respective audiences and carry out sufficient checks within and across Care Hubs to monitor

the management of risk alongside the Board's appetite for taking risk. The Head of Patient Safety shall take the lead in triangulating lessons for learning ensuring defects, alerts or changes in practice are conveyed to front line teams promptly.

Head of Quality (per care network) – To seek and provide assurance on the management of risks within their care group/hub, and that these are managed appropriately to improve safety for patients, carers, staff and visitors. To seek patient experience/feedback in identifying where there may be risks that require management. To ensure consistency with Trust approach. To conduct and contribute to thematic review across governance leads network. To identify of training needs and to advise and support risk owners.

Associate Directors (Associate Medical Director / Associate Director of Nursing, Health Professional & Quality, Associate Directors of Operations) and Network Directors – Managers; Clinical Lead and Medical Leads at all levels are expected to take responsibility for risk in their area; thereby ensuring that risks are managed appropriately to improve safety for patients, carers, staff and visitors.

To understand and support the embedding of this policy. To take an active lead to ensure risk management is a fundamental part of their team's governance arrangements and part of their approach to clinical and corporate governance. To take appropriate action in line with Trust's Risk Management Policy. To inspire and embed a robust risk management approach in their team.

To have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They shall sponsor their teams within their sphere of control, ensuring that risk management processes are adhered to. In addition, executive directors, clinical and all other directors shall also be responsible, where required, for the provision of specialist advice to the Board of Directors. This acknowledges that all directors are subject matter experts and have specific responsibilities for interpreting and applying national policy, legislation and regulations in respect of their specific areas of expertise.

Head of Patient Safety – Reports to the Deputy Director of Nursing, AHPs and Quality. Working alongside the Head of Risk and Compliance, they will take the lead in triangulating lessons for learning ensuring defects, alerts or changes in practice are conveyed to front line teams promptly. They will provide joint oversight the Patient Safety Data Analyst and provide strategic oversight of the local risk management system.

Patient Safety Data Analyst – Reports to the Head of Patient Safety and has operational responsibility for supporting, training and providing advice to staff in the management of risk. They shall oversee the effective utilisation of risk management processes across the PCFT. They shall analyse and distil risk exposures populated on the local risk management system, ensuring a clear and accurate picture of risk is available for relevant audiences at all times. They will be visible and act as central reference point for risk management issues. They shall be responsible for the effectiveness of the local risk management system, taking whatever action is necessary with colleagues, or the system Vendor, to ensure its effectiveness, validity, data quality and data completeness.

Service/ Team/ Department Managers – To oversee the identification, assessment and treatment of local risks, in accordance with the steps outlined in this policy. To report local risks within the local risk management system and ensure that these are known and

understood within the PCFT with explicit links to where these may impact upon the attainment of objectives.

All staff – To work within the Trust policies, guidelines and risk assessments to protect the health, safety and welfare of themselves, patients and others. To raise concerns about safety or risk issues of which they are aware and contribute to risk identification and risk assessment processes. To report significant events, incidents, accidents and near misses in accordance with Trust policy.

Service users and carers – To take responsibility for their own identified and assessed risk where they have capacity.

Service Providers and partners – To take responsibility for their own identified and assessed risk where these are present or emerge, working collaboratively with PCFT where these have shared controls or require system oversight, engagement and resolution.

Figure 2 General duties and responsibilities for PCFT staff

Main Duties	Board of Directors	Executive Directors	Care Group Triumvirates	Other Managers	All Employees
Strategy & Policy	Cultivate a culture in which risk management is seen as everyone's business. Determine PCFT's vision, mission and values. Set corporate strategy including ratifying a Clinical Strategy. Provide leadership.	Develop and oversee the implementation of strategic plans. Develop and communicate corporate objectives. Proactively anticipate risk. Provide leadership and guidance to employees, business partners and stakeholders.	Develop and Implement a Clinical Strategy. Alignment of care group 'Network' objectives to the PCFT strategy.	Align team/personal objectives to the PCFT strategy.	Deliver personal objectives. Abide by PCFT Values and Behaviours
Organise	Establish an effective risk management system. Establish and keep under review the Board's appetite for taking risk. Focus on material risk and proactive anticipation of future risk.	Develop & apply Risk Management processes. Accept and allocate ownership for risk. Share ownership for cross- enterprise risk.	Apply Risk Management processes. Accept and allocate ownership for risk. Proactively anticipate risk. Provide leadership and guidance.	Apply Risk Management processes. Accept and allocate ownership for risk. Proactively anticipate risk. Provide leadership and guidance.	Follow Risk Management Process. Accept ownership for risk.
Plan & Control	Decide what opportunities, present or future, the Board wants to pursue in developing preferred strategic options. Routinely, robustly and regularly scan the horizon for emergent opportunities and threats by anticipating future risks. Decide whether or not any signifcant risk can be accepted. Simultaneously drive the business forward whilst making decisions which keep risk under prudent control.	Design, apply and monitor the operation of controls to ensure the achievement of objectives and promote organisational success. Ensure failure is planned for – that contingencies are in place and tested for all reasonably foreseeable situations. Allocate, structure and prioritise resources within and across Networks so that risk is managed in accordance with the Board's risk appetite.	Design and apply controls to manage risk in line with the Board's appetite for taking risk. Prepare risk management mitigation plans. Ensure adequate emergency preparedness and contingencies for foreseeable disruptive events. Manage resources to optimum effect. Develop policies, guidelines, procedures and standards to govern the management of risk locally.	Design and apply controls to manage risk in line with the Board's appetite for taking risk. Remain alert to risk. Manage resources to optimum effect. Develop and implement risk management plans.	Undertake and keep up to date with mandatory training and other relevant training. Follow policies, clinical standards and relevant procedures. Act on lessons for learning.
Monitor	Keep under review material risk exposures that are outside the Board's appetite for risk taking at each formal meeting.	Challenge, support, supervise and hold colleagues to account for performance and continuous improvement. Make space for the dissenting voice to be heard.	Monitor the operation of controls and address identified gaps in control. Make space for the dissenting voice to be heard.	Supervise the work of others to ensure controls are applied correctly. Make space for the dissenting voice to be heard.	Report concerns, defects, adverse events or failures to contain risk adequately. Know that PCFT champions the freedom to speak up.
Audit	Determine Audit priorities using an approach which takes into account the potential for harm based on likelihood and impact. Take account of reports from the Audit Committee.	Determine Audit Priorities using a risk-based approach. Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues. Account for control of risk to the Audit Committee where required.	Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues. Account for control of risk to the Audit Committee where required. Undertake appropriate inspection/checks of controls for safety critical procedures. Use peer reviews as an addition source of monitoring where appropriate.	Cooperate fully and assist Internal Audit. Challenge recommendations if they are not agreed. Develop and implement changes in practice within the timescales agreed. Report when concluded.	Cooperate with Internal Audit and act on their findings. Carry out instructions based on agreed audit recommendations.
Review	Effectively hold those responsible for managing risk to account for performance and continuous improvement. Take those decisions which the Board reserves to itself .	Report to the Board all material risks and significant gaps in control.	Report to the Board all material risks and significant gaps in control. Escalate risk in accordance with this Policy. Ensure all risks are reviewed correctly.		

5. RISK STATEMENT

We are committed to having a risk management culture that underpins and supports the business of the Trust. We intend to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Board and management is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.

Line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. In line with our Just Culture approach, proactive identification of risks is encouraged and considered to be good professional practice.

All staff should have an awareness and understanding of the risks that affect patients, visitors, and staff and are encouraged to identify risks. The identification of risk is also a core aspect of our Emergency Preparedness, Resilience and Response (EPRR) framework which supports contingencies for our staff and our patients in times of extremis.

It is understood and acknowledged that there may be similar risks present within different teams, Care Hubs and Networks, but the scores, controls and actions required may be nuanced and specific to their locality. This would require local management and oversight. In other circumstances, the risk identified may apply Trustwide and therefore it is appropriate to manage this as such, with the applicable ownership, oversight and monitoring.

In order to facilitate widespread, effective risk management practice, staff will have access to comprehensive risk guidance and advice. Those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally.

There will be active and frequent communication between staff, stakeholders and partners.

As part of the Annual Governance Statement we will make a public declaration of compliance with risk management standards.

6. POLICY OVERVIEW

When identifying risk we anticipate what might prevent us from achieving our goals. To help identify risk, we look at our historical performance and trends, reported incidents, financial implications, workforce factors and previous events, as well as current challenges. We also

listen to the voices of people who use our services now and in the future. Colleagues are required to be open, honest, to think ahead and take an active part in identifying risk.

Risk analysis involves estimating the severity, the impact the risk has on PCFT and people in our care, and likelihood, the probability of that impact happening within a specific timeframe. At PCFT we use a 12 month forward view. The scores are multiplied to give an overall risk rating between 1 - 25. The risk rating is used to determine risk management priorities and to monitor acceptable aggregates of risk. Colleagues are required to challenge constructively any assumptions made regarding severity and likelihood scoring, and to strive to ensure risk is kept within agreed tolerance.

Risk is treated proactively using a combination of prevention, detection and contingency controls. Prevention controls ensure activities are performed in a certain way and typically involve policies, clinical or operational procedures, guidelines, and training or technical boundaries such as computer systems. Detection controls alert leaders to any deficiencies preventing risk and typically involves performance monitoring, audits, alarms or tests. Contingency controls are designed to allow PCFT to recover from a failure to manage risk and allow the PCFT to continue to function albeit in a modified way. These include business continuity plans and evacuation plans.

Colleagues are required to understand and implement controls designed to manage risk at the PCFT. Controls are the arrangements made or precautions taken to reduce risk at the time that the risk is identified. They are the current arrangements. Organisational learning is reflected in PCFT's ability to continuously reduce the frequency of the same adverse event (incident, complaint or claim). Controls are monitored and continuously improved as part of an open and learning culture.

7. POLICY EFFECT ON PCFT PROCEDURE

Step 1: Determine Priorities

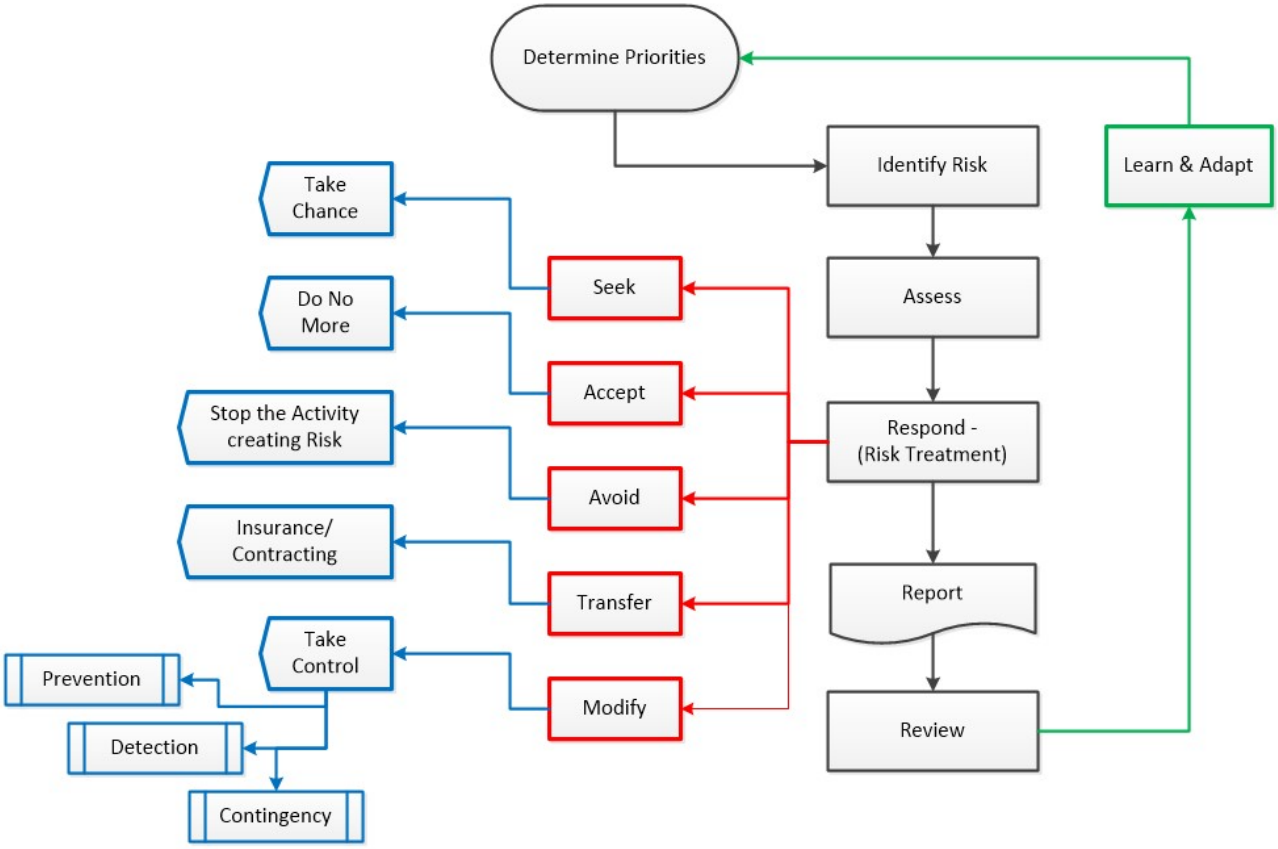
Risk is defined as the effect of uncertainty on the objective. It is essential, therefore, to be clear about objectives for each service and to express these in specific, measurable, achievable ways with timescales for delivery. Priorities will be determined by the Board of Directors and expressed through Care Hubs, service and personal objectives.

Step 2: Identify Risk

Risk will be identified by anticipating what is stopping, or could stop PCFT, Networks or local teams from achieving stated objectives/strategic priorities. Risk identification involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats. The identification of risk is an ongoing process and is never static, but is particularly aligned to the annual planning process. Staff may draw on a systematic proactive consideration of reasonably foreseeable failures alongside incident trends, complaints, claims histories, patient/staff surveys, observations, formal notices, audits or national reports to identify risk. In order to do this staff should identify what is uncertain; consider how it may be caused and what impact it may have on the objective.

Types of risk to consider include; risks related to safety and quality, risks to resources such as financial/ value for money or people/ staffing, risks to PCFT reputation, risks to regulatory compliance and risks to transformation and innovation

Figure 3 Illustration of risk management processes



Step 3: Risk Assessment

Once a risk has been identified, this should be risk assessed, in which the following steps are identified:

1. A summary of 'what the risk is' described in a clear and concise way
2. Risk cause, risk circumstance and risk consequence – Combined these provide an overview of what has caused the risk, for example high staff sickness, what the circumstances are such as unavailability of specialist clinical staff, and the consequence which might include a potential impact upon delivery of safe care.
3. Details of controls in place at the time of assessment, to prevent the risk occurring
4. Details of any gaps in control
5. Assurance sources in place at the time of assessment
6. Actions to be implemented to reduce the risk coming to fruition

The magnitude of the risk is calculated by multiplying the severity of impact by the likelihood of the risk occurring. Be realistic in the quantification of severity and likelihood and use,

where appropriate, relative frequency to consider probability. The risk scoring matrix and guidance is shown in the table figure 4.

Figure 4. Risk grading matrix

	Consequence				
Likelihood	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Rare	**1**	**2**	**3**	**4**	**5**
Low/Unlikely	**2**	**4**	**6**	**8**	**10**
Possible	**3**	**6**	**9**	**12**	**15**
High/Likely	**4**	**8**	**12**	**16**	**20**
Almost Certain	**5**	**10**	**15**	**20**	**25**

Step 4. Evaluate the Risk

There are a number of different options for evaluating a risk, determining how the Trust will respond to this. These options are referred to as risk treatment. The main options most likely to be used include:

- **Seek** - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. Seeking risk must only be done in accordance with the Board's appetite for taking risk.
- **Accept** - this strategy is used when no further mitigating action is planned and the risk exposure is considered tolerable and acceptable. Acceptance of a risk involves maintenance of the risk at its current level. Any failure to maintain the risk may lead to increased risk exposure which is not agreed.
- **Avoid** - this strategy usually requires the withdrawal from the activity that gives rise to the risk.
- **Transfer** - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co- production models of care delivery. Staff must take advice from the Executive Team before entering into any risk transfer arrangement.
- **Modify** - this strategy involves specific controls designed to change the severity, likelihood or both. This is the most common strategy adopted for managing risk at PCFT. For this reason, we expand on the nature of control as follows:

There are three types of control used to modify risk and comprise of:

- **Prevention/Treatment** - these controls are core controls and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre- procedure checks
- **Detection** - these controls provide an early warning of core control failure, such as a smoke alarm, incident reports, performance reports, audits
- **Contingency** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Contingency controls help to maintain resilience.

A combination of all three types of control is usually required to keep risk under prudent control.

