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Welcome from the Chairman and Chief Executive

The year 2013/14 has seen considerable change, challenge and success for Pennine Care NHS Foundation Trust (Pennine Care) but also for the NHS nationally.

“We provide care to people of all ages, from birth to the end of life. We are extremely proud of what Pennine Care has achieved over the last 10 years and look forward to continued success.”

A major development was the appointment of Michael McCourt as Chief Executive. Michael, formerly Director of Operations and Nursing, took up the post on 1 January 2014 having been appointed through an independent recruitment process.

As Chief Executive, Michael has led the development of the Trust’s new vision and strategy, which will launch formally in 2014/15 but has been a key programme of work and engagement throughout the year.

This year the NHS underwent one of the biggest national reforms since its formation in 1948, with the introduction of the Health and Social Care Act 2012 that saw Primary Care Trusts replaced by GP-led Clinical Commissioning Groups, the disestablishment of Strategic Health Authorities, the launch of Commissioning Support Units and the formation of NHS England, as well as the transfer of more commissioning powers to local authorities.

Pennine Care has continued to progress and move forward during this period of transition and has continued to build relationships with new commissioners and partners in order to deliver service transformation and improve patient care.

The Act also requires commissioners to promote and protect patient choice and many are opting to use competition as a vehicle for improving services. Pennine Care has experienced an increase in competitive tenders this year. The most significant was the tendering of community services in Oldham, where we were confirmed as the lead provider of community services in the borough. We also welcomed staff from Trafford community services on 1 April 2013, which the Trust secured as part of a procurement exercise in the previous year.

At the same time, the NHS is still required to deliver £20 billion savings from its total budget, which is the largest efficiency that the NHS has ever faced. In previous years, Trusts have achieved savings through modest service redesign but targets are becoming increasingly challenging and will require more large scale transformation.

For Pennine Care, the estimated savings target over the next five years is £42 million from an annual expenditure budget of approximately £276 million. In 2013/14 the Trust successfully delivered £7.2 in financial savings, meeting the required targets.

Focusing on patient safety and quality of services continued to be a key priority for Pennine Care in 2013/14 as well as embedding the Principles of Care programme. The Principles of Care is the staff’s response to the Francis Inquiry for how they will deliver safe and effective services to patients. We celebrated the achievements of services by holding the first Principles of Care Awards, which were voted for by staff and recognised excellence in practice.

We have continued to work closely with our Council of Governors this year and they have been involved in the Trust’s business more than ever before, such as having a lead role in the recruitment of the Chief Executive and being engaged throughout the Oldham tender to represent the voice of the community.

None of our services would continue to improve without the incredible hard work and dedication of our staff. This has been another year in which staff have continued to provide high quality care in very challenging times. We would like to personally thank them for this.

We are looking forward to the coming year and working together with our patients, staff and partners to continue to deliver the best possible services for our local communities.

“We provide care to people of all ages, from birth to the end of life. We are extremely proud of what Pennine Care has achieved over the last 10 years and look forward to continued success.”

John Schofield
Chairman
28 May 2014

Michael McCourt
Chief Executive
28 May 2014
INTRODUCTION

Since its formation in 2002, Pennine Care NHS Foundation Trust (Pennine Care) has grown to become one of the UK’s leading providers of community and mental health services.

Our 6,000 staff provide care to 1.3 million people across six boroughs, as follows:

- Bury, Oldham and Rochdale – community services and mental health
- Tameside and Glossop – mental health, health improvement and intermediate care
- Stockport – mental health
- Trafford – community services and child and adolescent mental health services (CAMHS)

Our mental health services provide care and treatment for people with mild to moderate conditions such as depression, anxiety or dementia, or more serious mental health illnesses such as schizophrenia, bi-polar disorder and more.

Our community services are wide-ranging and support people to stay out of hospital from birth right through to the end of their life, including district nursing, health visiting, audiology, podiatry, health improvement and intermediate care.

We also work closely with a range of partners including commissioners, NHS Trusts, the private sector, local councils and voluntary organisations to deliver innovative and integrated care to our communities.

Our services

Pennine Care is uniquely positioned to provide whole person care, addressing all aspects of health, lifestyle and wellbeing - from prevention to end of life.

Services are located across multiple sites, including health centres, community clinics, GP practices and hospitals.

Mental health services

- Primary care mental health services including Increasing Access to Psychological Therapies (IAPT)
- Working age adult inpatient and community services, including access and crisis, home treatment, assertive outreach and early intervention
- Older People’s inpatient and community services
- Community-based drug and alcohol services
- Child and Adolescent Mental Health Services (CAMHs), including community and inpatient services
- Psychiatric Intensive Care Unit (PICU)

Low secure rehabilitation and step-down rehabilitation services that are gender and age specific, designed to safely integrate individuals back into their local communities

Community services

- Adult nursing and therapies including district nursing, matrons, palliative care, physiotherapy and audiology
- Children’s nursing and therapies including health visiting, children’s community nursing, child protection and safeguarding, school nursing and crisis intervention
- Services supporting the management of long-term conditions such as pulmonary rehabilitation, expert patients, vascular diseases and cardiac rehabilitation
- Community dental services including minor oral surgery and dental access centres
- Health improvement teams focused on delivering interventions to help people stop smoking, get more active, eat healthily and weight management
- Services to support people with learning disabilities including community teams, supported living, respite and dental services
- Urgent and intermediate care services designed to care for patients in the community, avoiding hospital admission and reducing length of stay. Services include intermediate care units, community hospitals, IV therapy, urgent community care/rapid response and urgent treatment centres/walk-in centres

How we are commissioned

One of the largest reforms of the NHS came into force on 1 April 2013, creating new structures and commissioners. The Health and Social Care Act 2012 saw GP-led Clinical Commissioning Groups (CCG) gain commissioning powers, replacing Primary Care Trusts (PCTs).

Our main NHS commissioners are now:

- Bury Clinical Commissioning Group
- Oldham Clinical Commissioning Group
- Heywood, Middleton and Rochdale Clinical Commissioning Group
- Stockport Clinical Commissioning Group
- Tameside and Glossop Clinical Commissioning Group

However, a larger proportion of our community services are now commissioned by local authorities, since public health commissioning moved from PCTs into councils. This currently applies to health improvement services, but will also cover children’s nursing and health visiting from April 2015.