Step 5: Report Risk

Key outputs from the risk management system shall be reported to relevant staff / committees depending on the residual risk score as follows:

15 – 25	Executive Director, Trust Management Board, Board of Directors
10 – 14	Network and Risk Management Group
6 – 9	Specialty / Care Hubs Governance Meeting
1 – 5	Ward/ Team/ Department Management

The Board of Directors shall receive summary reports at each formal meeting to inform them of all material risk, the nature of controls and actions being taken.

The Risk Management Group will receive reports to inform them of the distribution of risk across PCFT, details of all significant risk (scoring 15+), material changes to the significant risk profile and progress with action plans.

Care Hubs will have access to the local risk management system and receive system generated Care Group specific reports in order to review the identification of risks within their wards, departments and specialties, and check that adequate controls are in place and actions are being implemented.

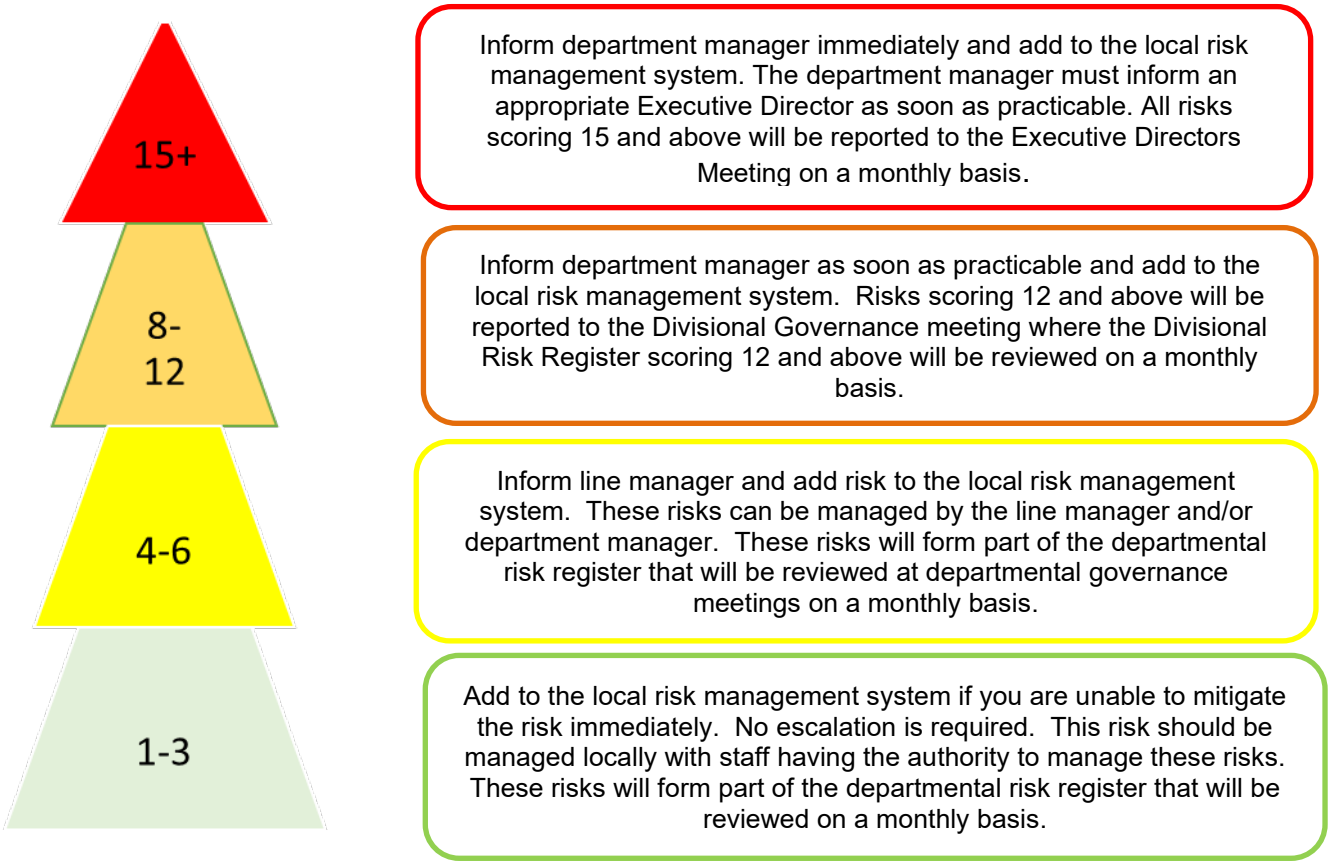
The Executive Team will be informed by the Director of Corporate Affairs of any new significant risk arising at the first meeting opportunity.

The Audit Committee will scrutinise assurances on the entire risk management system to ensure it remains fit for purpose and, at the Committee's discretion, will examine assurances on the operation of controls for all significant risk exposures or any other risk of interest to the Committee.

In the event of a significant risk arising out with meetings of the above, the risk will be thoroughly assessed, reviewed by the relevant Clinical Director, Care Group Directors of Nursing, Care Group General Managers and Executive Director and reported to the Chief Executive (or their deputy) within 24 hours of becoming aware of the risk. The Chief Executive, with support from relevant members of the Executive Team and advisors, will determine the most appropriate course of action to manage the risk. The Chief Executive will assign responsibility to a relevant Executive Director and for the management of the risk and the development of mitigation plans. The risk will be formally reviewed by the Executive Team at their next weekly meeting.

These arrangements for risk reporting are summarised in Figure 5.

Figure 5 Risk reporting summary



Step 6 Review Risk

Review risk at a frequency proportional to the residual risk. As a guideline it is suggested, as a minimum, risk is reviewed as shown in the table below. The purpose of these reviews is to ensure that the scoring, controls and assurances remain appropriate and are not affected by change in policy, climate and circumstance:

Green with scores 1 – 3	Very low risk	Review at least annually
Yellow with scores 4 - 6	Low risk	Review at least quarterly
Amber with scores 8 - 12	Moderate risk	Review at least bi monthly
Red with scores 15+	High risk	Review locally at least monthly, with committee oversight

The relationship between Risk Management Group, Quality and the Audit committees

To ensure effective oversight and scrutiny of the entire business of PCFT, the relationship between the Risk Management Group, Quality Committee and Audit Committee is based on inclusiveness, clarity of purpose and constructive challenge. The Risk Management Group will oversee the implementation of the Risk Management Policy, being a sponsor of good practice. The Risk Management Group will provide the Audit Committee with assurance on the effective operation of internal controls.

The Quality Committee is comprised of both Executive and Non-Executive Directors and will oversee the management and review of assurances on the operation of clinical/quality governance controls. This will include the detailed review of clinical controls and provision of assurance to the Audit Committee. In addition, the Quality Committee may undertake reviews of significant clinical risks in order to support the Risk Management Group.

The Audit Committee will oversee and satisfy itself that the system of internal control is effective. It will receive, but not be limited to, reports and assurance from the Chairs of the Risk Management and Quality Committees in addition to independent assurances from Internal Audit.

Three lines of defence model

The Three Lines of Defense Model is seen as a simple and effective way to clarify roles and responsibilities in relation to risk management. Importantly, it outlines the role Internal Audit plays in providing assurance on the effectiveness of governance, risk management arrangements and internal controls within an organisation.

The Trust's approach to risk assurance is based on the widely-adopted Three Lines of Defense model as endorsed by professional bodies such as the Charted Institute of Internal auditors, the Charted Governance institute and the Institute of Risk Management. The model provides a useful way to understand how the Trust's risk management assurance functions operate and interact.

The Model identifies three lines of defense in effective risk management:

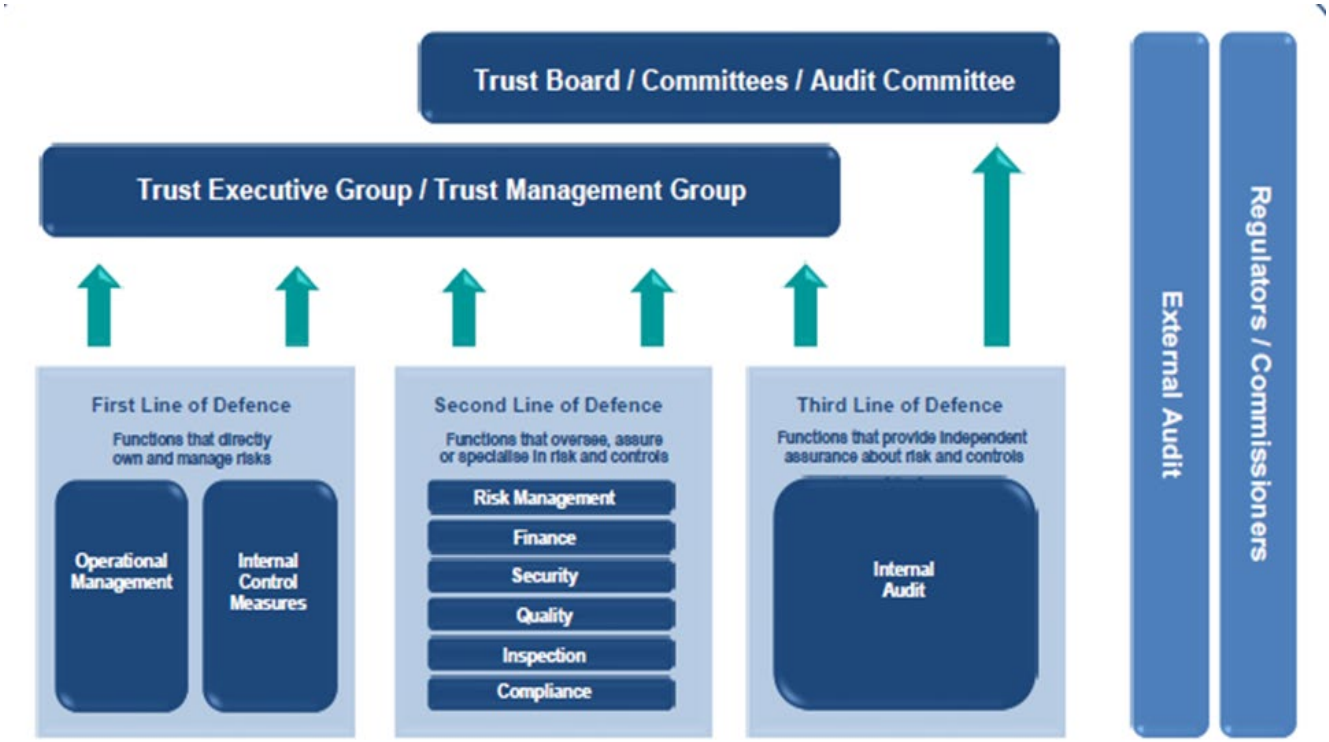
First line of defense - functions that own and manage risk

Second line defense - functions that oversee risk

Third line of defense - functions that provide independent assurance

The three lines of defense then work collectively to support the governing body, and senior management, in being able to focus at a strategic level. If responsibilities are clearly defined, each line of defense can understand the boundaries of its responsibilities and how its position fits with the overall organisational risk management structure. This is demonstrated in figure 6.

Figure 6. The Three lines of defense model



8. RISK APPETITE

Expressing risk appetite can support the organisation to take decisions based upon an understanding of the risks involved. The risk appetite statements below support the expectations for risk-taking to managers and improve oversight of risk by the Board.

Risk Category	Risk Appetite Statement
Quality and Patient Safety	The quality of our services and the safety of our patients is a priority for PCFT. Our preference is for risk avoidance and to keep quality and safety at the heart of what we do. We will, if necessary, take decisions of quality where there is a low degree of inherent risk and possibility of improved outcomes, and appropriate controls are in place.
Financial/ Value for Money	We are prepared to accept the possibility of limited financial risk. However value for money is our primary concern.
Compliance/ Regulation	We recognise that we operate in a regulated environment and as a Foundation Trust have a high level of compliance required from numerous regulatory sources. We have a minimal risk appetite in relation to this and will avoid decision making that may result in heightened regulatory challenge, unless there is clear evidence where similar actions have been successful.
Reputation	We have a minimal risk appetite relating to reputational risks. Risk is limited to those events where this is no change of significant reputational repercussions. The reputation of services from our local population and system partners is important to us as we move forwards.

People	Our people are at the centre of our decision making. We have a low risk appetite in relation to our staff safety at work however we are prepared to accept the possibility of some workforce risk as a direct result of innovation. The current workforce challenges faced across the NHS require us to look at the potential to improve recruitment, retention and development opportunities for our staff.
Innovation	The Trust has a greater risk appetite to pursue innovation, challenge current working practices and take opportunities where there are anticipated benefits for our local population. We will support a focus on growth and service development but priority will be given to improvements that protect current operations.

9. STANDARDS AND KEY PERFORMANCE INDICATORS

The following indicators shall form the Key Performance Indicators by which the effectiveness of risk management processes described in this policy shall be evaluated:

All verified significant risks (scoring 15+) are reported to the Board of Directors at each formal meeting of the Board.

All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of the Risk Management Group.

The risk profiles for all Networks and corporate services are reviewed by the Risk Management Group at least annually as part of a rolling programme of reviews. Locally managed risk registers are in place through the local risk management system and are maintained and available for inspection at ward/departmental level. These show details of control, assurances, location, owner, action plan (where necessary) and ≥80% of risks are within review date. Compliance with the above will be monitored by the Head of Risk and Compliance, reviewed by the Director of Corporate Affairs and an annual report submitted to the Risk Management Group.

Item monitored	Monitoring Method	Responsibility for monitoring	Frequency	Group or Committee
Risk Management Framework	Review	Corporate Affairs Team	Annual	Executive Directors Audit Committee
Annual Governance Statement	Internal / External Audit	Corporate Affairs Team	Annual	Audit Committee
Risk Management Process	Internal Audit	Assurance Team / Divisions	Annual	Audit Committee

10. BOARD ASSURANCE FRAMEWORK

The maintenance of a Board Assurance Framework (BAF) is a governance requirement. It incorporates a register of the highest scoring risks faced by the organisation in meeting its strategic objectives. It provides us with a simple but comprehensive Board view of PCFTs

risks to the achievement of our strategic objectives and the gaps in assurances on which the Board relies. It is maintained by the Director of Corporate Affairs, on behalf of the Board.

The BAF is developed by identifying the risks that may threaten the achievement of the Trust's objectives. It includes the following information:

- Details of the key controls in place to mitigate identified risks
- Assurances that those controls operate effectively
- Gaps in controls and/or assurances
- Further action required

The BAF is regularly reviewed by the Board of Directors and it's committees. The purpose of the committee scrutiny is to seek assurance that the system of internal controls designed and implemented by management is appropriately designed; consistently applied and is operating effectively.

11. TRAINING

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

Training required to fulfil this framework will be provided in accordance with the Trust's Training Needs Analysis.

Management and monitoring of training will be in accordance with the Trust's Core and Essential Training.

Specific training will be provided in respect of high level awareness of risk management for the Board.

Risk Awareness Sessions are included as part of the Board's Development Programme.

Training will be available on risk assessment, particularly the scoring or grading of risks, and how to use the risk register.

The specific training required by staff group are outlines below.

Staff groups	Training need	Frequency	Format	By who
Executive and non-Executive Directors of the Board	Board Risk Awareness training	Annual	Workshop session as part of Board Development Programme	Director of Corporate Affairs
Trust senior managers	General Risk Awareness Training	Every 5 years	PowerPoint presentation/workshop	Head of Risk and Compliance
	Risk assessment training	Every 5 years	PowerPoint presentation/workshop	
	Risk register training	Every 5 years	PowerPoint presentation/workshop	

	Management of risk for senior managers	Every 5 years	PowerPoint presentation/workshop	
All new staff	Risk awareness training and an understanding of the role of risk management in the organisation	Once only Completed as part of induction	PowerPoint presentation/workshop	Corporate Induction Programme
Existing staff	Ad hoc bespoke training Risk assessment training	As required Ad hoc /as required	Variable according to need PowerPoint/workshop	Head of Risk and Compliance/ Patient Safety Data Analyst
Staff involved in risk management	Individually addressed according to individual needs	Dependent on individual needs and experience	As required	Local managers

All other mandatory training will be booked and managed in accordance with Trust's Core and Essential Training processes.

12. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy.

13. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

14. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

15. SAFEGUARDING

All staff have a responsibility to promote the welfare of children and young people and to protect adults at risk of abuse, enabling them to retain independence, well-being, dignity and choice. This requires a 'Think Family' approach as neither children, young people, adults and their families and carers exist or operate in isolation. Safeguarding is a range of activities undertaken by all of us supporting all adults and children's rights to be safe.

Where there are safeguarding concerns all staff should act upon them in line with the Trust Safeguarding Families Policy and Local Safeguarding Partnership Procedures.

16. ANTI-FRAUD, BRIBERY AND CORRUPTION

The Trust is committed to reducing the level of fraud, bribery and corruption within the NHS and has adopted a Local Anti-Fraud, Bribery and Corruption Policy. Individuals should refer and adhere to this policy. Risks relating to this agenda are appropriately assessed, captured and recorded within the local risk management system and reported through the Trust meeting structure.

Concerns about fraud, bribery or corruption should be reported to the Trust's nominated Anti-Fraud Specialist using the contact details contained within the Local Anti-Fraud, Bribery and Corruption Policy. These details can also be found on the Trust's Counter Fraud intranet page.