We are also now commissioned by NHS England to provide community dental services, as well as some specialist mental health services.

We have focused on building relationships with our newly-formed commissioners and partners over the last year, ensuring we can develop and improve local services for patients together in the future.

“Pennine Care is uniquely positioned to provide whole person care, addressing all aspects of health, lifestyle and wellbeing - from prevention to end of life.”
STRATEGIC REPORT

The purpose of the strategic report is to provide an overview of the Trust’s business and accounts from 2013/14. This year has been significant in Pennine Care’s transformation, progression and growth.

“Our vision is to deliver the best possible care to patients, people and families in our local communities by working effectively with partners, to help people to live well.”

The strategic report includes information on:
- Appointing a new Chief Executive
- Redefining our vision and strategy
- Moving to devolved autonomy
- Service transformation and re-design
- Patient engagement
- Principles of Care
- Corporate social responsibility
- Clinical information system
- Community services developments
- Mental health developments
- Future trends and challenges
- Financial performance and information
- Our staff
- Sustainability
- NHS Constitution

The strategic report has been approved by the Board of Directors.

Michael McCourt
Chief Executive
28 May 2014
Appointing a new Chief Executive

In April 2013 the Trust’s former Chief Executive, John Archer, resigned from his post. Mr Archer had been on suspension since November 2012 and was subject to an investigation, which later concluded. In the period from November 2012 to December 2013, Martin Roe held the post of Acting Chief Executive.

Pennine Care has now moved forward with the appointment of a new Chief Executive. On 1 January 2014, Michael McCourt took up the post to lead the organisation. Michael was formerly the Trust’s Director of Operations and Nursing and was appointed following a robust and independent recruitment process.

He has worked for the NHS for nearly 30 years, is a qualified nurse and has held a number of clinical and non-clinical roles. That, combined with his extensive Board level experience, will provide Pennine Care with strong leadership to provide our patients with the best possible care.

Commenting on his appointment at the time, Michael said: “I consider it a privilege to be given the opportunity to lead Pennine Care as Chief Executive and take forward its vision and strategy in the years ahead. My priorities will be to empower staff to improve patient care, continue to foster our partnerships and focus on delivering integrated, patient-centred care.”

Our vision

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

Our ambition is to remain the partner of choice for mental health and community services. We will do this by continuing to provide high quality whole person care, whilst empowering people to self-care.

Our strategic goals

The initiative also included a refresh of the Trust’s supporting strategic goals, to ensure they continue to steer the organisation in the right direction:

- Put local people and communities first
- Strive for excellence
- Use resources wisely
- Be the partner of choice
- Be a great place to work

The new vision and strategy will be officially launched in April 2014; however more information is available in the Trust’s vision document ‘Working together, living well – our vision for transformation’. Visit www.penninecare.nhs.uk for more information.

Moving to devolved autonomy

Due to the size and complexity of the organisation, the Board of Directors recognised that we needed to make some fundamental changes to the Trust’s internal reporting structures. This meant moving from a centralist approach to a more devolved, local way of operating within each borough.

As part of a comprehensive assurance process, the Trust spent the year working towards establishing divisional business units (DBUs). The main difference is that these units have more powers to make decisions locally, without having to gain approval from the central committees or the Board. However, successes, risks and issues are reported to the Board by exception, ensuring they continue to gain assurances about the Trust’s business and operations.

Having local structures means we can respond more quickly to the needs of local patients, services and commissioners. Each DBU is led by a Service Director and senior management team, with corporate support.

The DBUs are as follows:
- Bury community services
- Oldham community services
- Heywood, Middleton and Rochdale community services
- Trafford community services
- Mental health
- Specialist services

The Trust also has separate directorates for health improvement and dental, reporting into a DBU.

As part of the authorisation process, each DBU had to develop a robust 12 month business plan. These plans were celebrated at a joint workshop with all divisional teams, Board members, Council of Governors and corporate leads on 11 March 2013.

A more detailed overview of the Trust’s new committee and governance structures can be found within the Directors’ Report, starting from page 54.

Service transformation and re-design

As with all NHS Trusts and public sector bodies, Pennine Care must deliver efficiencies of a minimum of 4% every year. This equates to approximately £42 million over the next five years, from our budget of £276 million.

The target for the financial year 2013/14 was £7.2m which was fully achieved.

However, it is becoming more difficult to deliver financial efficiencies through modest re-design and small cases for change. This means that we will need to be bolder in our thinking in order to deliver transformation at pace and scale. We will also need to strengthen our joint working with primary care, secondary care and the local authority to address the challenges together.

We are committed to working closely with our staff to provide leadership and support as we manage these challenges over the coming years. As part of this, a communications and engagement plan is in place to ensure staff are provided with regular updates and that the Trust communicates in an open and transparent way. We also continue to work in close consultation with our staff side colleagues on any transformation plans or cases for change, as well as conducting quality impact assessments to ensure that the quality and safety of patient care are not compromised.

Patient engagement

Listening to the views and experiences of patients to shape and change our services is a key principle for Pennine Care, from the Board to frontline. We collect and listen to the views of patients in a number of ways, many of which have been established for some time. However, this year we have made considerable progress in improving our approaches, acting on feedback and really empowering patients to self-care.

Service user and carer conference

Service users and carers attended a conference to discuss how our services should be improved to help people with long-term conditions. The event was held during self-care week in November and attendees participated in two workshops looking at how service users and carers can influence services and how they should be treated as an equal partner with healthcare staff.

Living Well Academy

The Living Well Academy is an innovative new project that aims to help people to gain a greater understanding of health conditions and how best to manage them.

The programme will focus on supporting patients with chronic obstructive pulmonary disease (COPD), cardiovascular disease, diabetes, dementia, stroke, or those at the end of life. It will also have a significant focus on meeting the needs of carers.
A series of educational health and support courses will be developed during 2014/15, as well as an interactive online platform to support self-care. Patients and carers must lead the development of the programme and the Trust is planning to work with as many people as possible as part of an engagement programme in the new financial year.

The Living Well Academy is being supported by a range of partners including each local Clinical Commissioning Group (CCG) and Local Authority, as well as voluntary sector agencies. It will be launched as a two-year pilot, with dementia being the first stage as a proof of concept.

Corporate social responsibility
In 2012/13, Pennine Care launched a Corporate Social Responsibility Strategy (CSR) for how the Trust will make a difference to the communities it serves.

As part the CSR strategy, Pennine Care aims to be the provider and employer of choice, delivering quality services that reflect the needs of the users and making a wider contribution to its local communities.

Developing a new children’s hospice
As part of its CSR commitment, Pennine Care has formed a partnership with Bury Hospice to develop a new children’s hospice for north Manchester. The hospice will be located in Radcliffe on the same site as Bealey Community Hospital, which is also run by the Trust.

A grant of £507,000 was secured by Bury Hospice to kick start the development and the partnership launched a campaign to raise £1m for the project in total. The hospice will be called Grace’s Place and will provide much needed support to children and families from Bury, Oldham and Rochdale, who have a terminal or life-limiting illness. An independent Board of Trustees has been established to oversee the management of the project.

Eco-school mentoring project
Pennine Care provided mentorship support to a group of high school pupils as part of an eco-school project, run by the Engineering Development Trust (EDT).

EDT is a national charity set up to inspire future engineers and scientists. It runs an initiative called Go4Set that works with schools and businesses around the country to set environmentally-themed projects for students, with the aim of encouraging more youngsters to explore a career in sciences or engineering.

A team from Fairfield High School for Girls in Droylsden took part in the project and received mentoring support from the Trust over 10 weeks.

Mission Christmas
The Trust supported local radio station Key 103 with its Mission Christmas appeal to provide a toy to vulnerable children in Manchester on Christmas Day. The Trust’s staff showed their generosity and donated a large number of toys to the appeal.

10 Principles of Care
In 2011, staff developed a set of 10 Principles of Care that outline our key values and behaviours which are essential for providing safe, high quality care and services for our patients. Services have worked on embedding the principles into practice and a short video has been developed to showcase the progress made by some teams. The video can be viewed on the Trust’s YouTube channel: www.youtube.com/penninecarenhs

Over 500 staff from all roles and areas of the Trust attended road shows held in each borough which celebrated success and also engaged with staff for their views and input into taking forward key organisational issues.

The 10 Principles of Care are:

- **Safe and effective services**
  “It’s my responsibility”

- **Meaningful and individualised**
  “It’s how I would want to be treated”

- **Engaging and valuing**
  “No decision about me, without me”

- **Constructive challenge**
  “We can be even better”

- **Governance procedures enable**
  “Everything I do is about excellence in practice”

- **Focused and specific**
  “I’m clear about the vision and how I can influence”

- **Competent skilled workforce**
  “I make a difference in what I do”

- **Clear and open communication**
  “I have a voice”

- **Visible leadership**
  “I am a clinical leader”

- **Shared accountability**
  “Trust board, services, teams and individuals all have a role”

This year, the Trust also launched the Principles of Care Awards. Teams could self-nominate or nominate others and a winner was selected from each division as voted by more than 800 staff. The Chairman then chose an overall winner, which was Butler Green Intermediate Care Facility in Oldham.

Butler Green is a 28-bed unit based in Chadderton. A team of health professionals provide enhanced recovery and rehabilitation to help local people avoid being admitted to hospital, or to avoid a long stay.

The team received the award after working in partnership with hospital staff to improve the safe discharge and transfer of people from The Royal Oldham Hospital.
Clinical information system
This year Pennine Care launched a two-year programme to roll out a new electronic patient record system across all of its community and mental health services. Known as Paris, the system will help to streamline systems and processes and improve the quality of patient information available, as well as reducing duplication and paperwork.

The children’s community nursing teams from Bury, Oldham and Rochdale were the first services to start using the system. Nurses have been trained and issued with mobile tablet devices to allow them to access Paris at the point of care, whilst working with a patient. This means that they no longer have to use paper-based systems and will not have to return to base to update a patient’s record, freeing up more time to deliver patient care.

The remaining community and mental health services will be mobilised over the next two years, with services prioritised according to service need. Over time we will exchange information with other systems such as those operated by GPs, Local Authorities and Acute Trusts.

Community services
Pennine Care provides community services across Bury, Oldham, Rochdale, Stockport and Trafford. These services are focused on providing care to patients at home or in the community, helping them to manage their conditions and avoid going into hospital.

Community services tend not to work in isolation but have strong links with the hospital, social care, voluntary agencies and of course, each other. This means that in each of the boroughs we serve, integration is a top priority so we can provide joined-up care for our patients by working closely with our partners.

Bury care co-ordination pilot
Nurses from Pennine Care launched a project with GP practices in Radcliffe and Bury Council to provide more care co-ordination to families and people with long-term conditions.

The programme provides all families taking part with increased health visiting contacts including a daily text and phone service as well as regular home visits. The scheme hopes to assist families and children living in areas recognised as deprived who are most likely struggle to travel to clinics and hospitals. By working together with parents and other services, parents are offered opportunities to improve their confidence, knowledge and skills.

Bury integrated sexual health service
Pennine Care launched an integrated sexual health service in Bury, in partnership with The Pennine Acute Hospitals NHS Trust. In the first year of operation, the service provided integrated care to an impressive 10,386 service users. The move brought together community and secondary care into a single service located at Townside Primary Care Centre. The integration has delivered a number of benefits including providing a wider range of services in one place, more comprehensive packages of care, improved facilities and closer partnership working.

Oldham community services tender success
Following a formal tender, NHS Oldham Clinical Commissioning Group reappointed Pennine Care as the preferred provider of core community services, special elective services and enhanced intermediate care across Oldham. The Trust was also appointed as the lead provider of end of life care in the borough, whilst continence services and respiratory services were not retained.