Alternatively concerns can be reported via the NHS Fraud and Corruption Reporting line on 0800 028 4060 or using the online report tool, www.reportnhsfraud.nhs.uk. All contacts are dealt with by experienced trained staff and anyone who wishes to remain anonymous may do so.

17. MONITORING

The effective application of this policy / guideline, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design.

Monitoring will take place on an annual basis as part of the annual report and will be reportable to the Quality Group as the relevant body.

18. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

19. REFERENCES

Equality Act 2010

Freedom of Information Act (2000)

Home Office Risk Management Policy and Guidance, Home Office (2011)

A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)

NHS Audit Committee Handbook, Department of Health (2011)

UK Corporate Governance Code, Financial Reporting Council (2010)

Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance, Audit Commission (2009)

The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)

Risk Management Assessment Framework, HM Treasury (2009)

Understanding and Articulating Risk Appetite, KPMG, (2008)

Board Guidance on Risk Appetite, Good Governance Institute (2020)

Good Practice Guide: Managing Risks in Government, National Audit Office (2011)

Pennine Care
NHS Foundation Trust

Report to the Board of Directors
Wednesday 3 May 2023

Deloitte recommendations under Well Led review.	
Paper prepared by	Andy Chittenden, Director of Corporate Affairs
Executive Sponsor	Clare Parker, Exec Director of Nursing, Healthcare Professionals and Quality Governance; Deputy CEO
Date of Report	18 April 2023
Purpose of the report	To update the Board on progress made in actioning the agreed recommendations of the autumn 2022 *Well Led* review by Deloitte LLP.
Executive summary / key issues	Progress has been made in addressing management actions arising from the review.
Recommendation	The Board is asked to scrutinise the assurance provided, triangulating it with assurance arising from the reports of Chairs of the Board's assurance Committees, appearing at the latter stages of the Board agenda.

Preamble
The Board received and adopted all recommendations within the *Well Led* review commissioned from Deloitte LLP at its meeting on 2 November 2022.

The approach taken by Deloitte for the review covered all eight key lines of enquiry within the NHSEI Well Led Framework, but focussed on four of them:

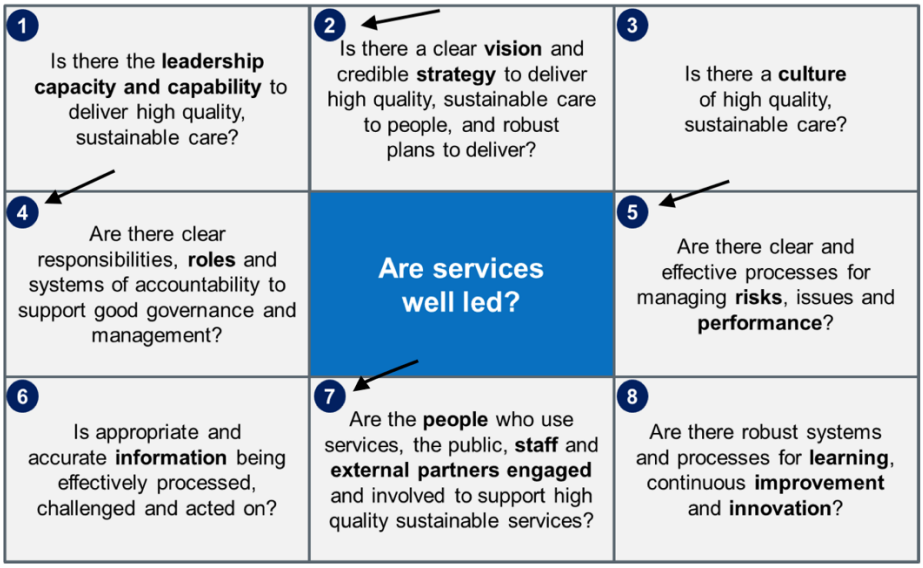


Figure 1 The NHSEI Well Led Framework

At the Board meeting on 2 November 2022, the Board considered the recommendations report, which was accepted in full. The Board approved clear timelines for delivery of the recommended actions; aligned each action to an Executive Lead; and also aligned each recommendation to the Board, or one of its Committees for scrutiny of assurance of completion. Actions are intended for completion by the end of April 2023, and review by the Board on 3 May 2023.

This report provides the Board with an opportunity to:

a) Triangulate assurance provided here with escalation reports from the Chairs of the Quality Committee and the Performance & Finance Committee in relation to their scrutiny of those recommendations allocated to those Committees. They met respectively on 21 February and 22 February 2023.
b) Scrutinise the progress being made on the remaining recommendations, for which a small number remain to be completed.
c) Note that where the intention of the recommendation was to constructively challenge the Trust, and the Trust has accepted the challenge, resulting in review of, or adjustments to governance arrangements, the item has been closed. This does not mean that the topic will slip out of focus – but that it will remain a matter for consideration by a relevant scrutiny body, such as a Committee.

The most recent additions to the tracker during the past month are presented in red text.

Monitoring implementation
The Board and its Committees will be provided with updates until completion is achieved.

Recommendations
The Board is asked to:
a) Consider the report, in the light of escalation reports from the Committee Chairs.
b) Direct any further action required or assurance sought.
c) Note the progress made in completing management actions in relation to the recommendations.

Deloitte Well-Led report recommendations sorted by delivery date as at 18 April 2023
(Most recent edits in red text).

KLOE	No	Recommendation	Priority rating* determined by Deloitte	Provisional Executive Owner	Committee scrutiny	Provisional planned completion yymmdd	Comments	Date last reviewed Execs	Date due to go to Committee	Date to be reviewed at Board	Proposed completion date if different.	Open or completed
KLOE1 Board Leadership	18	**KLOE 1 Board Leadership:** The Board is going through a transitional period and would benefit from board and executive development activities. In addition to supporting team building, board development activities should incorporate good practice in effective scrutiny and challenge as a unitary board, while executive specific activities should consider integrated working and joint executive accountability.	MEDIUM	Director of Workforce	ARC	230430 230503	GGI retained to deliver Board development sessions for the whole Board; for Executives and for NEDs. Duration of programme into H2 2023/24. The programme is multi channel, including whole Board; Exec groupp; NED group; individual coaching. This recommendation ('the Board would benefit from Executive and Board development activities..') is considered closed as a development programme with an external consultant has been put in place. Board and Executive development will remain a focus for th Board's ARC committee.	23.1.23 17.4.23	15.2.23 Postponed from 18.1.23. Next meeting date TBC	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 5 Risk & Performance	11	Progressing the current trajectory, the Trust should continue to roll-out the consistent use of the BAF across the board and committees. This should aim to reach a point where the relevant committees assume ownership for their respective risks, the Audit Committee provides assurance through a programme of deep dives, and the highest risks are actively discussed at the Board. The Trust should commission its internal auditors, or other specialists, to review practical use of the BAF in practice within a six-month period of this review.	MEDIUM	Deputy Chief Executive	Audit Committee	230131 230201	MIAA has agreed ToR to review the BAF in early 2023. Six over-arching strategic risks have been recognised as populating the BAF and scrutiny of the controls effectiveness assigend to relevant committees. MIAA reported substantial progrss in the structure, content of the BAF. Leaders and managers across the Trust are increasingly recognising the six strategic risks and cross referencing mitigating workstreams to them. All actions are complete as at 23 Feb 2023, with the exception of Audit Commitee 'deep dives' which we plan to be undertaken by way of details assurance papers about risk management and the use of the BAF. Audit Committee paper 15.3.23 on risk management governance assurance based on the three lines of defence approach to an assurance paper.	23.1.23 17.4.23	IT outage prevented reporting on 15.12.23, 15.3.23 26.4.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 5 Risk & Performance	12	In parallel to embedding use of the BAF in committees, the Trust should refine the number and articulation of risks in the BAF to around ten strategic risks; add a front sheet to highlight changes to scoring, new or emerging risk, risks which have been closed and the number of risks scored outside of appetite; and more explicitly link the BAF with the CRR. The last point would benefit from an executive led Risk Management Group to assimilate the highest corporate risks with strategic risks (see R13).	MEDIUM	Deputy Chief Executive	Audit Committee	221207	BAF refined to 6 strategic risks. Adopted by Board 7.12.22 for the duration of the strategic plan 2022-25. Commentary provides a developing narrative to the risk horizon and connection with operational risks. Management have formed a Risk Management Group. The Risk Management Group has ToR. Reporting to variety of fora is becoming more standardised. A revised risk management policy has been drafted and is available to all staff during a 30 day consultation. It is planned for approval as *fit for purpose* at Trust Management Board on 19 April. Ratification, so that it comes into force *is planned for the Board meeting on 3 May 2023.*	23.1.23 17.4.23	IT outage prevented reporting on 15.12.23. 15.3.23 26.4.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 5 Risk & Performance	13	The Trust should introduce an executive led Risk Management Group with responsibility for oversight of the CRR, integration of the CRR with the BAF, and ensuring line of sight on risk from Board to operational level.	HIGH	Deputy Chief Executive	Audit Committee	221207	Deputy CEO has established a Risk Management Group. Met 13.12.22. Group will review high scoring risks; network risks, corporate services risks by rotation.	23.1.23 17.4.23	IT outage prevented reporting on 15.12.23.	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 5 Risk & Performance	14	Given the volume of work required to cleanse risk registers at the operational level and embed consistency of practices in applying risk management techniques, the Trust should review the need for a risk manager to support review and development in this area.	MEDIUM	Deputy Chief Executive	Audit Committee	221130	Head of Risk and Compliance appointed to an 8c role, commences 6.3.23.	23.1.23 17.4.23	IT outage prevented reporting on	01/02/2023 01/03/2023 03/05/2023	15.3.23 6.3.23	Closed
KLOE 2 Vision & strategy	3	With a view to addressing the balance of board time between strategic and operational matters, the Chair should lead a process for updating the annual plan to ensure that there is a structured programme for the board and committees to influence and review progress in relation to the development of the clinical services strategy, network level strategies and other enabling strategies. This should be done alongside the development of a set of Key Performance Indicators (KPIs) for the Board and committees to monitor implementation of the strategic objectives.	MEDIUM	Chair Chief Executive	Board	230430 230503	Annual cycle of business reviewed and approved by the Board for 2023 at meeting on 7.12.23 and reviewed 1.2.23. Further development of performance reporting is underway. Board meeting agenda has been adjusted to coalesce around five headers: culture; strategy; resources; performance; accountability. This triangulates with requirements to give more prominence to culture and strategy within Board meetings (as set out as desirable in the revised Code of Governance effective 1.4.23). There are nine measures and further sub-measures associated with the Big 4 Ambitions, set out in strategy documents. Trust Management Board engaged with annual planning process 22.3.23 with Board engagement planned for 5.4.23. The Board has also procured further independent Board development advise from an external adviser, which includes observations on Board practice and performance. The Board most recently considered the Annual Plan on 5th April.	23.1.23 17.4.23	1.2.23 1.3.23 3.5.23	01/02/2023 01/03/2023 03/05/2023		Open
KLOE 4 Good Governance	4	The Trust should review the potential benefits to the effectiveness of Board and committee meetings through greater use of exception reporting; more assurance-based committee escalation reports; wider ED participation to promote multi-disciplinary working; and occasional committee exposure to network leaders.	MEDIUM	Chief Executive	Board	230111	Amendments have been made and are in progress re Board rhythm and effectivness: - 2023 to have fewer formal meetings (target 9) - 2023 to have target 10 development sessions - revised 'shape' to Board agenda giving prominence to culture and strategy - portfolio of improvements to performance reporting being planned - and evidence coming through in strategic performance report quarterly. - an appetite (IPC constraint allowing) to hold Board meetings in a wider variety of locations (May Board planned for a local Town Hall). The Board has also procured further independent Board development advice from an external adviser, which includes observations on Board practice and performance. This item is considered closed, though Board and committee performance will remain a current topic via the Board development programme with an external partner.	23.1.23 17.4.23	1.2.23 1.3.23 3.5.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 4 Good Governance	6	The Trust should reinstate leadership development activities aimed at the collective development of the triumvirate leadership teams at the network and care hub levels. This programme should focus on raising support for the development of functional skills, as well as for promoting more integrated accountability and working across professional groups, but especially the role of senior medical leaders.	MEDIUM	Director of Workforce	People & Workforce Committee	230430 230503	Collective leadership development sessions undertaken with Tier 1-3 members and corporate colleagues in October/November 2022. Executive led session held with Tier 2 in December and further sesson planned 16th January 2023 to discuss accountabilty and performance framework and governance structures. Leadership strategy in draft setting out ongoing objectives for leadership development activities to further embed collective leadership model and effectively induct new leaders into the collective leadership model. This recommendation ('to reinstate leadership development acytivities') is considered closed, though leadership development will continue to be an area of interest for the Board and People & Workforce Committee.	23.1.23 17.4.23	24.1.23 28.3.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 4 Good Governance	8	The Trust should ensure that time is ring fenced for the leadership responsibilities of network and care hub medical/clinical directors and that sufficient support is made available for the individuals to contribute the allocated time. This should be done alongside a review of whether there is a need to adjust the current number of sessions allocated to the role.	HIGH	Medical Director	People & Workforce Committee	230430 230503	Recruitment initiatives are beginning to support backfill sessions for CDs and Network Ass Medical Dirs. Job planning remains key to identifying the relevant resources t fully release clinical and other leaders into their roles.	23.1.23 17.4.23	24.1.23 28.3.23	01/02/2023 01/03/2023 03/05/2023		Open
KLOE 4 Good Governance	10	The Board should seek assurance from the relevant executive director that the central services restructuring has adequately considered the distribution of functional resource between central services and those embedded within the networks. Specifically, it should ensure that network and care hub leaders have the appropriate resource to support in key areas such as informatics, transformation, quality governance, finance, and HR.	MEDIUM	Director of Workforce	People & Workforce Committee	230430 230503	Director of Workforce is the Exec sponsor for the corproate transformation work supported by Deputy Director of Strategy. Reporting to the organisational redesign group a corporate transformation programme workstream has led work to review/evaluate the outcomes of the redesign and assess whether fit for purpose within the current climate. Report to be completed by end Jan with recommendations for any changes/additional resource requiements for consideration. Review completed in April 2023 setting out the additional roles corporate functions consider are required. Further work is underway to benchmark, prioritise and if required put forward a business case to support funding for	23.1.23 17.4.23	24.1.23 28.3.23	01/02/2023 01/03/2023 03/05/2023		Open
KLOE 7 Stakeholder Engagement	15	The Trust should consider available mechanisms to raise the visibility and profile of NEDs and the wider ED group with staff. In addition to increased service visits, this could potentially include enhanced use of webinars, newsletter profiling and other online communications. In addition, there may be opportunities for wider NED in-person engagement through activities such as aligning members with networks or facilitating occasional meetings between NEDs and staff groups.	MEDIUM	Director of Strategy	People & Workforce Committee	230430 230503	This is included in the Communications Plan. The Trust is raising visibility and profile via a number of different and increased ways - which includes promotion in our *Together We Can* weekly updates for staff (*Who's that?* colleague' features, general stories re: visits, events, news), including with quotes/video clips in our high profile 'gold' awareness weeks/months, social media, comms projects/events (eg: *Great Big Thank You*, Christmas e-card) and board photo structure used in Trust-wide welcome and team posters. Staff Survey results of autumn 2022 released spring 2023 illuminate on an improving culture, which isrecognised by staff and represents a faster improving situation than many local peers and a wider peer groupp of mental health, learning disability and autism sevioce providers. This recommendation ('to consider mechanisms to raise the visibility of EDs and NEDs..') is considered closed, though the topic will remain of interest to the People & Workforce Committee.	23.1.23 17.4.23	24.1.23 28.3.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 7 Stakeholder Engagement	16	To leverage existing leadership capacity and address external perceptions regarding a lack of senior leader external engagement, the Trust should develop a stakeholder engagement plan that maps out all key external relationships and develops a prioritised plan for engaging externally. This plan should consider the combined role of EDs, NEDs, network leaders and potentially governors.	MEDIUM	Director of Strategy	People & Workforce Committee	230430 230503	We have undertaken a mapping exercise and have identified representation at all key ICB and locality meetings. This includes non-executive, executive and network/care hub level representation. More detailed stakeholder mapping has been undertaken as part of the development of our Partnership Strategy that is planned to be complete by April 2023. This recommendation ('to develop a stakeholder engagement plan') is considered clsed as key stakeholders have been mapped and specific individuals identified with specific fora for engagement. The topic will remain of interest to the Performance and Finance Committe through it's scrutiny of BAF Risk % (losss of stakeholder engagement).	23.1.23 17.4.23	24.1.23 28.3.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 3 Culture	19	**KLOE 3 Culture:** As part of the process for developing an accountability and performance framework, the Board should consider whether there is a need to rebalance its approach to managing poor behaviours, accountability and holding to account. Any rebalancing should be done in line with the excellent work the Trust has done in relation to areas such as embedding values and Just Culture.	MEDIUM	Director of Workforce	People & Workforce Committee	230131 230201	The trust has an existing behaviours framework that describes expected behavours for everyone (in support of the values), and an appraisal process (MYC) and supervision arrangements that provides a structured way of managing performance along with a capability policy and training for managers that supports management of poor performance. The expectations on managers to effectively manage poor performance and behaviours will be strengthened through the work to develop the accountability and performance framework. The appraisal process for line managers/senior managers has been strengthened to give additional guidance to senior managers on the areas they are required to seek assurance on from their staff with line management responsibility. The new MYC documentation is currently in final draft. The guidance has been strengthened to ensure the golden thread for each individual is clear on their objectives and how they connect to the strategic objectives and annual business plan. This recommendation (' to consider whether there is a need to rebalance its approach to managing poor behaviours, accountability and holding to account') is considered closed. People and Workforce Committee will continue to have oversight of employee	23.1.23 17.4.23	24.1.23 28.3.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 2 Vision & strategy	2	As an aid to supporting the strategic planning process, the CEO should ask the network leadership teams to produce strategic plans for their respective networks. This process, which should be supported by central planning resource, could be used to support the development of network and care group level leaders, whilst also providing bottom-up content to influence the corporate plan and enablers.	MEDIUM	Chief Executive Director of Strategy	Performance & Finance Committee	230430 230503	This is being developed as part of the 23/24 planning round. Leadership Teams have been involved in a wide ranged planning meetings, including clinical leadership. Specific recent events took place at Earl Mill on 10 April and 24 April. Network and care hub level plans are currently being finalised and should be in place by May Board.	23.1.23 17.4.23	25.1.23 22.2.23 29.3.23 27.4.23	01/02/2023 01/03/2023 03/05/2023		Open
KLOE 4 Good Governance	5	The Trust should develop an accountability and performance framework that provides greater guidance regarding the governance structure within networks and care hubs. This process should be used to raise consistency across networks, but more importantly to promote joint accountability and responsibility across professional groups with a view to enhancing multi-disciplinary working within the triumvirates. For example, closer integration between quality, performance, workforce, and finance forums.	HIGH	Chief Operating Officer	Performance & Finance Committee	230430 230503	•Review of governance structures underway to align in each network and care hub. •Networks in the process of combining the Network Ops and Performance meeting with the Network Quality meeting. •Head of strategic performance and planning has in development the performance and accountability framework which has been shared with Networks for feedback on 16/01/23. •To be further shared with care hubs for feedback. Workshop held 16.1.23 where themes identified to incorporate into performance and accountability framework. Report planned for Exec Directors 20.2.23 setting out engagement timetable andsign off. Further discussion and iterations underway in March 2023, which include consideration of the future role of Trust Management Board in the light of the SoRD being approved by P & F in Feb 2023.	23.1.23 17.4.23	25.1.23 22.2.23 29.3.23 27.4.23	01/02/2023 01/03/2023 03/05/2023		Open
KLOE 4 Good Governance	7	The Trust should consider the appointment of an accountable officer for each network and care hub to ensure there is clarity regarding where overall responsibility lies for delivery.	HIGH	Chief Operating Officer	Performance & Finance Committee	230131 230201	Discussions have been had at the triumvirate away day on 12th Dec 22 and at the collective leadership away day on the 16th January 23 focusing on the performance and accountability framework Dec 23 Review of the JDs for Network roles undertaken. Jan 23 Slide deck to Execs to discuss recommedations. Further engagement is being undertaken as there was found to be no consensus for a Network Accountable Officer being designated from amongst each triumvirate. There is an intention to launch a refreshed Performance and Accountability Framework in April 2023, after review by execs on 13 March 2023 and TMB on 22 March 2023. Further discussion and iterations underway in March 2023, which include consideration of the future role of Trust Management Board in the light of the SoRD being approved by P & F in Feb 2023. This action ('to consider the appointment of an accountable officer...') is considered closed as this has been undertaken, but the collective view was that it was not preferred.	23.1.23 17.4.23	25.1.23 22.2.23 29.3.23 27.4.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 4 Good Governance	9	The Trust should introduce Executive Review Meetings as a priority to provide enhanced executive oversight of network performance and to promote integrated working at the executive and network levels. Consideration should also be given to introducing a similar arrangement between the network and care hub leaders. These arrangements should be captured in the accountability and performance framework.	HIGH	Chief Operating Officer	Performance & Finance Committee	230430 230503	Network Quarterly Executive reviews instigated and dates in calender. First review took place on the 22nd November. Care hub quarterly reviews to be implemented subsequetly. Captured in the governance of the new accountabilty and performance framework, developed by Head of Strategic performance andf planning. This recommendation ('to introduce Executive Review meetings...') is considered closed as these meetings have been built into the performance governance arrangements now in use. The topic will remain of interest to the Performance and Finance Committee.	23.1.23 17.4.23	25.1.23 22.2.23 29.3.23 27.4.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 2 Vision & strategy	1	Whilst recognising the executive team has collective responsibility for developing a clinical services strategy, the team should assign executive leadership responsibility for development of this strategy to the Medical Director. The MD should then use this platform as a mechanism for specifically engaging medical leaders at all levels of the organisation in its formulation and implementation.	HIGH	Chief Executive Medical Director	Quality Committee	230430 230503	The substantive Medical Director is the Exec Lead for the clinical strategy as of 1 Jan 2023. There is a programme of clinical engagement in place to shape the strategy during winter 2023. Progress has been disrupted by the requirement for mask wearing within meetings attended by 10+ colleagues, which has impacted opportunities for clinical engagement. Further engagement session took place with the Board 1.3.23. It was agreed that further clinical engagement would be undertaken. This recommendatin ('to assign the clinical strategy to an Exec Lead') is considered closed, but the topic will remain current. The Quality Committee and Board will remain engaged.	23.1.23 17.4.23	24.1.23 21.2.23 28.3.23 25.4.23	01/02/2023 01/03/2023 03/05/2023		Closed
KLOE 7 Stakeholder Engagement	17	Building on the current momentum, the Trust should take a strategic decision on how high it wishes to prioritise service user and carer involvement. This should include consideration of the Board's appetite for making the level of investment required to bring the organisation in line with best practice in relation to service user/carer participation and co-production.	MEDIUM	Deputy Chief Executive	Quality Committee	230430 230503	Currently benchmarking against other organisations level of resource and also board level appointments. Will align with the progress of workstream of review of corporate redesign/integrated leadership. Aiming for board development session in Spring to explore appetite.	23.1.23 17.4.23	24.1.23 21.2.23 28.3.23 25.4.23	01/02/2023 01/03/2023 03/05/2023		Open
KLOE 8 Innovation	20a	**KLOE 8 Innovation:** Trust aspirations are high regarding the development of a best-in-class approach to Quality Improvement and broader leadership development. Plans are currently aspirational, and the Board should take a decision on how high a priority these areas are for investment.	MEDIUM	Director of Strategy Deputy Chief Executive	Quality Committee	230430 230503	The Strategic Delivery Hub is revising improvement and programme arrangements across the trust and ensuring QI approaches are embedded. A refreshed approach to QI is currently being developed.	23.1.23 17.4.23	24.1.23 21.2.23 28.3.23 25.4.23	01/02/2023 01/03/2023 03/05/2023		Open
KLOE 8 Innovation	20b	**KLOE 8 Innovation:** Consideration should also be given to mechanisms for improving cross-Trust sharing of learnings from incidents.	MEDIUM	Deputy Chief Executive	Quality Committee	230430 230503	Utilising the aspirations set out in the Quality strategy, also feedback from MIAA learning lessons and wider learning forums. A new Learning and Assurance Group has been set up from December 2022 which has trust wide representation. The Director Serious Incident panel is also in place. Consideration of a digital solution is being explored alongside the functionality of Ulysees. Implementation of PSIRF is being planned.	23.1.23 17.4.23	24.1.23 21.2.23 28.3.23 25.4.23	01/02/2023 01/03/2023 03/05/2023		Open

Report to the Board of Directors
Wednesday May 2023
Part I

Pennine Care
NHS Foundation Trust

Strategic risk; the Board assurance framework	
Paper prepared by	Andy Chittenden, Director of Corporate Affairs Alexia Charnley, Head of Risk and Compliance
Executive sponsor	Clare Parker, Executive Director of Quality, Nursing and AHP's
Date of report	18 April 2023
Purpose of the report and action required	The purpose of this report is to make strategic risk visible to the Board. To do so, this report covers the Board Assurance Framework 'BAF', the Risk Management Policy and planned training.
Executive summary / key issues for Board's attention (and links to other strategies etc.)	The Board Assurance Framework is made up of six key risks, agreed and overseen by the Board. Minor changes to the controls and assurances are outlined within the document included as Appendix 2 and highlighted in red for ease of review. Work is ongoing to ensure that all high scoring operational risks and newly added risks are aligned to the six strategic risks articulated within the BAF, which supports insight and foresight in effective decision making. Those operational risks scoring 15+ are reviewed and owned by a member of the Executive Team. There are currently 22 risks within this profile, including those relating to capacity in services, digital, recruitment and staffing and quality. A full summary of these is included within Appendix 1. The Trust is committed to a programme of training which supports our ambitions of a well led organisation. This is under development with progression outlined within the report.
Recommendation	That the Board discuss and endorse the descriptions, controls, assurances and scores of the risks within the BAF, together with the extent to which they jeopardise the achievement of our strategic objectives, subject to any comments of actions received at the meeting.
Where else has this report been considered and when?	Strategically significant risks are presented to each Trust Management Board, last held 19 April 2023. Each committee has oversight of the individual risks recorded within the Board Assurance Framework, reviewed as below: People & Workforce Committee 26 March Quality Committee 25 April Audit Committee 26 April Finance and Performance Committee 26 April

Impact on our five-year plan areas of focus – select one of the following options	**Mark with 'X'**
1. The impact is clear from the report, there is limited impact, or the impact is considered elsewhere	x
2. The impact is not yet clear and is still being assessed	
3. There is significant impact on one or more of the areas of focus*	

Preamble

This report is prepared to provide oversight of the Trust Board Assurance Framework, the significant risk profile (those operational risks scoring 15+), updates on the Risk Management Policy and training plans. This incorporates the agreed management actions resulting from the MIAA audit of risk management policy and processes in place at the Trust in February 2023. That review was shared with Audit Committee on 15th March 2023.

Board Assurance Framework

The Board Assurance Framework, or 'BAF' is comprised of six risks with the potential to prevent us achieving our strategic objectives. Their longevity is aligned to the period of the strategic plan 2022-25. These have been previously presented and agreed by Trust Board, covering six core areas of focus, shown below.

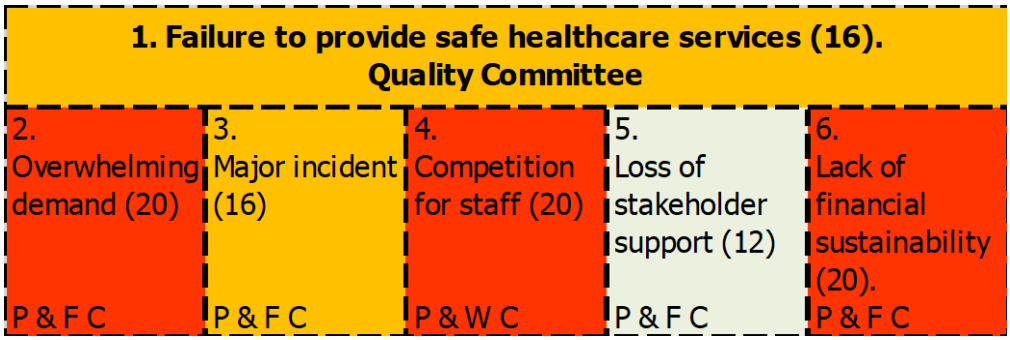


Figure 1 Helicopter view of the Trust's six over-arching strategic risks comprising the BAF.

These risks are overseen through our Committees, where the controls and assurances are considered in each meeting. Changes to these, with any associated impact upon scores are recorded within the BAF, which is included for Board oversight as Appendix 2. Changes identified within the meetings of the Workforce, Quality and Finance and Performance Committees are shown in red for ease of reference, but scores remain unchanged at the time of reporting.

Each of the six risks has been reviewed within Board Committee meetings most recently as follows have been reviewed:

March 18th	Workforce & People Committee	Risk 4
April 25th	Quality Committee	Risk 1
April 26th	Performance & Finance Committee	Risks 2, 3, 5, 6
April 26th	Audit Committee	Overview of all

The scrutiny at the P & F Committee has included a lengthy discussion about access to capital within the GM conurbation and concern about the ambiguity re ownership and long term access to The Meadows. This has been reflected within the P & F Committee Chair's report in March.

Changes in risk profile since March 2023 Board (5.3.23)

The Trust's risk profile reflects (BAF risk 5 *Loss of Stakeholder Support)* the strong emphasis that the Board places on cooperation with the GM conurbation system, through the ICS and with the ICB. All Board members are outward facing in their roles, with the Chair, CEO and Executives having specific, agreed links to role holders and system fora to enable the Trust to carry out its duty to cooperate in system plans.

Currently, the GM system is under significant regulatory scrutiny, for multiple reasons. PCFT does not operate in isolation of these system pressures and is subject to them, and to some extent, the raised level of scrutiny as well.

Whilst the score of BAF risk 5 remains unchanged at 12, and our operational risk profile has relatively few aligned risks to this BAF risk, this report highlights for the Board just how great an impact our membership of a system has and will continue to have on our ability to deliver our strategy.

Developing risk practice at PCFT

Following the appointment of the Head of Risk and Compliance, who took up her role on 6th March 2023, work is ongoing to ensure that these six risks are woven through our approach to risk management and committee structures. Each operational risk agreed to be strategically significant, scoring 15+, is aligned to one of the BAF risks, as are all newly recorded risks which are identified by staff. It is our objective for all risks recorded within the risk register to be aligned to one of the six BAF risks, which will support our oversight, insight and foresight of the aggregate risk faced by the Trust.

Figures 2-5 below provide insight into developing risk management practice at PCFT:

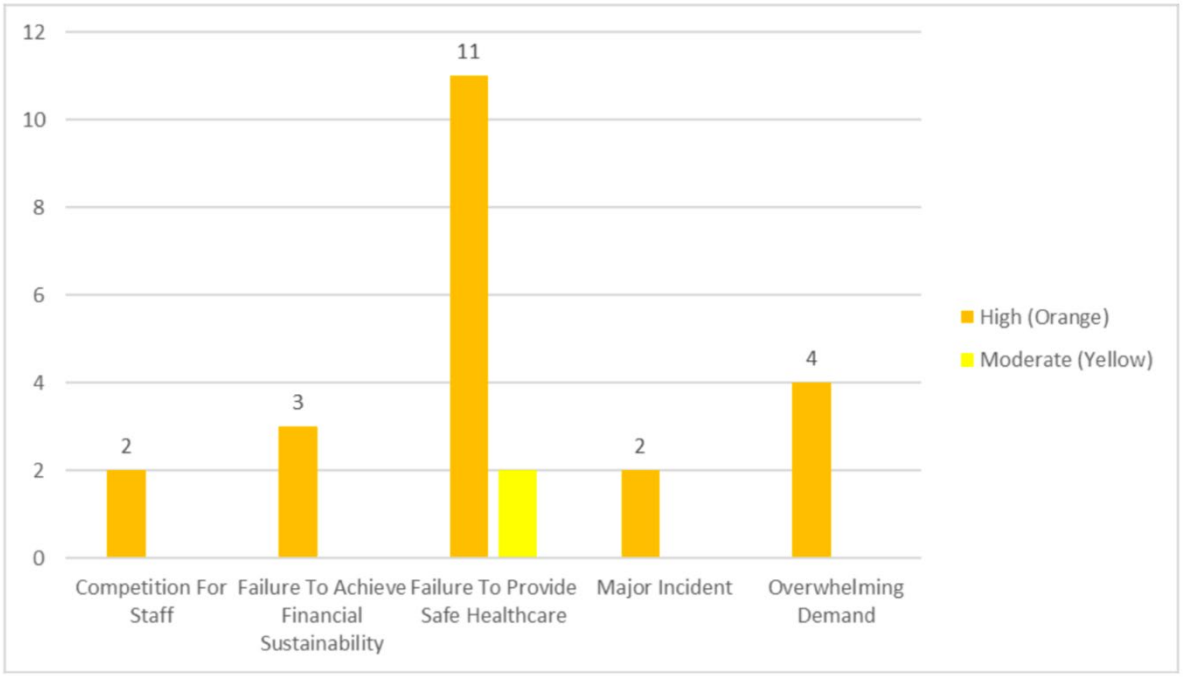


Figure 2 New risks added within the last month, aligned to over-arching BAF risk. (Note: more than 20 risks were added to Ulysses during March, continuing an upward [positive reporting] trend, being the largest figure for new risks reported for many months.