The tender was a significant project in 2013/14 and the outcome was a fantastic achievement. It has further strengthened the Trust’s reputation as a leading provider of community and mental health services in Greater Manchester. It is a real testament to the staff and services who work tirelessly to provide high quality care to local people.

Integrated Oldham diabetes service
The new Oldham Diabetes Service was officially launched in 2013/14, to provide integrated care to patients. It is jointly provided by Pennine Care and The Pennine Acute Hospitals NHS Trust, working collaboratively with NHS Oldham Clinical Commissioning Group. The service focuses on improving education and training for GPs, empowering patients to self-care and providing more specialist care in the community. Community and secondary care clinicians are now co-located at Glodwick Primary Care Centre.

Oldham cancer support project success
Around 150 people affected by cancer have already benefited from the very best care and support thanks to the Macmillan 1 to 1 project. £150,000 was awarded by Macmillan Cancer Support to launch the initiative, which aims to improve cancer services in primary care and the community by providing people with dedicated care that meets their needs.

The team of specialist nurses supports patients, their families and carers to understand their medical condition and have more involvement in their treatment and care. They offer a holistic package of care including physical, emotional, financial, psychological, social and spiritual needs.

The pilot will run until 31 March 2015 and it is hoped that it will be rolled out across the whole Oldham borough.

Integrated care teams active in Rochdale borough
Community matrons and district nurses are now working as part of integrated teams in the majority of GP practices in the Rochdale borough. Monthly disciplinary team meetings are held to review patient care plans and feedback has been positive, with all parties feeling the time is well spent with clear outcomes for the patients discussed, and the learning achieved through individual patient discussion is generalised more widely. The Trust is also working with the CCG to explore how psychological therapies could become part of the integrated team model as it continues to evolve.

Rochdale borough community paediatrics service launched
Pennine Care won the contract to provide a Community Paediatrics Service in Rochdale, which is responsible for the care and treatment of children and young people with complex health needs. This includes those with autism, epilepsy or cerebral palsy, an undiagnosed learning difficulty, special educational needs and looked after children.

Patients receive care from a range of health professionals including paediatric consultants, specialist doctors, nurses, health visitors, physiotherapists, occupational therapists and speech and language therapists. The team also works closely with colleagues from other agencies to provide integrated care wherever possible, and has strong links with the Child Development Service, already provided by the Trust in Oldham.

Physio Direct success
Physio Direct is a pilot scheme where patients can self-referral into the MSK physiotherapy service, without having to see a GP first. The pilot has involved five GP practices from Rochdale and four from Oldham. The aim is to improve referral to treatment times and promote self-management, as well as reducing GP visits, sickness absence from work and reliance on medication.

Results from the pilot have demonstrated positive outcomes, with 72.5% of patients saying that the service has helped to speed up recovery and 87.5% did not need to see their GP afterwards. Impressively 97.5% said they would use the service again.

Trafford community services
Trafford’s community health services transferred to Pennine Care on 1 April 2013 following a competitive procurement exercise led by NHS Trafford Clinical Commissioning Group.

This includes adult and children’s community services, as well as Child and Adolescent Mental Health Services. Over the last 12 months the Trust has worked closely with Trafford Council on providing integrated children’s services as part of a section 75 agreement and has supported the opening Trafford Urgent Care Centre by enhancing community services as part of the New Health Deal.

The integration of Trafford community services into the organisation was managed on a staged approach, learning lessons from the Transforming Community Services Programme. A single Service Director was appointed for the borough, who reports into the Trust’s main governance structures.
Mental health and specialist services

The Trust provides a range of mental health services to people of all ages for a range of conditions ranging from anxiety and depression, to schizophrenia or bipolar disorder.

Many of our services are delivered in the community, but we also have a number of mental health wards on hospital sites or secure units.

Psychiatry liaison services

Around 7,500 people across Greater Manchester benefitted from the Trust’s new and innovative psychiatry liaison services. The initiative, known as RAID (Rapid Assessment Interface and Discharge) involves experienced mental health workers working on hospital sites to support people with mental health and/or alcohol problems.

The practitioners assess people who may require mental health or alcohol support and ensure they receive this support quickly to reduce the risk of problems escalating. The teams also provide people with any additional practical, emotional and social support they need and either deliver this first-hand, or signpost people to other services that can meet their needs.

There are three strands to RAID:

- Accident and Emergency (A&E) Liaison - for people who attend A&E in relation to mental health issues and as a result of self-harm.
- Alcohol Liaison - for people who attend A&E, or are staying on a ward, with alcohol or drug-related problems.
- Older People’s Liaison - for older people on hospital wards who are experiencing dementia, delirium or depression.

The service is delivered at several hospitals across the Trust’s footprint, including The Royal Oldham Hospital, Fairfield General Hospital, Tameside General Hospital and Stepping Hill Hospital. The Accident and Emergency element is also delivered at Rochdale’s Urgent Care Centre.

Telehealth demonstrated positive outcomes

Community services continued to utilise Telehealth, with around 177 monitoring kits being installed in patient’s homes. Each borough had a different focus for how they would deploy the equipment, with Bury focusing on patients with heart disease, Oldham chronic obstructive pulmonary disease (COPD) and Rochdale predominantly COPD, heart disease and diabetes.

As part of a three-month study, the Trust found that Telehealth attributed to a 15% reduction in hospital bed days when averaged across the three boroughs. Patient satisfaction surveys also demonstrated that Telehealth helps patients to self-manage, whilst reducing anxiety, with the vast majority of patients feeling more involved in their healthcare.

Maximising the use of technology continues to be one of the Trust’s core principles and will feature as a major priority in the next financial year.

District nursing review

District nursing is widely recognised as being the foundation of adult community services, with the single largest workforce and significantly high caseload. The Trust this year launched a comprehensive review of the district nursing services across Bury, Oldham and Rochdale. This included a detailed workforce review, caseload analysis and engagement programme. The project will continue into the new financial year but a new vision for district nursing was identified as:

“Our vision is to provide a district nursing service that everyone is proud of, by delivering high quality care in our local communities, with clinical leadership and patient needs at its heart. We want to empower patients to be independent and will work closely with our partners to ensure our services are accessible, flexible and responsive.”