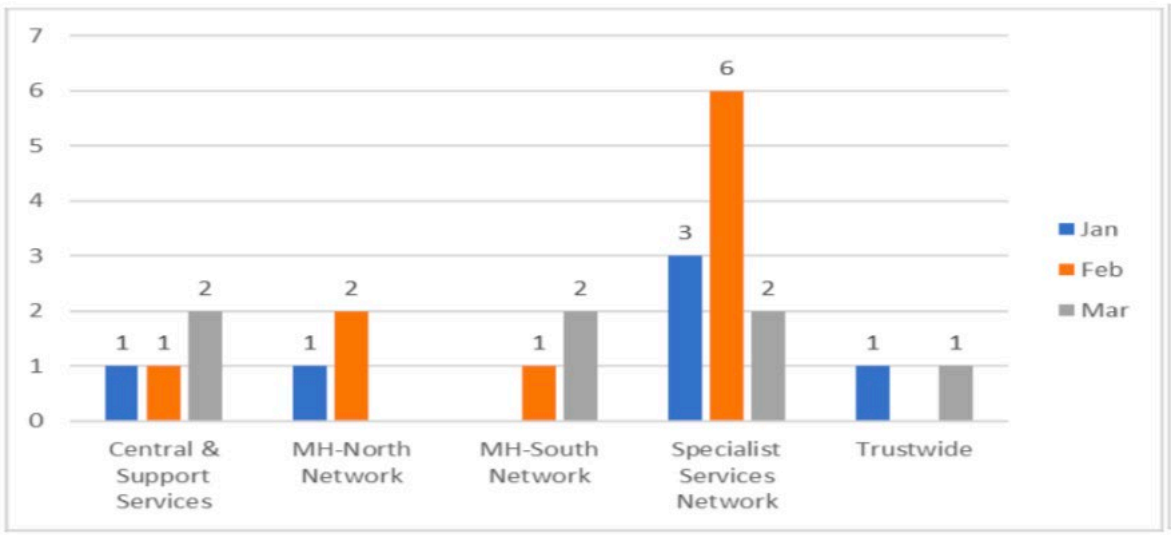


Figure 3 Risks closed down during the last three months Jan – March 2023. (Note: Risks closed down during the month were generally of a medium score).

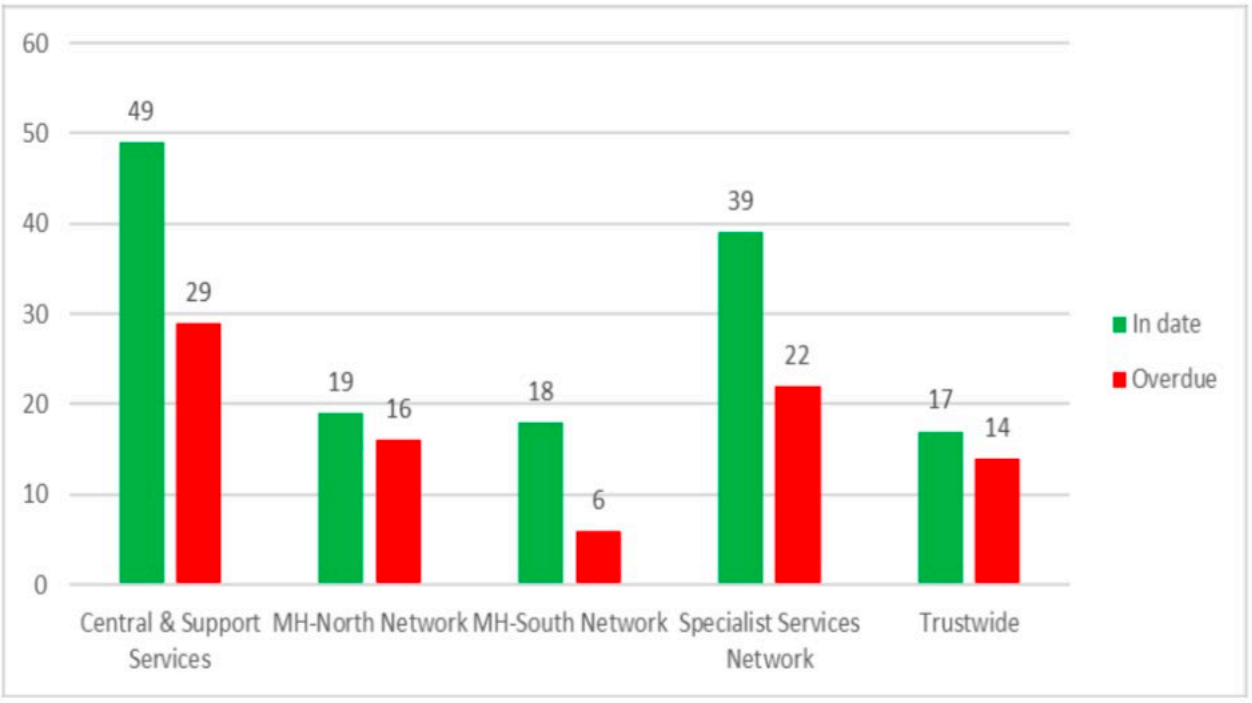


Figure 4 Risks shown by network, within and overdue planned review dates. (Note: All networks have fewer risks overdue for review than those within date).

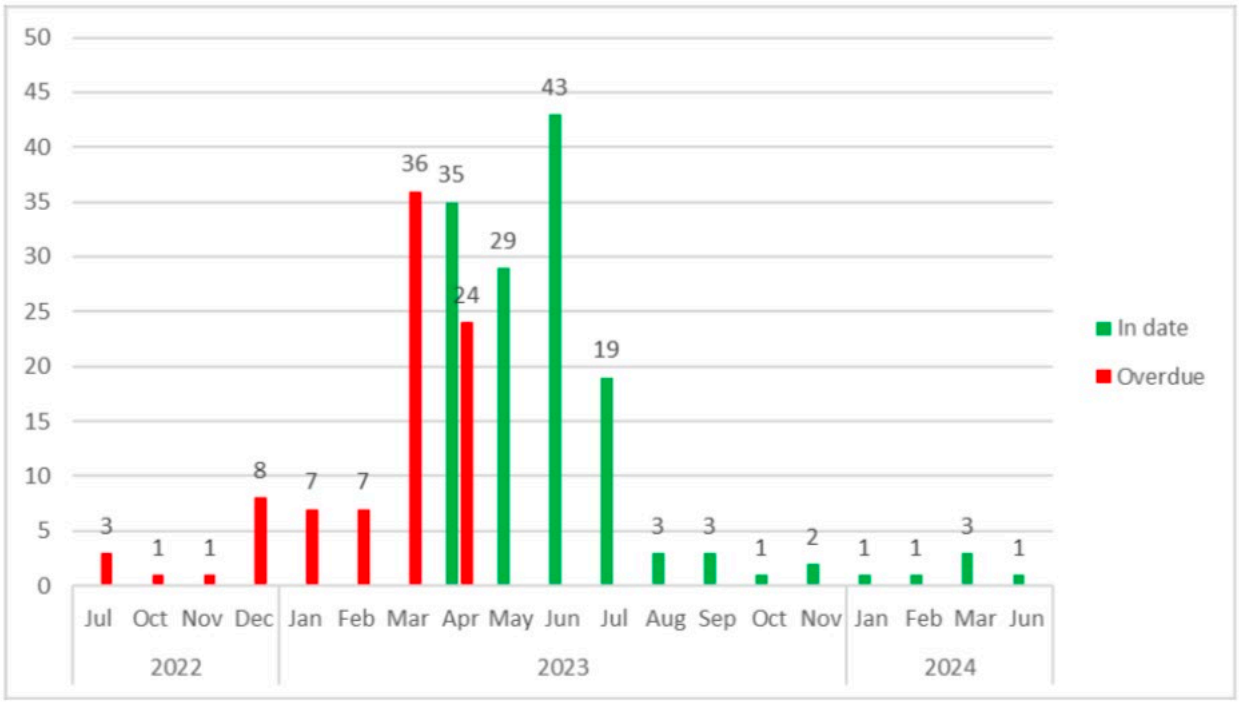


Figure 5 Whole Trust - Risks registered within Ulysses that are within and overdue for review.
(Note: On a Trust-wide basis, those risks within review date now outnumber those overdue).

Strategically Significant Risk Profile (15+)

There are currently 22 operational risks scoring 15+, comprising the strategically significant profile. These are risks which have been reviewed and agreed to score 15+, with the support of a member of the Executive Team. These are overseen within Network forums as well as Executive Team and Trust Management Board, with Risk Management Committee providing the forum in which these are challenged and scrutinised.

The current profile of risks scoring 15+ relate to the following areas:

Capacity in services	Digital	Health and Safety	Medicine/ Pharmacy
EPR Programme	Quality	EPRR	Recruitment/ Staffing
Finance		Training	

A fully summary of the 22 risks is provided within Appendix 1 for reference, however members are to note that owing to the dynamic nature of risk, there may be changes to scores or new risks which are currently under review and approval which are not included in this report at the time of its preparation. It is anticipated that risks relating to Adult Community Mental Health Teams, CAMHS inpatient workforce, care hub estate, lone working processes and workforce education will be included within the next report, reflecting the emerging risks within our services and teams.

Risk Management Policy

The Risk Management Policy is one which required engagement and ratification by Trust Board members. The policy has been reviewed and refreshed to reflect current arrangements, with comments received from stakeholders. Additions have been made to include some commentary on risk appetite, the three lines of defence model and amendments to roles and responsibilities. It is anticipated that this will strengthen understanding and application of risk management principles, supported by a programme of training.

The policy is included within the agenda of the meeting for ratification, but this overview is intended to provide members with context and assurance. In advance of Trust Board, this has been presented to Risk Management Committee, Trust Management Board and members of committees have had opportunity to provide feedback.

Training plan

To support further progression of our risk management ambitions, a programme of training is under development. The aim of this is to build upon the existing skills and knowledge within our workforce, further developing understanding and application of risk management principles. This training will be delivered over the course of 2023/24 and provide tailored sessions for all levels of staff.

The first session of this training is planned for delivery on 18 May 2023, with senior members of the Quality Team after which it can be adapted following feedback. Bespoke training on risk is also suggested for delivery at a Board Development Session, with a date to be agreed for members. It is our ambition to facilitate and undertake training to 80% of staff identified as core delegates before the end of quarter 3, 2023/24. This aim allows for flexibility of attendance over traditional holiday periods and progression alongside other Trust wide priorities, with scope for provision of twilight sessions, delivery through Microsoft Teams or in person, within locality settings.

With a basis rooted in the ISO standard risk management guidelines, progress will be included within future reports.

Recommendations

That the Board discuss and endorse the descriptions, controls, assurances and scores of the risks within the BAF, together with the extent to which they jeopardise the achievement of our strategic objectives, subject to any comments of actions received at the meeting.

Appendix 1

Pennine Care
NHS Foundation Trust

Risk No	Owner	Relating to Strategic Risk	Risk Type	Risk Title	Current Rating	Review date	Latest Update
0996/01-15	Medical Director	Failure to provide safe healthcare	Medicines Management	EPMA Purchase and Implementation	16	16/04/23	positive progress: PM interview friday 20th to review business case, meeting with Civica 24th to demo new version of EPMA system and HI team in support of a restart of EPMA project in around May 2023
1030/05-16	Executive Director of Finance	Failure to provide safe healthcare	Digital	Electronic patient records are not available to staff due to a lack of technology (hardware and software)	20	08/04/23	A Digital Strategy has been completed which will include a plan to have reliable infrastructure delivered over the next 3 years (dependent on approval of funding from GNM)
1061/08-16	Executive Director of Quality & Nursing	Failure to provide safe healthcare	Training	Mental Health Law training (MHA/MCA/DoLS) - demand exceeds supply. Lack of staff capacity to deliver training to the number of staff across the Trust that require this.	15	30/05/23	MCA/DoLS online course now available to staff via LMS. MHA online course should hopefully go live via LMS on the 1st April 2023 New risk drafted to replace this following MDT discussion regarding Mental Health Law Team capacity and demand.
1103/02-17	Medical Director	Failure to provide safe healthcare	Medicine / Pharmacy	Management of shared care for prescribing and physical health is not commissioned and agreed with primary care	15	16/04/23	updated OMT paper sent 9th Jan 23 with recommendations and agreed actions
1351/09-19	Executive Director of Finance	Competition for Staff	Capacity in Services	Lack of skills and capacity within the finance team to achieve objectives of ensuring efficient and effective systems and processes	15	30/04/23	Continuing to pursue various avenues to mitigate the risk

1368/12-19	Executive Director of Quality & Nursing	Failure to provide safe healthcare	Quality	Implementation of the new Mental Capacity (Amendment) Act 2019	20	30/05/23	Government had given no new date re LPS implementation but could be as early as April 2024. Safeguarding looking to put a business case together to look at additional resource to help with the implementation, monitoring and review of the LPS scheme New risk drafted to replace this following MDT discussion regarding Mental Health Law Team capacity and demand
1375/02-20	Executive Director of Finance	Failure to achieve financial sustainability	Finance	The Trust fails to identify and release RECURRENT efficiency savings	20	21/03/23	VI Programme, along with PMO support to the programme, still maturing
1452/06-21	Executive Director of Finance	Failure to provide safe healthcare	EPR Programme	Staff may not have access to contemporaneous patient information to support informed clinical decision making	16	08/04/23	Currently delivering an IT makeover programme, where we are supporting end users on PARIS use. In addition, a task and finish group has been set up to review the use of PARIS moving forward
1466/08-21	Executive Director of Quality & Nursing	Competition for Staff	Recruitment / Staffing	Safer Staffing - Trustwide	15	08/05/23	Ongoing risk, Staff Vacancy for safer staffing lead resulting in delay in progress. Older Adult and Adult Inpatient staffing reviews completed December 2022 to be taken to EDs March 2023
1467/08-21	Executive Director of Quality & Nursing	Competition for Staff	Staffing	No have appropriate AHP resource across the trust	16	09/05/23	No changes to risk – following two business cases to the Exeutive Team - currently awaiting decision from ED relating to funding.
1487/10-21	Executive Director of Quality & Nursing	Failure to provide safe healthcare	Quality	Patient Safety – Ligature knife purchase and issue	15	30/04/23	Looking to purchase a different knife. A T&F Group being implemented to look at what type of knife should be purchased
1500/12-21	Chief Operating Officer	Over-whelming Demand	Recrutiment/ Staffing	CAMHS Capacity & Demand Due to increased demand and waiting times for CYP	15	16/04/23	CYP waiting is not totalling 5k with increasing numbers of neuro developmental referrals arriving in service. Job plans reviews are being completed in all services.

1519/03-22	Execuitve Director of Finance	Major Incident	Digital	Increased Cyber Risk	16	08/04/23	Audit outlined a number of issues, PM engaged to manged specific issues highlighted, and report commissioned to look at Cyber Strategy for trust.
1535/06-22	Executive Director of Finance	Failure to provide safe healthcare	Digital	Telephony System out of support Trust wide	16	08/06/23	Migration to new platform has commenced
1539/06-22	Executive Director of Finance	Major Incident	Digital	SQL 2012 – support ends July 2022	16	08/04/23	Working through upgrading those that can be upgraded
1573/08-22	Medical Director	Failure to provide safe healthcare	Medicines / Pharmacy	Medicines Clinic Room and Clinic Fridge Temperatures	15	12/03/23	1st T&FG group agreed need for automated system Estates / capital planning and procurement on board with urgent review escalation paper to quality group next T&FG 13th Feb
1593/10-22	Medical Director	Overwhelming Demand	HMR Memory Team	Significant backlog of service users awaiting diagnosis in HMR Memory Assessment Service, due to several factors including temporary closure of the service during the pandemic, shortages of medical workforce, increase in referrals when the service reopened and reduction of appointments per clinic from 4 to 3	16	07/04/23	We have been informed that additional investment has been agreed by finance and recruitment has begun to source a temporary locum to work on the backlog. In addition Saturday clinics have begun with medics currently seeing 3 patients each with a plan to increase to 4 from end March 2023. Routine appointments have been reduced to 3 patients from 4 giving currently no net additional output to address the backlog.
1601/11-22	Chief Operating Officer	Major Incident	Emergency Preparedness, Resilience & Response	NHS EPPR Core Standards	16	15/06/23	Risk reviewed as part of induction - risk remains at current score with existing controls. Recruitment to EPRR role completed and induction planned for May 2023. Training programme under development.

1666/02-23	Executive Director of Quality & Nursing	Failure to provide safe healthcare	Safeguarding Team Staffing Levels	Named Nurse for Safeguarding Children and Looked After Children as a joint role	16	25/05/23	Newly added risk
1668/02-23	Chief Operating Officer	Failure to provide safe healthcare	Trustwide	Gap to commissioned neuro development services	16	30/03/23	Newly added risk
1673/03-23	Executive Director of Quality & Nursing	Failure to provide safe healthcare	Trustwide	Failure to implement a robust process for the oversight and management of risk	15	08/06/23	Newly added risk
1674/03-23	Executive Director of Quality & Nursing	Failure to provide safe healthcare	Trustwide	Failure to ensure effective mechanisms for developing a robust process for the oversight and management of health and safety	15	08/06/23	Newly added risk

PCFT: 2022-25 BOARD ASSURANCE FRAMEWORK

1 Failure to provide safe health care. **Risk appetite: *see target score***

Overall risk owner: Clare Parker

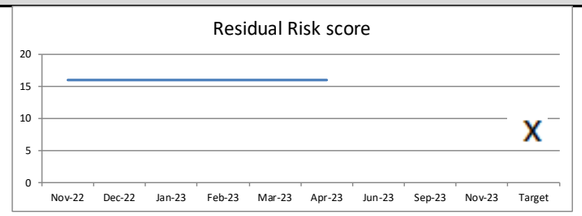
Which of the four ambitions will be impacted ?