The next phase of the project will involve developing a robust transformation strategy and plan, to ensure district nursing continues to be the cornerstone of community care.
Military Veterans’ Service delivers positive outcomes

The Military Veterans’ Service provides mental health treatment and support to ex-service personnel and their families across the North West. Pennine Care held an event on 24 October 2013 at the Imperial War Museum North to showcase the service’s success and outcomes that were evidenced by an independent evaluation from Manchester University.

The service launched as a pilot in September 2011 and in the first 23 months of operation it received 1110 referrals, over 80% of which were for ex-Army personnel.

The evaluation found that the service’s clinical outcomes were good, with a greater impact than antidepressants alone. Clinical outcomes were especially encouraging for veterans who left military service early and also had a forensic history, as well as for those with poor social adjustment at referral.

Significantly, service users who had an alcohol misuse problem achieved positive outcomes. The service also appeared to be cost effective in comparison to local primary-care mental health services when considering improvement in depression.

The event was attended by Dr Dan Poulter MP, Parliamentary Under Secretary of State, regional commissioners, providers and armed forces representatives.

The North West Military Veterans’ Service was also awarded a national Positive Practice in Mental Health Award for its innovation.

Triangle of Care carer engagement programme

The Triangle of Care was first formulated by the Iraq Veterans of America and the National Mental Health Development Unit to emphasise the need for better involvement of carers and families in the care planning and treatment of people with mental health problems.

The Triangle of Care approach was developed by carers and clinicians to improve carer engagement in acute inpatient and home treatment services. It recommends better partnership working between service users and their carers, and organisations.

Pennine Care launched its Triangle of Care programme in September 2013 and all of the Trust’s inpatient wards are taking part. Carer Champions were recruited to support the delivery of the programme, which has involved developing carer information packs, delivering training for staff on how to effectively engage and support carers and improving how information is shared with carers.

Over the last year, the Trust has conducted ward assessments with carer champions to measure progress and it is proven to be helping staff to better understand how to support and involve carers when their loved ones are in our care.

Plans for a dementia unit in Rochdale

NHS Heywood, Middleton and Rochdale Clinical Commissioning Group this year unveiled plans to develop an innovative new unit at Rochdale Infirmary that will provide specialist care for frail and elderly patients with dementia.

Provided by Pennine Care and The Pennine Acute Hospitals NHS Trust, the Oasis Unit will bring together mental health nurses and general nurses to ensure patients with dementia are provided with the highest levels of care, from assessment to treatment.

A patient’s length of stay will be between five and seven days depending on their individual needs, as opposed to the current 48-hour length of stay and discharge target for the Clinical Assessment Unit (CAU). This will ensure referral and care pathways are designed to meet the needs of each individual patient, providing a better quality of continuing care.

Pennine Care’s community services will also provide support to ensure care continues when patients return home. It is a fantastic opportunity to integrate local physical and mental health services in order to provide patients with a complete package of care, as well as supporting families and carers.

The unit will launch officially in April 2014.

Trust formed unique partnership with fire service

Pennine Care joined forces with Greater Manchester Fire and Rescue Service (GMFRS) this year to protect and improve the health, safety and wellbeing of local people.

Staff from Pennine Care and GMFRS provide training and support to one another, as well as signpost service users to their services as part of the initiative. The partnership delivers the mutual aims of reducing the risk of fire, injuries and deaths; protecting people, property and the environment from harm; improving the health and wellbeing of local communities and improving fire safety awareness and mental health awareness between staff.

Investment in Oldham’s older people’s services

The Trust has been developing a new model of mental health support for older people with mental health difficulties across Oldham following a £400,000 investment from NHS Oldham Clinical Commissioning Group.

All patients diagnosed with dementia will be offered a memory liaison practitioner to provide an initial care plan, ongoing contact and an annual review of their condition. Memory clinics will also be held in GP practices, with mental health staff and GPs working together to assess patients’ needs. Patients will be offered a 10 week support and education programme to help them understand and come to terms with their diagnosis, as well as receive psychology, occupational therapy and speech and language therapy all from the same service.

A team of nurses will also be providing specialist mental health input into care homes by forming care plans to help staff understand and manage the needs of complex patients who often end up in hospital when their condition deteriorates.

Mental health team forms unique partnership with GMP

Mental health practitioners from the psychiatry liaison teams have formed a partnership with Greater Manchester Police (GMP) in Oldham to launch a new mental health triage pilot.

The pilot, which is the first in Greater Manchester, allows officers to ring a single triage number if they encounter an individual who potentially has a mental health condition. The mental health team will then advise whether the individual is known to mental health services and will work with the Police to determine the best action to take in a crisis.

By working more closely with the Police, our staff are able to quickly identify people who are already accessing our services and can help those who don’t to be assessed more quickly. We hope that it will help to provide a more joined-up approach to treating patients and will alleviate some of the pressures faced by both the Police and the NHS.

New CAMHS website has young people in mind

Children and young people can now learn more about local Child and Adolescent Mental Health Services (CAMHS) following the launch of a new dedicated website

The website www.withinmind.nhs.uk was developed to appeal to youngsters by using vibrant colours, illustrations and graphics. The content has also been written in a more conversational style, making it easy for young people to relate to and understand.

The site includes a guide to mental health conditions including signs and symptoms to look out for, tips for good mental health, details about mental health services and what to expect, real life stories and guidance about other services that can provide support and advice. There is also a section where professionals and referrers can obtain more detailed information about services in their area.

CAMHS woodland retreat won national award

The Woodland Retreat, located at Pennine Care’s inpatient CAMHS units in Bury has won a national award for ‘Best External Environment’.

The Building Better Healthcare Awards 2013 awarded the Woodland Retreat for its imagination and inclusion of service users. The state-of-the-art treehouse was the first mental health unit of its kind in the country and introduced young people from the Hope and Horizon units to relaxation and learning, enhancing the units’ therapeutic approach.
Family wellbeing project
As part of a CQUIN target on parental mental health, CAMHS teams have worked with families to understand more about the pressures of family life and how they cope. This has led to the development of 10 tips for family wellbeing. A briefing promoting the tips was distributed to GPs to share with families they come into contact with as well as promotion in the local media.

Musical madness
Over 100 people attended a musical extravaganza led by service users from the rehab and high support directorate. Service users teamed up with a Rochdale charity, The Backdoor Music Project, to produce an afternoon of singing, dancing and music at The Curtain Theatre in Rochdale.

The project’s volunteers worked with service users on a weekly basis to develop their musical and theatrical skills, ranging from playing an instrument, singing, dancing and DJing, through to stage and sound production, lighting, costume and theatre make-up. They then used these skills to plan and deliver the entire performance – which was titled ‘Musical Madness 2 – The Theatrical Return’.

In addition to delivering a successful event, the project has helped the service users to develop their independence, self-esteem, and confidence by challenging them in a supportive and fun atmosphere.

Bury recovery celebration
Bury’s Drug and Alcohol Service held a Recovery Fair in August 2012 which was opened by the Police and Crime Commissioner for Greater Manchester, Tony Lloyd.

The aim was to mark the hard work and commitment of service users who have successfully overcome drug and alcohol problems. During the event service users shared their successful recovery journeys and took part in a range of activities.

Future priorities and challenges
As a leading Foundation Trust, Pennine Care is required to develop a Service Development Strategy for the next five years. It sets out how we intend to develop our services, improve the quality of patient care and make the required efficiencies over that period. It explains the context the Trust is currently working in, identifying key themes and our priority programmes for the coming year.

It highlights that we will require a radical and focused programme of transformational change to achieve our ambitions. The strategy has been developed through a series of conversations and engagement sessions with partner agencies, governors, service users and carers and the Board of Directors.

It is intended to support and provide the narrative for our five-year strategic plan and two-year operational plan.

This strategy is refreshed each year to ensure it continues to meet the needs of patients and the priority transformation programmes have been refreshed as follows:

- Living well – supporting people to live well
- Easy access – ensuring service users and referrers can access our services and expertise easily
- Whole person care – delivering integrated physical and mental health care, that is locally focused and tailored to individual needs
- Places that work – develop and implement the most productive model for each neighbourhood
- Better use of technology – implementing an effective clinical information system, rolling out mobile working and utilising assistive technologies
- Fewer buildings – reduce the Trust’s spend on estates by 25%
- Different ways to deliver care – explore different organisational vehicles to deliver high quality care

As part of the Service Development Strategy and Operational Plan, the following key challenges have been identified:

Growing demand for care
Population demographics and the health problems we face as a society are changing rapidly. Increased life expectancy and the growth in lifestyle-related conditions mean that the way that care is delivered currently cannot continue.

In particular, the Trust is working on its approach to managing long-term conditions, in respect of both physical and mental health and the inter-relationships between the two.

Changing populations
Not only is the population growing, it is also becoming more diverse. We know that significant health inequalities exist in many of the communities we serve and that access to services and care is not always sufficient or appropriate enough to have the necessary impact. Therefore, the Trust is reshaping its community service delivery into neighbourhood teams designed to meet local needs.

Economic climate
Current spending projections suggest that significant financial pressures will remain for the next 20 years. NHS England has estimated that an additional £30 billion will need to be found on top of the ‘Nicholson Challenge’ of £20 billion by 2015. More than one in five NHS hospitals are set to be in deficit by the end of this financial year and more than one in three Directors of Adult Social Care are also forecasting deficits. Whilst the NHS has its own substantial targets, these are relatively modest compared with the scale of the reductions that most of the Local Authorities in our geographical footprint are subject to. This presents additional challenges as health and social care providers need to work together to ensure that service changes are coherent and do not place each other under additional pressure.

The Trust is working closely with Local Authorities and other private and third sector providers to identify opportunities for service integration or partnership working, aimed at managing the ongoing efficiency requirements whilst maintaining service delivery.

Early intervention and early help
Whilst the overall service offer is reducing, there is an increased focus on changing the relationship between public services and the communities that use them. This requires services to act early and appropriately with clear pathways to professional advice, support and/or interventions as soon as possible, to tackle emerging issues before they escalate to acute and/or complex problems.

Integrated out-of-hospital care
The separation between general practice and hospital specialists, as well as between health and social care, can often inhibit the provision of timely, high quality integrated care for people who need to access a range of services relevant to their needs. Care needs to be based on the co-ordinated delivery of support to individuals in a way that enables them to maximise their independence, health and well-being. The Trust is therefore working hard to enable care co-ordination across its geographical footprint in a range of service areas.

Greater patient voice
Patients are calling for a more person-centred, better co-ordinated approach to their care. National Voices have described this as: ‘I can plan my care with people who work together to understand me and my care plan, allow me control, and bring together all the services to achieve the outcomes important to me’.

The Trust is planning to review how it engages with patients and ensures the patient voice is at the centre of service improvement. This will continue to be a key focus in the years ahead.

Increased focus on self-management and shared decision-making
There is a large and growing body of evidence that a system which supports people with long-term conditions to manage their own health has benefits for the person, their health and for health services. Creating such a service requires shifting the habits of clinicians from focusing on managing disease to helping patients stay as healthy as possible. This is a fundamental culture shift that requires a new understanding of the role of the patient, clinician and the system itself. It has gained significant traction amongst patient groups as an opportunity to gain greater control of their care. It is also widely recognised as one of the key enablers to reducing the demand on services.
Change at scale and pace
In light of the challenges faced by health and social care, the need to transform the way that care is delivered must happen at both pace and scale. This will be challenging in the context of financial constraints, an increasingly competitive environment and rising demand. The Trust is working with local communities and key stakeholders to develop a shared vision for service delivery in each borough that will facilitate greater community resilience and effective use of resources for the maximum health impact.

Increased competition
A key aspect of the recent health reforms has been the extension of competition in the NHS, with the expectation that commissioners will routinely test the market and tender for services. Over the last two years, the Trust has been involved in an unprecedented number of tenders in order to protect its existing business and to grow its market share. There is recognition that responding to formal tenders is resource intensive and may be less efficient than more collaborative means of service re-design and improvement.