1	Outstanding care	x	3	People with lived/living experience shaping decisions	x
2	Everyone has the opportunity to live a fulfilling l	x	4	Colleagues feel engaged & involved in improvement	x

Which of the enabling sub-strategies are relevant to mitigation ?

1	Clinical strategy	x	6	Leadership strategy	x
2	Quality strategy	x	7	Estates strategy	x
3	Service transformation strategy	x	8	Digital strategy	x
4	Research & development strategy.	x	9	Partnerships strategy	x
5	People Plan	x	10	Communications strategy	x

Links to risks reported in the Board's September 2022 BAF: S1.2; S1.3;



Amendment date:	Apr-23
Committee scrutiny:	Quality Committee
TARGET: S x L	3 x 3 = 9
Nov-22	4 x 4 = 16
Dec-22	4 x 4 = 16
Feb-23	4 x 4 = 16
Apr-23	
Jun-23	
Aug-23	
Oct-23	
Dec-23	

Related operational risks:	Main Controls (programmes, initiatives and projects) 1-6	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Further action	Assurance RAG
From Ulysses - Safeguard online portal: 0996/01-15. EPMA purchase and implementation. Project paused until spring 2023. (16). Budget included within draft '23-24 capital plan. 1030/05-16. Electronic patient records not available to some teqms due to a lack of h/w and s/w. (20) 1061/08-16. Mental health law training for staff. (15) 1103/02-17. Management of shared care for prescribing and phycial health is not commisisoned and agreed with primary care. (15) 1368/12-19. Liberty Protection Safeguards practice replacing DoLs April 2024 - requiring training and change in staff practice. (20). 1430/01/21. S136 suite provision is not commissioned but is staffed by non-dedicated clinicians. (9) 1442/04/21. Adult Acute In-Patient Qualified Staffing Levels (Saxon & Taylor Ward). (15). 1452/06-21. Staff may not have access to contemporaneous patient information to support informed decision making (refer 1030/05-16 duplicate). (16) 1487/10-21. Patient safety - ligature knife purchase and issue. (15). 1495/12-21. Tameside Liaison Services insufficient staffing. Limited high risk space within A&E. 1503/12-21. Lack of outside space (Arden Ward) and lack of access to outside space (Norbury Ward) (15). 1508/02-22. Lack of clinical and office space for psychological medicine in Stockport primary care. 1511/02-22. Wifi within some rehab and other units inadequate. (15). 1514/02-22. Inpatient window ligature points (12). 1523/04-22. Hope Unit [CAMHS] - inadequate fire safety system. (16). 1535/06-22 Telephopny system out of vendor support contract. 1550/06-22. Tameside services delivered from some unsuitable buildings (20) 1558/07-22. Unsustainable MDT processes in Stockport MAS. 1567/08-22. Hope Unit - bathroom door ligature anchor points. (12). 1573/08-22. Medicines clinic room and clinic fridge temperatures (15). 1597/10-22. Colleagues working from community venues of which Estates and Facilities unaware. Edenfield unit at GMMH has reduced medium secure bed capacity, placing pressure on regional medium secure beds elsewhere. 1627/12-22 Governance arrangements for the Living Life Well service in Tameside & Glossop, 1638/01-23. Inconsistent adoption of lone working arrangements described in lone working policy. 1639/01-23. Inconsistent use of radios, personal attack alarms amd mutual response to incidents. 1667/02-23. South Network Care Hub - lack of access to budgetary data. Not yet agreed significant. 1668/02-23. Gap in commissioned neurodevelopment services (16) 1673/03-23. Lack of robust risk management governance arrangements. (15) 1674/03-23. Lack of robust health and safety governance arrangements. (15) Risks brought forward from Sept '22 BAF: If we are unable to provide safe, effective, consistent and high-quality care, this could result in patient/ carer harm, regulatory non-compliance and have an adverse effect on Trust reputation. S1.2. Risk sourced from quality monitoring intelligence. (15) S1.3. Risk sourced from unequal impact of Covid on health and wellbeing. (15) Risks identified by Exec Team (21.11.22) Triangulation of incidence of various quality issues including variety of clinical views; leadership styles, potential closed culture and incidents within the CAMHS service - top be reviewed at OMT initialy (Dec '23). Ligature risks across the estate require capital and space to decant patients whilst works undertaken.	1. Clinical strategy	Simon Sandhu	Strategy will consolidate the 'getting it right first time' approach ('GIRFT') - under the purview of Strategic Delivery Board. Annual appraisal and revalidation of doctors, annnual report to QC Oct 22. Clinical effectiveness annual report.	Clinical strategy still in developmet as at winter '22-23. Due to be reviewed at Board March 2023. There is service offer variation amongst Boroughs due to differences in historic variability in commissioning priorities. Non-uniform approach to standardisation across all areas eg Productive Ward; Safer Staffing models; effective Multi-Disciplinary team working. Not all services offered have national standards. PCFT reliant on some paper based systems for medicines administration.	Estates decisions linked to service transformation planning support the clinical strategy - which remains in development. Service mapping to establish 'core' and 'non-core' services is ongoing. Not all services have been reviewed for optimum case loads for clinicians. Access for other organisations to PARIS (clinical record) is not straightforward. Feedback on safe levels of medical staffing. Implementation of changes in clinical supervision policy.	Complete the clinical strategy H1 calendar 2023. Radcliffe Place opening circa May '23.	A.
	2. Well Led **Quality Group** Health Safety and Security Committee; Safeguarding Forum. Maintenance of competent and capable workforce, through training, operational management, supervision, appraisal and professional development. Dialogue with regulators to feedback on quality standards. Processes to pick up issues/variations in quality and for staff to raise concerns e.g., through the Whistleblowing policy & Freedom to Speak up Quality Strategy Directors Serious Incident and Complaints Panel. **Patient Safety** Clinical Risk Assessment and Management Policy and training. Suicide and Self-Harm Prevention Strategy Central Alerting System (CAS) policy and procedure (April 2018); Patient Safety Team; - Incident investigation and process for learning from incidents (and complaints). Patient Safety strategy Setting and monitoring of optimal/safe staffing levels Learning and Assurance Oversight Group established by Deputy CEO to review external reviews to benchmark where PCFT is in relation to recommendations i.e GMMH/Panorama programme, Ockenden, East Kent maternity, GMMH CQC report.	Clare Parker	Board oversight of the implementation of the external reviewer recommendations (all accepted in full). Quality Committee frequent oversight of control systems. Report to Board. Quality account. Quality Committee Report. Quality Committee Review. Report on near misses / never events reported to Directors Serious Incident Panel. Workforce planning update to Quality and Performance Committees. Listening events. Corporate Risk register. IPC BAF. Performance Dashboards. Mixed gender accommodation eliminated November 2022. GM Quality Group - Deputy CEO is a member. Impact of junior doctors strike action on six rotas (March 23) was managed safely.	Demand modelling to match estate to services. Programme of eradication of ligature points is incomplete and insufficient capital available. Some patients have insufficient access to external spaces. Under resourced and skilled health and safety governance. Impact of any further planned industrial action by Trust staff (junior doctors) and neighbouring Trust staff (multiple professional bodies). The Trust lacks a Moving and Handling Lead, which could reduce the effectiveness of professional practice, exposing staff, patients and the Trust to unforseen risk. Policy governance arrangements are insufficiently effective - under review March 2023.	Yet to establish system of peer review. There is scope to improve the systems and processes for identifying learning opportunities and communicating the learning, verifying that practice improvements are captured. A task and finish group has been established internall to review the gvernance arrangements supporting effective *seclusion* practice.	Capture intelligence from strike action by junior doctors relevant to planning for other types of strike action. A review of CAMHS governance by an external party will provide an insight into any further improvements that may be made within the service (Spring 2023).	A.
	3. Patient/service user safety programme	Clare Parker	Ligature Prevention Group Leadership visits and safety walks to services. Safeguarding annual report. Mandatory training compliance. Restrictive Practice Group. Medical Devices Safety report. Quality Account. Infection Prevention and Control Annual Report. Complaints & Compliments Annual Report. Ward Accreditation programme. NAPICU accreditation. Physical intervention training (BILD). Blanket use of restrictions practice (Board paper 1.3.23)	In 2022 we are planning the patient safety incident reporting framework and designing the implementation plan. Quality element of IPR requires further improvement. Safeguarding Named Nurse left the Trust in 2022 - filled Spring 2023 Insufficient access to mandatory training for Level 1 / Level 2 / Level 3 Safeguarding training. Implementation of PSIncident Responce Framework. (aimed for Oct 2023). Not made Patient Safety Training Syllabus mandatory training as at Nov 2022. CQC rating of 'requires improvement' on the question of whether services are Safe and Effective at CQC inspection in July-September 2019 (published December 2019) - and unchanged from previous CQC inspections in August-October 2018. Report published January 2019. Some areas still not compliant such as electronic patient records. Gaps in control over key locking system across some areas of the estate.	PCFT is introducing Liberty Protection Safeguards (LPS) in place of DoLs, which requires substantial investment in staff training. Improve learning from patient safety incidents and issues. Patient safety forum. Frameworks created to enable teams to have a consistent way to ensure that processes are in place. Health and safety governance has weaknesses and subject to internal audit review winter 2023. Regional role required by the system to develop a plan to re-open medium secure beds at Edenfield or provide alternative beds elsewhere. Learning and Assurance Report (Board 1.2.23) contains red rated actions.	Implement the Research & Innovation Strategy (approved Board 1.2.23). Implement PSIRF from Sept 2023. Deliver IT capital investments after £4.5M network upgrade commitment Feb 2023. Health and Safety Adviser role recruited into from 1 March 2023.	A.
	4. Clinical effectiveness programme	Clare Parker	Clinical audit programme of audit activity and Annual Report. Clinical effectiveness annual report (QC Oct 22). Medicines safety Group. Controlled Drugs Accountable Officer reports. Annual appraisal and revalidation of doctors, annnual report to QC Oct 22. Mortality reviews. Benchmarking through national audits. Benchmarking through CQC's Insights Report (reported to Board). Peer and network reviews External visits / accreditations / inspections including peer reviews. Internal audit of clinical audit. PROMS (although limited and quickly out of date).	Lack of an electronic proscribing system (EPMA) fails to reduce avoidable errors. Programme of Trauma Informed Care training and implementation yet to be funded (£0.5M).	Wider comparator data from GM system		A.
	5. Patient/service user experience programme	Clare Parker	Independent Hospital Managers review cases of deprivation of liberty. Processes to pick up issues/variations in quality and for staff to raise concerns e.g., through the Whistleblowing policy & Freedom to Speak up. Quality Strategy. Directors Serious Incident and Complaints Panel. On-going work with system partners (system health inequalities group) to improve identification of minority and vulnerable groups within the population, ensuring that we reach into these communities and make it as easy as possible for people to access appropriate care when required. Restoration of services is aligned to appropriate capacity to areas of the Boroughs that have the most actual and potential need. CQC scrutiny. FFT data above national average; Complaints & Compliments; PALS; Carers Strategy Group; Care Programme Approach. PLACE inspections. Community Mental Health Survey Oct 2022. PCREF framework being implemented. Triangle of Care.		MIAA review of learning lessons. A complaint escalated to the PHSO is understood to be likely partially upheld - from which there may be learning to be gained (spring 2023).		A.
	6. Quality improvement programme	Gaynor Mullins	EPR programme.	Improvement approach not yet agreed. PMO structure currently in formation. Business information team capacity escalated to Board. Health and safety systems and processes are ineffectively operating.	Our systems and processes for reporting on quality are still at a relatively early stage of development.		A.

PCFT: 2022-25 BOARD ASSURANCE FRAMEWORK

2 Overwhelming demand. ***Risk appetite: see target score***

Overall risk owner: Donan Kelly

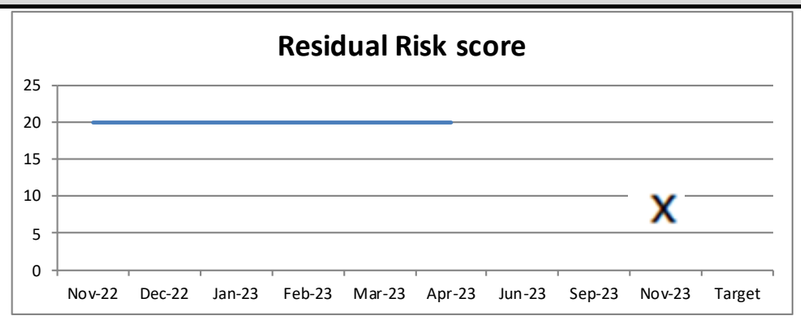
Which of the four ambitions will be impacted ?

1	Outstanding care	x	3	People with lived/living experience shaping decisior	x
2	Everyone has the opportunity to live a fulfilling l	x	4	Colleagues feel engaged & involved in improvement	x

Which of the enabling sub-strategies are most relevant to mitigation ?

1	Clinical strategy	x	6	Leadership strategy	x
2	Quality strategy	x	7	Estates strategy	x
3	Service transformation strategy	x	8	Digital strategy	x
4	Research & development strategy.	x	9	Partnerships strategy	x
5	People Plan	x	10	Communications strategy	x

Links to risks reported in the Board's September 2022 BAF: Winter pressures BAF



Amendment date:	Apr-23
Committee scrutiny:	P & F C
TARGET: S x L	3 x 3 = 9
Nov-22	4 x 5 = 20
Dec-22	4 x 5 = 20
Feb-23	4 x 5 = 20
Apr-23	
Jun-23	
Aug-23	
Oct-23	
Dec-23	

Related operational risks:	Main Controls (programmes, initiatives and projects) 1-6	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Further action	Assurance RAG
1479/09-21. Limited capacity in Tameside services to complete quality records for patient safety and experience investigations. *1500/12-21. CAMHs capacity and demand.* *1501/12-21. Tameside has a long secondary care psychological therapy service waiting list.* *1543/06-22. Stockport waiting times for adult ASD / ADHD could result in service being overwhelmed.* *1662/02-23. Ambiguity re ownership and long term use of The Meadows facility.* *Transformation programme risks:* *Adult acute and crises care:* *Medical engagement in Tameside, Stockport and HMR re inpatient standards (16).* *Business intelligence support across acute care transformation (16).* *Absence of workforce transformation lead (16).* *Lack of available qualified workforce to deliver against expansion / transformation of 24/7 provision (25).* *Adult Community Care* *Recruitment challenges re implementing Living Well teams and core mental health staffing. Transformation Lead vacancy. (16)* *Capacity for Clinical Directors and GP to engage in LW design is limited. Communication complex. Risks to ARRS funded posts; skill mix model and integration into LW (16).* *Interoperability and systems jeopardise success of Living Well teams. Complex landscape, involving local autorities and VCSE (20).* *Older People's Care* *Lack of 24/7 HIT support gatekeeping and providing a robust alternative at admission. (16).* *Digital* *Access to capital funding is required to deliver transformation - speficially Front Line Digital Funding (15+)* *Estates* *Estates not always made aware of services operating from new venues or discontinued. (15)* *Service transformation risks.* *As Lead Provider for CAMHS, PCFT carries risks associated with contractual obligations to pay for activity above funded allocation and for major incident consequences.*	1. Commissioning with parity across the Greater Manchester footprint	Donan Kelly	Trust wide winter plan. MH demand and Capacity undertaken to support winter planning. MH winter scheme funding. Stepping up of MH urgent/emergency care schemes.	ICB governance arrangements and commissioning intentions still being developed winter '22-23. Joint planning arrangements for 23/24 MHIS &SDF still under development.	There is a lack of parity across commissioned services for MH, learning disabilities and autism across greater Manchester. Significant service gaps in core services in some localities (refer Dir		A.
	2. ICB solutions to variations in service	Donan Kelly	Uptake of Flu/Covid vaccination being monitored across the GM system. GM MHLDA BOARD. GM Mental health joint planning group. GM MH financial regulation group.	ICB governance arrangements and commissioning intentions still being developed winter '22-23.	Metrics reported and data quality within the integrated performance report continue to be refined.		A.
	3. Capacity and demand modelling	Donan Kelly	Self-referral access through MH Crisis lines. Crisis Liaison teams in all A&E departments. CRHTTs. Staff winter Flu/Covid vaccination programme . Staff wellbeing hubs. Effective triage process of all those referred. Access to services through Crisis, Urgent and routine pathways dependant on need. Trust wide demand and capacity work undertaken. Data improvement programme being implemented early 2023. Winter planning paper to Board 230201. Achieving 18 week trarget for Talking Therapies (Feb 23 data).	Business continuity plans require strengthening. Capacity and demand modelling requires testing and strengthening. Incidence of out of area placements (particularly adult males) and delayed transfers of care - Spring 2023, considerable increase in the trend line, worsening the patient experience. Impact of patients displaced from GMMH's Edenfield medium secure facility. Withdrawal of an independent sector service provider has left 8,000 patients across the conurbation on the neurodevelopmental pathway without an immediate alternative. 170 children and young people added to Stockport CAMHS and 1600 others across the PCFT footprint. Average wait 23 weeks with 2200 currently waiting more than 18 weeks (Feb 23 data).	Demand for services increasing capacity within service based on block contracts. Ownership of and certain long term access to The Meadows facility remains ambiguous. Spring 2023 - increasing CMHT waiting. Impact of junior doctors strike action 14-18 April '23.		A.
	4. OPEL framework for mental health service escalation	Donan Kelly	GM MH Opel Framework developed, and Metrics monitored and reported through GM SORT Trust wide daily patient flow meetings. Daily locality huddles. Weekly locality DTOC escalation meetings. Weekly GM DTOC meeting. Weekly OMT meeting for organisational oversight and management of escalation EPPR plans and 'Gold' command structure in place if required BCPs in place and reviewed.	SORT reporting of wider system pressures in health and social care. Review of Rehab bed capacity with possible change of function to mitigate increasing inpatient demand. Gaps in ICB planning and control of wider gaps in H&SC that will impact on patient flow.			A.
	5. Live data on operational pressure to support evidence based decision making	Donan Kelly	Exec Team considering the investment required to deliver the planned standard of business reporting (Nov '22).	Busines support team may not be the size and scope required to deliver planned improvements. Gaps in operational performance data for key service lines. Gaps in data quality processes.	PCFT data warehouse not yet estabiiushed to deliver the frequency, breadth or data quality of information required.		A.
	6. Service transformation	Gaynor Mullins	Strategic Delivery Board exercise oversight over transformation activity.	PMO programme maturity is in early stage. Support services such as digital may not be aware of current projects and requirements to support.	Scale of transformation programme and unmatched resource may hinder delivery and risk investment.		A.