Quality and safety
Nationally there has been a number of substantial failings in care over the last couple of years, including Mid-Staffordshire NHS Foundation Trust and Winterbourne View. This has had a significant impact on the way that services and changes are monitored and delivered. Commissioners, and other local stakeholders, have a duty to ensure that service changes and service efficiencies do not have a detrimental effect on quality. In response to this, the Trust has implemented a robust approach to Quality Impact Assessments, which ensures that proposed service changes are reviewed rigorously to protect quality standards.

More information on quality and safety can be found in the quality account.

Growing role of Local Authorities
Local Authorities now have an increasing commissioning role, with responsibility for public health commissioning transferring under their control on 1 April 2013. We have already seen a greater focus on wellbeing services, with a move away from the NHS being the provider of choice, as well as significant reductions in budgets, resulting from the financial challenges that Local Authorities face.

The other key change is the development of Health and Wellbeing (HWW) Boards, an important feature of the Health and Social Care Act 2012. However, in spite of many being chaired by senior elected members, most of those in the Trust’s footprint have not started to fully address the immediate and urgent strategic challenges facing local health and care systems.

Increased use of technology
We expect to see significant growth and improvements in the use of technology for diagnostics, assessment, treatment and information sharing, all of which requires investment. As described earlier in the strategic report, the Trust’s deployment of mobile working, implementation of Paris and utilisation of telehealth technology are key projects in the Trust’s development. We are also planning on exploring a more digital first approach for communications and maximising our use of social media.

Healthier Together
Originally starting as a reconfiguration of acute hospital care in Greater Manchester, Healthier Together has now developed into a review of health and social care across the local economy and is part of the wider public service reform agenda. The Healthier Together programme is clinically-led and is managed by a Service Transformation Team that is accountable to Greater Manchester’s twelve Clinical Commissioning Groups (CCGs). It aims to develop a model of care that will help the NHS and other care providers in Greater Manchester provide quality services that are safe, accessible and sustainable for future generations.

The Trust is engaging with the Healthier Together programme through a range of clinically-led groups and is influencing a shift in focus towards community models.

Despite all of these challenges, Pennine Care remains in a strong position as a provider of high quality physical and mental health care. The plans set out in this report can be viewed in more detail within the Service Development Strategy and Operational Plan, which can be found on the Pennine Care website www.penninecare.nhs.uk
The assessment of the Trust’s financial performance by Monitor, the Independent Regulator of Foundation Trusts, excludes these items from the calculation of the ‘risk rating’ applied to the Trust. Overall the Trust has performed in line with its plan for the year.

Overall performance
The following are the main headlines of financial performance for the Trust in 2013/14.

* The overall income and expenditure position shows a surplus of £0.758 million compared to the Trust target surplus of £3.425 million. Before exceptional items, the Trust had an underlying surplus of £5.674 million, which represents 2.0% of income.
* During 2013/14 Monitor changed its Financial Risk Rating regime and introduced the Continuity of Service Risk Rating (CoSRR) which focuses on a Trust’s financial capability to continue to deliver services. The Trust’s CoSRR for 2013/14 was a level 4, which is the highest score awarded for Trusts considered low risk with no regulatory concerns. The Trust’s score was in line with 2013/14 plan.

Income and expenditure position
The following table summarises the actual financial performance as at March 2014.

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual results '000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>283,615</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-276,671</td>
</tr>
<tr>
<td>Non-normalised EBITDA</td>
<td>6,944</td>
</tr>
<tr>
<td>Restructure costs</td>
<td>1,057</td>
</tr>
<tr>
<td>Net impairment of fixed assets</td>
<td>3,859</td>
</tr>
<tr>
<td>Normalised EBITDA</td>
<td>11,860</td>
</tr>
<tr>
<td>Non-operating costs (including depreciation and dividend)</td>
<td>-6,186</td>
</tr>
<tr>
<td>Normalised net surplus/deficit</td>
<td>5,674</td>
</tr>
<tr>
<td>Normalising adjustments (restructuring and impairment)</td>
<td>-4,916</td>
</tr>
<tr>
<td>Net surplus/(deficit) per accounts</td>
<td>758</td>
</tr>
</tbody>
</table>

Income
Following the national reform of the NHS, the Trust now receives the majority of its income from Clinical Commissioning Groups (CCG) for patient care and from Local Authorities for public health provision. Prior to the formation of CCGs in April 2013, income was received from Primary Care Trusts (PCT).

The Trust’s income increased for 2013/14 by £39.7m, and included £19.4m for the contract for community services in Trafford. Total income for patient care, including Local Authority commissioned services for 2013/14 was £271m – 95.4% (2013/14: £232m – 95.2%).

The following table highlights the income received from key commissioners.

<table>
<thead>
<tr>
<th>PCT/CCG</th>
<th>2013/14 Income '000</th>
<th>2012/13 Income '000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bury CCG</td>
<td>37,882</td>
<td></td>
</tr>
<tr>
<td>Bury PCT</td>
<td>43,660</td>
<td></td>
</tr>
<tr>
<td>HMR CCG</td>
<td>46,702</td>
<td></td>
</tr>
<tr>
<td>HMR PCT</td>
<td>55,738</td>
<td></td>
</tr>
<tr>
<td>Oldham CCG</td>
<td>46,448</td>
<td></td>
</tr>
<tr>
<td>Oldham PCT</td>
<td>57,110</td>
<td></td>
</tr>
<tr>
<td>Stockport CCG</td>
<td>23,712</td>
<td></td>
</tr>
<tr>
<td>Stockport PCT</td>
<td>23,855</td>
<td></td>
</tr>
<tr>
<td>Tameside and Glossop CCG</td>
<td>23,886</td>
<td></td>
</tr>
<tr>
<td>Tameside and Glossop PCT</td>
<td>27,827</td>
<td></td>
</tr>
<tr>
<td>Trafford CCG</td>
<td>19,676</td>
<td></td>
</tr>
<tr>
<td>NHS England</td>
<td>35,958</td>
<td></td>
</tr>
<tr>
<td>Western Cheshire (NW Specialised Commissioning)</td>
<td>10,353</td>
<td></td>
</tr>
</tbody>
</table>

Total 27,636 10,556

In addition, the Trust received £12.2 million 4.6% (2012/13 £11.7 million 4.8%) for the delivery of non-patient care services, such as support education and training support, staff salary recharges and provision of non-clinical services to other NHS bodies.