PCFT: 2022-25 BOARD ASSURANCE FRAMEWORK

3 Major incident. ***Risk appetite: see target score***

Overall risk owner: Donan Kelly

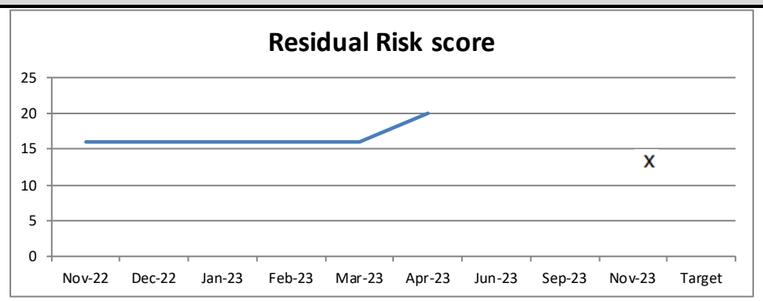
Which of the four ambitions will be impacted ?

1	Outstanding care	x	3	People with lived/living experience shaping decisior	x
2	Everyone has the opportunity to live a fulfilling l	x	4	Colleagues feel engaged & involved in improvement	x

Which of the enabling sub-strategies are relevant to mitigation ?

1	Clinical strategy	x	6	Leadership strategy	x
2	Quality strategy	x	7	Estates strategy	x
3	Service transformation strategy	x	8	Digital strategy	x
4	Research & development strategy.	x	9	Partnerships strategy	x
5	People Plan	x	10	Communications strategy	x

Links to risks repoarted in the Bord's September 2022 BAF: S3.X (Cyber)



Amendment date:	Apr-23
Committee scrutiny:	P & F C
TARGET: S x L	3 x 3 = 9
Nov-22	4 x 4 = 16
Dec-22	4 x 4 = 16
Feb-23	4 x 4 = 16
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Dec-23	

Related operational risks:	Main Controls (programmes, initiatives and projects) 1-6	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance		Assurance RAG
1104/02-17. Integrated service directory out of date. (20) *1163/07-17. Network resilience instability. (20)* *1169/07-17. Outage of national systems embedded within Trust processes. (20)* *1413-08-20. Continued access challenges at Tameside's Etherow building.* *1452/06-21. Inappropriate password sharing in PARIS; inadequate training; poor patient data quality. (16)* *1497/12-21. Lack of H & S support within the care hub.* *1523/04-22. Fire alarm detectors across Hope & Horizon accessible to patients. (16)* *1519/03-22. Increased cyber risk. (16)* *1535/06-22. Telephony system contract lapsed and system unsupported. (16)* *1539/06-22. SQL boxes required to be upgraded; liable to cyber attack. (16)* *1601/11-22. EPRR Core Standards self assessed as non-compliant. EPRR Manager post vacant.* *1674/03-23. Lack of robust health and safety governance arrangements.* *Other risks identified anecdotally:* *EPRR self assessment and submission against revised core standards, Nov 22 was partially compliant (71%).* *Lack of Log Books (on order)* *Lone worker devices issued to 800 staff but inconsistent adoption.* *Potential for strike action by staff.*	1 Incident planning and control governance arrangements: Commander training	Accountable Emergency Officer Donan Kelly	Self assessment November '22 provides limited evidence of effective control. COO is identified as AEO. EPPR Policy is in place but due to be reviewed and updated. Emergency Planning Policy and Major incicdent Policy are in place. PCFT has allocated resource to fund a WTE 8a EPRR Manager role.	Covid pandemic has interrupted EPRR training and exercise to demonstrate resilience. Incomplete Commander training. Circa 50 operational leaders to be trained by March '23.	PCFT self assessment Nov 22 was 71% compliant with Core Standards with Commander training being outstanding. Core Standards revised summer 2022 post Covid. P & F workplan captures EPRR.		A.
	2 Incident planning and control governance arrangements: Loggist training	Accountable Emergency Officer Donan Kelly	EPRR Manager has developed training for Loggists and added to LMS (not in use).	Incomplete Loggist training. No recent training undertaken. Variety of practice in place. Training Needs Analysis incomplete.	Reports to F & P annually to provide further assurance that governance arrangements, including training, tightened.		A.
	3. EPRR Policy, governance structure and processes	Accountable Emergency Officer Donan Kelly	Revised PCFT Policy EP001 in draft. Existing policy in place but refers to earlier standards. Governance structure to support best practice to be established early 2023 (to be discussed at OMT 21 Nov '22).	EPRR governance arrangements still to confirm: EPRR governance within care hubs and services; Escalation routes; Methodology for exercise testing; If EPRR Management Group required; EPRR Management Group ToR; Training needs analysis. EPRR Manager vacancy from 1.12.22	Vacant Band 8A EPRR Manager role due to be filled in ~~April~~ May 2023.	Substantial programme of training required. Assurance on the design and reliability of local evacuation plans required.	A.
	4. Site lockdown planning	Accountable Emergency Officer Donan Kelly	Business continuity plans in place (not tested uniformly) and North West Emergency Accommodation Plan for Secure Services v4.1 High risk areas are site reviewed and supported by Local Lockdown procedure. Trust Security and Police Liaison Manager is currently working to create, assess and exercise a new robust overarching plan. No testing of overarching plan can be evidenced . Quarterly Security Management Meeting is in process of establishment as at April '23).	Arrangements for local site and area specific lockdowns required - requires a consistent approach and testing. ~~Vacant Band 8A EPRR Manager from Dec 2022.~~ EPRR Manager due in post 9.5.23	Due to Covid, irregular testing has been carried out to confirm effectiveness of the lockdown planning arrangements and business continuity plans.		A.
	5. Chemical, biological, nuclear and radiological release planning	Accountable Emergency Officer Donan Kelly	Within the Trust Major Incident Policy there are specific HAZMAT/CBRN arrangements and processes to follow. Policies are reviewed very two years or in the event of changes to legislation or local arrangements and links into the GM mutual Aid arrangements. The HAZMAT (Hazardous Materials) Officer from GM Health Protection Unit will lead on the response before contacting the fire and rescue service. Local training utilising current NARU and national guidance and material was previously provided but has been postponed due to the pandemic.	Guidance and action cards are issued to from of service staff and are included within the Major Incident Policy, however this needs revisiting now that we are working to flexible arrangements and staff in post may have changed.	No evidence around training or inventories pack.		A.
	6. Business continuity management system ('BCMS')	Accountable Emergency Officer Donan Kelly	Trust Major Incident, Emergency Planning and BCP Policy highlight standards to be achieved demonstrating our statement of intent and requirement to carry out a Business Impact Assessment to inform a BCP. Trust BCMS is described in the Emergency Planning and Business Continuity Policy. Services within the scope and exclusions from the scope and the purpose and function of the system are described. The BCMS highlights the requirement to undertake e.g. Statutory, Regulatory and contractual duties which has been further enhanced during the pandemic. The BCMS including responsibilities, competencies and levels of authorisation and how any risk should be assessed and documented (e.g. Risk Register) and appropriate measures identified to mitigate where possible, and include dates for review and monitoring. DPST Toolkit self assessment June 2022 'standards met'.	The Trust has a process for internal audit with a review of the emergency response decisions making process being conducted. Evidence of changes can be found through the COVID logs .	Covid Enquiry - it is unknown what part the GM system or PCFT may play or when learning may be available.		A.

PCFT: 2022-25 BOARD ASSURANCE FRAMEWORK

4 Competition for staff. *Risk appetite: see target score*

Overall risk owner: Nicky Littler

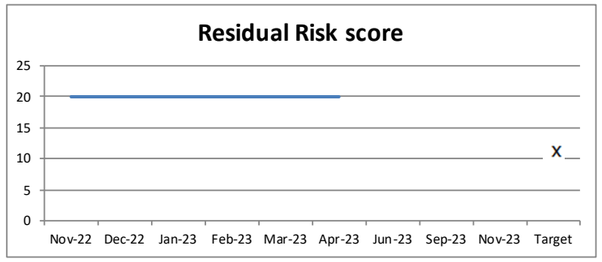
Which of the four ambitions will be impacted ?

1	Outstanding care	x	3	People with lived/living experience shaping decisior	x
2	Everyone has the opportunity to live a fulfilling l	x	4	Colleagues feel engaged & involved in improvement	x

Which of the enabling sub-strategies are mlost relevant to mitigation ?

1	Clinical strategy	x	6	Leadership strategy	x
2	Quality strategy	x	7	Estates strategy	x
3	Service transformation strategy	x	8	Digital strategy	x
4	Research & development strategy.	x	9	Partnerships strategy	x
5	People Plan	x	10	Communications strategy	x

Links to risks reported in the Board's September 2022 BAF: C1.1; C1.2; P1.1; P1.2; P1.3; P1.4; P1.5



Amendment date:	Apr-23
Committee scrutiny:	P & W C
TARGET: S x L	3 x 3 = 9
Nov-22	4 x 5 = 20
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Related operational risks:	Main Controls (programmes, initiatives and projects) 1-6	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Further action	Assurance RAG
From Ulysses / Safeguard - the online risk reporting portal: *1351/09-19. Finance team skills and capacity.* *1378/-5-20. Care coordinator vacancies across Tameside & Glossop CMHTs.1442/04-21. Adult Acute In-Patient Qualified Staffing Levels (Saxon & Taylor Ward) (15)* *1466/08-21. Safer staffing - trust wide. (15).* *1467/08-21. AHP resource. (16)* *1413/11-21. Long waiting times due to lack of consultant cover in Tameside.* *1481/09-21. Mental Health Law staffing shortages. (16). Not yet agreed significant.* *1500/12-21. CAMHS capacity & demand due to increased demand and waiting times for CYP. (16)* *1516/03-22. Cambeck Close short staffed resulting in risk to provision of service (not yet agreed significant).* *1542/06-22. Shortage of qualified nursing staff on Norbury Ward.* *1544/06-22. Stockport Home Treatment Team and Older Persons HITS Team has long term B6 RMN vacancies; Stockport older adult consultant vacant.* *1593/10-22. HMR Memory Team - gaps in team jeopardise service delivery, waiting list growth, 12 week diagnostic target may be missed.* *1615/11-22. Home Treatment Team experiencing long term sickness and failure to recuit multiple roles.* *1625/12-22. CAMHS inadequate qualified nursing cover.* *1647/01-23. Capacity or Education & Workforce Devt Team to meet service demand. (15)* *Risks identified in relation to the People & Workforce Strategy* *• The ability to compete with other employers to recruit and retain the available appropriately skilled and experienced staff.* *• National and regional workforce supply challenges for particular professional groups.* *• Our ability to fully engage and involve staff in decisions about their services and employment given pressures and increased demand on our services.* *• The scale and scope of change required for the future workforce and risk of burnout of staff.* *• Workforce planning methodologies and ways of working across systems in localities present complexities and the changing landscape with the development of ICS will take time to embed.*	**1. Health and wellbeing and engagement:** Refresh the health and wellbeing strategy - staff wellbeing service, psychological wellbeing support. Improving attendance Colleague engagement activities. Violence at Work Working Group. Values and Behaviours Framework. Partnership working with trade union colleagues. • Staff Engagement and communication plans including: * CEO communication via weekly Ask Anthony, Q&A sessions * Executive Q&A sessions * OD engagement activities * Clinical presence visits • Regular team meetings led by local managers. • Care Hub engagement/listening events. • Quality Improvement programmes. • Mechanisms for staff insight group feedback. • Mechanisms for staff feedback on strategy development/other organisational changes. • FTSU policy and processes. • Formal consultation processes in line with trust policy. • Partnership working and availability and promotion of trade union • Lessons learnt processes/organisational learning events • Health safety and Wellbeing support – psychological safety, reducing violence and aggression, staff wellbeing. • Access to staff wellbeing service and resilience hub. • Clinical and management supervision. • Health and wellbeing activities – annual programme of events.	Nicky Littler	Values and behaviours framework - the *Just Culture* WRES and WDES reports. FTSU feedback. Whistleblowing themes. HR casework reports. Effective staff side relationships via Partnership Committee Team brief. Carer passports. Managing Attendance Group. Staff feedback through engagement methods (including staff survey and people pulse) Lessons learnt processes/organisational learning events Autumn 2022 staff survey (results spring 2023) provided assurance that staff (nearly 2000 responses) have welcomed and responded to the open, visible leadership style of CEO and Exec Team. The Trust was one of the most improved mental health, learning disability and autism services poviders in terms of response to staff being asked if they would recommend PCFT as a place to work. Overall headcount continues to increase - but staff turnover also has risen (Feb 23 data). Time to recuit performance has reduced to an ave of 71 days (target 70 days) as at Feb 23 data point.	Break out / relaxation areas for staff taking planned breaks during shifts are inadequate in number and quality at some of the service locations. Network groups for staff re long Covid and menopause being planned. Management reporting improvement requirements to enable full suite of workforce reports for care hub/network level	Staff survey results identify weaknesses and gaps in staff experience, line management support and incidence of violence, harrassment and aggression from service users and staff resulting in stress and anxiety.		A.
	2. Leadership and management. Leadership and management development programmes. Support and training packages for leaders and managers incl Manager Information Hub; Good Manager Guide; Compassionate Leadership Programme. Coaching and mentoring support for leaders	Nicky Littler	Manager Information Hub launched. TED tool launched and in use.	Manager checklist in development. Good Manager Guide will be relaunched with checklist. Performance and Accountability Framework in development. Draft leadership strategy	Staff survey results identify weaknesses in some areas relating to line management support and team effectiveness.	Complete review of delivery of corporate re-design outcomes - March 2023.	A.
	3. Capable and skilled workforce Learning needs analysis My Yearly Conversation Coaching and mentoring including equality mentoring scheme Management and Clinical supervision requirements. Annual plan for the investment in apprenticeship roles to support workforce development (including Nursing Associates, Clinical Associate Psychologist). Utilisation of CPD funding aligned to LNA and annual personal development planning process. Core and Essential skills programme delivery. Utilisation of training opportunities for MHLDA – HEE monies. Widening participation training programmes. Performance management policy.	Nicky Littler	My Yearly Conversation planned to include EDI targets People and workforce steering group – programme updates. • Workforce transformation group – monitoring of recruitment to new investment posts. • Time to Hire/vacancy data. • Bank and Agency monitoring. • MIAA. • Integrated performance reports. • Performance Huddles. • Student placement numbers. • Staff in post report/monitoring workforce plan. • Successful recruitment activity. • Integrated Performance report. WRES and WDES reporting.	Workforce data required to monitor the funding allocation across different staff groups, protected characteristics and service to ensure fair and equitable spread. Career pathway mapping under development to support career progression.	Gap in recording of management and clinical supervision and locally agreed training. IPR at February Board illuminated staff pressures.		A.
	4. Effective and sustainable workforce Resourcing quality improvement programme Streamlining recruitment process through stakeholder engagement Recruitment initiatives and activities targeted to hot spot areas. Widening participation programmes to increase future supply Training roles and HCSW supply programme Retention work programme Health and wellbeing activities to support employee experience and attendance	Nicky Littler	Time to recruit reporting (KPIs developed) User experience monitoring and new starter feedback. New recruiment processes launched 1.10.22 Recruitment and Retention Steering Group Oversight of staff in post numbers and vacancies.	People Planning Toolkit under review to develop broader recruitment tools for more inclusive attraction. Financial break even is achieved on account of underspend on vacancies. High Registered Nurse vacancy rate Identify pipeline talent Estalish community partners incl schools, colleges, Unis, LAC, Veterans. Identify key roles per network / care hub for which bespoke recruitment needed.	Vacancy management aligned with ESR and finance data. Satff churn up from 10.5% to 12% during Aug '21 - Dec '22.		A.
	5 Equality, Diversity and Inclusion programme. nti-racism survey and action plan. WRES/WDES and gender pay analysis and inclusion action plan. EDI awareness programmes, induction, training and positive promotion. Advancing MH equalities quality improvement programme. Staff networks providing support to organisational programmes and feedback on staff experience. Equality mentoring programme in place. New EQIA in place. Learning and development programmes.	Nicky Littler	Two service user / carer workshops held to explore what might encourage those with likved experience to join the NHS. EDI steering group oversee action plans and progress. WRES/WDES and gender pay gap reporting process and national benchmarking. EQIA process. National AMHE QI programme review. Employee relations monitoring.	Local EDI leads identified to suport local activities and link with corporate programmes. Community engagement and feedback. Data sets on protected characterstics for patient/service user not available for all activities and/or routinely reviewed.	Required to develop the monthly integrated performance report on People metrics.	Gender pay gaps remain to be reduced and eradicated (refer Board report 1.3.23).	A.

PCFT: 2022-25 BOARD ASSURANCE FRAMEWORK

5 Loss of stakeholder support. ***Risk appetite: see target score***

Overall risk owner: Gaynor Mullins

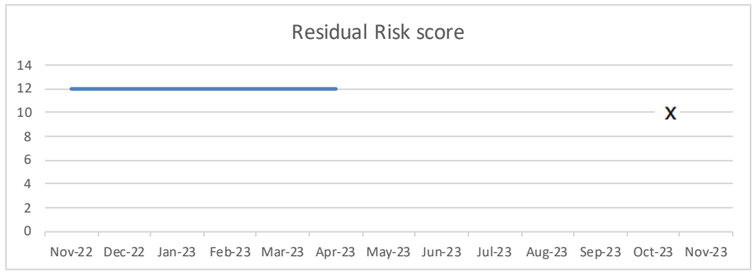
Which of the four ambitions will be impacted ?

1	Outstanding care	x	3	People with lived/living experience shaping dec	x
2	Everyone has the opportunity to live a fulfilling l	x	4	Colleagues feel engaged & involved in improver	x

Which of the enabling sub-strategies are relevant to mitigation ?

1	Clinical strategy	x	6	Leadership strategy	x
2	Quality strategy	x	7	Estates strategy	x
3	Service transformation strategy	x	8	Digital strategy	x
4	Research & development strategy.	x	9	Partnerships strategy	x
5	People Plan	x	10	Communications strategy	x

Links to risks reported in the Board's September 2022 BAF: S1.2; S1.3; PA1.1; PA1.3; PA1.4; PA1.5;



Amendment date:	Apr-23
Committee scrutiny:	P & F C
TARGET: S x L	3 x 3 = 9
Nov-22	4 x 3 = 12
Dec-22	4 x 3 = 12
Feb-23	4 x 3 = 12
Apr-23	
Jun-23	
Aug-23	
Oct-23	
Dec-23	

Related operational risks:	Main Controls (programmes, initiatives and project	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Further action	Assurance RAG
1552/06-22. Stockport system partners reviewing Saffron Ward function and purpose, which could impact our service model. *Legacy CCG structures continue to seek assurance via meetings and reports which erodes capacity to build ICB relationships.* *Competing priorities amongst providers and members of integrated care system.* *Emerging and ineffective governance.* *Inability of PCFT to ensure that mental health, learning disabilities and autism service needs are recognised appropriately in system plans.*	1. Integrated Care System and ICB partnership working	Gaynor	Greater Manchester Mental Health Board co-chaired by the SRO for MH at the ICB and one of the MH CEOs in Greater Manchester. The three CEOs of mental health providers in Greater Manchester meet frequently as do Directors of Strategy. Provider Federation Board has been asked to lead on Mental Health programmes and Programme Director in place. Governance and programme arrangements reviewed and revised autumn '22. Developing clinical strategy to set out vision for services and associated plans.	ICB governance arrangements - finer detail - remain emergent; still being developed and finessed as at winter 2022.	ICB governance arrangements are aimed to be completed by April 2023. Arrangements still in development and there is some duplication at GM and localit level which is impacting capacity and speed of decisions.		A.
	2. Relationship building and working at place.	Gaynor	Relationship building and working at place and has identified team for each system Board, provider collaboration and MH group. Working with ICB and localities to ensure arrangements across ICB and localities are aligned. Established a PCFT Strategy Group across Exec Lead arrangements; and substantive leads in place for each borough. PCFT Chair re-appointed for further year to 31.10.24 to ensure we maximise collaborating opportunities with GMMH and other neighbours.	PCFT services across north, south and specialist services are not contiguous with the five Boroughs served. Capacity of Network Directors and Associate Directors to engage in ICB and place structures. The five Boroughs work in different ways and arrangements still emerging. Capacity gaps in planning & performance and wider corporate services.	ICB level assurance mechanisms yet to be confirmed and previous arrangements / reporting flows continue which causes duplication and impacts PCFT capacity to resource.		A.
	3. PCFT playing an active role in provider collaboration with: a) GMMH b) wider provider collaboration c) Tier 4 CAMHS LPC	Gaynor	a) GMMH Exec Team engagement with counterparts in local provider. Agreement to work with GMMH on a range of issues. b)Provider ollaboration Established Exec to Exec meetings with acute & community sector partners to discuss issues. Engaged in Provider Federation Board ('PFB') and associated structures. Programme Director in place for PFB MH programme work to refine governance. c) Lead Provider Collaborative PCFT is the Lead Provider in a collaborative of all Greater Manchester Tier 4 CAMHS services. Established formal governance in place. Commissioning team operates with appropriate separation of duties. PCFT Board Committee 'LPC Committee' seeks and scrutinises assurance re control systems effectiveness. Connected to other North West LPCs to share best practice.	a) Capacity impacting ability to progress areas of joint work. Recent incident at GMMH impacted upon capacity. B) Governance arrangements / detail of arrangements across the ICB / PFB still developing. C) Some capacity gaps with the LPC commissioning function.	Programme of engagement with GMMH (other than mutual aid) significantly reduced whilst GMMH respond to its major incident. Not all of the governance arrangements are, or ever will be, in PCFT's purview to determine and therefore cannot be assured as we depend upon effective partners.		G.
	4. Wider collaboration in the external community sectors including Education; Research; CCG 'legacy' functions; Voluntary, Community, Social Enterprise; politiicians.	Gaynor	Chair, CEO and Dir of Strategy well networked amongst civic society leaders. Mapping of services has commenced to support strategy development across the system.	Partnership Strategy in development, which will map stakeholders and set out approach. Engagementwith Trust Management Board 22.3.23	Board session in January 2023 to focus on partnerships.		G.
	5. Council of Governors and FT Membership	Andy	Staff and Public Members are engaged via the Corp Governance team via numerous channels. Engaged staff and public members become candidates in elections for the CoG, some of them winning and being elected to the CoG. The CoG has numerous mechanisms for holding the NEDs to account for the performance of PCFT, including appointment and re-appointment of NEDs, including the Chair. The PCFT Annual Report contains KPI data on membership and engagement, including election results. The CoG have a Membership Engagement Committee and a Quality Committee. The Chair of the Board is the Chair of the CoG and in regular contact with many Governors, including the Lead Governor and Deputy Lead Governor.		Mechanisms to capture and feed back voices of young people who make up significant proportion of service users less well developed than for other ages.		G.

PCFT: 2022-25 BOARD ASSURANCE FRAMEWORK

6	**Failure to achieve financial sustainability.** *Risk appetite: see target score*	Overall risk owner: Nicky Tamanis

Which of the four ambitions will be impacted ?

1	Outstanding care	x	3	People with lived/living experience shaping decisions	x
2	Everyone has the opportunity to live a fulfilling l	x	4	Colleagues feel engaged & involved in improvement	x

Which of the enabling sub-strategies are relevant to mitigation ?

1	Clinical strategy	x	6	Leadership strategy	x
2	Quality strategy	x	7	Estates strategy	x
3	Service transformation strategy	x	8	Digital strategy	x
4	Research & development strategy	x	9	Partnerships strategy	x
5	People Plan	x	10	Communications strategy	x

Links to risks reported in the Board's September 2022 BAF: S2.3; S3.4.

Amendment date:	Apr-23
Committee scrutiny:	P & F C
TARGET: S x L	3 x 3 = 9
Nov-22	4 x 5 = 20
Dec-22	4 x 5 = 20
Feb-23	4 x 5 = 20
Apr-23	
Jun-23	
Aug-23	
Oct-23	
Dec-23	

Related operational risks:	Main Controls (programmes, initiatives and projects) 1-6	Lead	Assurance re: effective control	Gaps in control	Gaps in assurance	Further action	Assurance RAG
From the Sept 2022 BAF: *1375/02-20. Value improvement activity fails to deliver planned savings. (20)* *1550/06-22. Under-investment in T & G estate potentially jeopardises service delivery. Noty yet agreed as significant.* *1667/02-23. South Networkl Care Hub - lack of access to financial information sufficient to meet management needs. Not yet agreed significant.* *Other identified risks* *#1 Significant cost and operational pressures risk overspend against budget - particularly Agency spend to cover high vacancy rate and Tertiary spend* *#2 Pay awards remain under negotiation / arbitration.* *#3 Significant investment required to reduce waiting list backlogs.* *#4 Transformation projects generating significant future funding pressures.* *#5 Future funding not yet agreed - growth has been agreed but no funding for investment / service development.* *#6 Inherited widespread non-compliance with Financial Regulations with regard to contracting and procurement.* *#7 The potential impact of strike action.* *#8 Long term power pricing is a significant expected cost pressure from '23/24.* *#9 Risk share arrangements with NW regional MH providers in the provider collaborative.* *Note: Capital Department Expenditure Limits 'CDEL' currently apply to capital expenditure. Although PCFT has cash available to allocate to capital projects, central NHS control has limited the Board's freedom to allocate that capital. This exacerbates attempts to mitigate risks where capital allocation would play a significant role such as estates and digital infrastructure.*	1. V I Programme	Nicky Tamanis	Value Improvement Steering Group: A governance framework has been developed for the delivery of the Value Improvement Programme, which includes a revised Equality and Quality Impact Assessment (EQIA) process. The programme of work is supported by the Strategic Delivery Hub with a dedicated programme manager to ensure schemes are progressed with identified leads. External Audit of arrangements for value for money – no significant issues to report for 2020/21 or 21/22. Using the support of a programme manager all potential schemes are being validated and assessed for deliverability. Value improvement workshop held with senior managers 21.2.23. Value Improvement targets for 2023/24 have been allocated to Networks and Corporate departments. Initial assessment of financial benefits and opportunities to be completed by mid April 23.	The Value Improvement Programme is relatively immature, with many schemes still in idea stage. Revenue allocations including non-recurrent top up funding have only been notified for one year; 2023/24 which inhibits the development of a longer-term strategy. Coordinated ICB value improvement programmes across Greater Manchester currently in development, in addition to specific locality based efficiency groups	Although on target to hit 2022-23 taget, the performance is biased towards non recurrent savings. The recurrent financial opportunities for the 2023/24 programme have yet to be identified		A.
	2. Financial controls, including budgetary controls	Nicky Tamanis	Established systems are in place for monthly monitoring of performance and reporting to the Board, to the GM ICS and NHSE. The Value Improvement Group is in place, monitoring the delivery of the Value Improvement Programme and trajectories with frequent reporting to P&FC. GM Provider DoFs meet bi monthly to review the system-wide financial position. Current financial performance is tracking the annual plan, and the forecast does not identify significant risk to the delivery of the plan in year. Tracking and reporting of financial performance including performance against run rates and, when applicable, value improvement targets in monthly finance reports, which show only small variances from plan. Cash flow forecast indicates a strong cash position with the actual cash position above plan. Scheme of reservation and delegation (v13) updated and approved (with delegated authority from Board to do so) by P & F Committee on 22.2.23. Independent sources of assurance: NHSE review of financial plans and assumptions at ICS level. Internal Audits in place covering key financial systems including budgeting, core processing systems, and financial management. External Audit assessment of Value for Money arrangements. NHSE / GM ICS scrutiny of plans, submissions and monthly updates. GM ICS and NHSE oversight of efficiency programmes. Financial plan approved by GM ICS and NHSE.	Identify changes required through clinical strategy work-streams for medium and long-term sustainability and work collaboratively across the localities and wider system to propose and take forward agreed changes. PMO structure. There are key vacancies which have been hard to fill. The recruitment challenge is recognised nationally. Key areas of challenge are Financial Accounts where we have a longstanding Chief Financial Accountant vacancy, business intelligence where there are senior analyst vacancies and digital particularly with regards to cybersecurity skills. The Medium Term Financial Strategy is uncertain: assumptions are becoming clearer following the three year CSR, with national capital planning assumptions confirmed for three years and revenue planning assumptions expected to be confirmed during 2023/24 for a longer time span. ~~Planning guidance for '23/24 not due for publication until mid December earliest.~~ Outstanding internal audit actions across the Trust.	Medium-term planning assumptions are available to the Trust and there has been work completed with commissioners to understand how best to work together to deliver priorities from the funding available. The Comprehensive Spending Review provides only remains relatively short term planning horizons for the NHS settlement at provider level.		G.
	3. Staff costs controls	Nicky Tamanis	PCFT continues to underspend against staff establishment due to operating with high vacancy levels.	Without long term revenue and capital commissioning commitments, service planning and staff establishment plans are without key data.	~~Scheme of reservation and delegation requires updating in 2023.~~		A.
	4. ICB and Contractual income controls	Nicky Tamanis	Established systems are in place for monthly monitoring of performance and reporting to the Board, to the GM ICS and NHS England. Internal Contract Management Group. MHLD Transformation Programmes. Strategic Delivery Board. NHS England key indicators of effective financial management. External Contract Review Group chaired by GM Commisssioner. MHLDA Partnership Board	Emerging ICS governance on MHLDA financial flows and joint planning arrangements – PCFT involved in the joint development of MHLD governance. Development of a broader range of BI metrics that support operational oversight and planning.	A Financial Recovery Sub Committee has been established by the GM ICB to oversee system level financial recovery. GM ICB financial sustainability (or lack thereof) potentially will impact PCFT's access to the capital and revenue required to achieve our own sustainability. The lack of governance and established SOP for MH&LDA across GM is the source of some confusion with regards to decision making.	ICB requiring multiple short notice revisions to budgets.	A.
	5. Capital controls	Nicky Tamanis	CPG (capital planning group) develops and recommends the capital programme for approval to the P&FC and Trust Board. CPG prioritises for approval any proposed capital schemes. Digital Strategy and Portfolio Board develop the Digital Strategy for the Trust with proposals on capital resourcing taken via the CPG.	The long-term capital programme needs to be assessed against the available CDEL and additional funding sources. The CDEL funding for '23-24 needs to be worked through at ICS level and subject to some negotiation (the allocation formula would result in a shortfall against Trust needs). Develop and maintain 5 year capital plan.			R.
	6. Provider collaborative controls	Nicky Tamanis	Monthly meetings held with GM DoFs to discuss the financial and performance positon - the Financial Advisory Committee.		Capital demands for 2022/23 have been constrained within the CDEL and this pressure is expected to continue into future years. There is a need for a robust capital allocation methodology overseen by the Provider Collaborative.		A.

Pennine Care
NHS Foundation Trust

Information circulated to Board members outside of Board meetings

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March 2023

No.	Date	Item	Sender
1.	02.03.23	Good Governance Institute – Non-Executive Director meetings with David Holden	Anthony Hassall
2.	20.03.23	Save the date for the staff awards evening - booked for Friday 24th November 2023, 6.00 – 11.00 pm	Karen Hamer on behalf of the Comms team
3.	31.03.23	Slides from the from the Combined North West system Leaders and Chairs call – (i) NHS NW Black Asian and Minority Ethnic Assembly and (ii) Health Inequalities	Karen Hamer on behalf of Evelyn Asante-Mensah
4.	11.04.23	Board Performance Report for February 2023 circulated as no April Board meeting	John Starkey
5.			
6.			
7.			
8.			
9.			

Note: The Board also receives:

- *a weekly email overview of all serious incidents reported to StEIS*
- *a weekly media update.*