Expenditure
As at 31 March 2014 the Trust employed an average of 5,476 whole time equivalent staff and expenditure on pay costs (including directors costs and excluding termination benefits) is the single largest item of expenditure for the Trust with £214.5m or 76.6% of operating expenses (2012/13 £182.44m 74.1%).

Of the non-pay related expenditure, £2.3m was expended on drugs (2012/13: £2.4m) and £7.5m was spent on clinical supplies and services (2012/13: £6.06m). The following pie chart sets out the major headings of operating expenses for the Trust.
The Trust continued to monitor its performance against the Better Payment Practice Code that requires payment of all trade creditor invoices with 30 days of receipt, and a valid invoice (unless other terms have been specifically agreed with the supplier). The target set is 95% for both value and volume of invoices. The results for the year were 96.85% by value and 95.64% by volume.

The Trust continues to work towards the Government’s initiative to pay small and medium enterprises with 10 working days.

**Capital investment**

The Trust has continued to invest its surplus cash balances in its capital infrastructure in line with the capital strategy approved by the Trust Board. Total capital spends in 2013/14 was £5.9m with the main areas of spend on the following projects:

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Spend in 2013/14 (£’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult acute wards</td>
<td>2,727</td>
</tr>
<tr>
<td>IM&amp;T (including mobile working)</td>
<td>1,337</td>
</tr>
<tr>
<td>Life cycle investment</td>
<td>556</td>
</tr>
<tr>
<td>Other new developments</td>
<td>696</td>
</tr>
<tr>
<td>Minor improvements</td>
<td>562</td>
</tr>
</tbody>
</table>

The overall carrying values for property, plant and equipment at 31 March 2014 have been updated through a full revaluation exercise including site visits to all owned properties completed by the District Valuations Officer. A full revaluation exercise is a recurring requirement for all Foundation Trusts, and Pennine Care brought forward the current exercise to provide comfort on the carrying value of assets transferred from PCTs and to ensure all standing data for the asset base is up to date.

The impact of the revaluation exercise is a small overall reduction in the carrying value of assets, although within this total position there are upwards and downwards swings in value. Some of the adjustments are recognised directly in the revaluation reserve, giving no impact on expenditure, other movements are recognised as an expense or gain in year, in accordance with accounting standards.

**Better payment practice code**

**Regulatory requirements**

The Trust submits an Annual Plan to Monitor setting out what the financial plans are for the forthcoming year. It provides a forecast of the financial performance of the Trust and this is used to provide a quarterly and annual risk rating.

During 2013/14 Monitor revised its financial risk rating (FRR) compliance assessment and introduced the Continuity of Services Risk Rating (CoSRR). The CoSRR focuses on the Trust’s financial capability to continue to deliver services. The two ratings defined by the CoSRR are:

- Capital service capacity which measures the coverage of debt servicing requirements, including capital and interest payments on all loans and PFI arrangements, and the annual PDC Dividend payable to the Department of Health
  - Liquidity ratio which measures the liquidity days based on net current assets (excluding inventories) divided by operating expenditure, multiplied by 360

The CoSRR replaces the former FRR compliance framework assessment which sets out to demonstrate the following:

1. **Achievement of plan** – has the Trust achieved its plans?
2. **Underlying performance** – did the Trust achieve its goals in the way it set out to, using planned resources?
3. **Financial efficiency** – did the Trust use its money wisely?
4. **Liquidity** – does the Trust have enough cash resources to carry on its day-to-day business?

The new CoSRR provides a Trust with a rating from 1 to 4, where 4 equals the highest score and the Trust is therefore considered low risk with no regulatory concerns. The old FRR rated from 1 to 5, with 5 being the lowest risk with no regulatory concerns.

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**Cost efficiency**

In line with the national guidance, the Trust agreed a tariff adjustment for 2013/14 with commissioners. The agreed deflationary adjustment reduction mainly applied to NHS commissioner contracts was between 1.3% of contract income.

In light of the income reduction and to address known cost increases, the Trust developed a series of cost improvement plans (CIPs) totalling £7,227m within its 2013/14 plan.

The Trust’s Integrated Business Planning Group, on behalf of the Trust Board, has overseen the CIP programme throughout the financial year. This group has monitored progress against the schemes.

The Quality Group has also ensured they were delivered without compromise to patient care and quality through the monitoring of quality impact assessments.

As a result of the dedication and hard work by staff, 95% of the 2013/14 CIP was delivered by identifying recurrent schemes. As there was slippage on start dates on a number of schemes, the required savings were found non-recurrently to ensure the Trust achieved its financial plans.

**Cash and liquidity**

The cash balance has decreased by £6.479m during the year however there is a corresponding increase in trade and other receivables of £7.908m. The accumulated current assets provide assurance to the Board and Monitor on the Trust’s ongoing liquidity and the cash balances allow the Trust to invest in its capital infrastructure (i.e. the purchase of mobile devices) to compliment the roll out of Paris; and enhancement and maintenance of the Trust’s estate.

Due to the very low interest rates offered by the banking sector during 2013/14, the interest returns have been modest at £117k (2012/13 £117k) however the Trust will continue to maximise opportunities to generate additional interest in line with Trust policy.

The closing cash balance of £20.945m represents approximately 27 days of operating expenditure of the Trust.

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**Operating expenditure by type 2013/14**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation and impairments</td>
<td>15%</td>
</tr>
<tr>
<td>Employees and directors pay</td>
<td>12%</td>
</tr>
<tr>
<td>Establishment and travel</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
<tr>
<td>Premises and rental costs</td>
<td>5%</td>
</tr>
<tr>
<td>Professional fees</td>
<td>3%</td>
</tr>
<tr>
<td>Redundancy</td>
<td>1%</td>
</tr>
<tr>
<td>Services from NHS bodies</td>
<td>2%</td>
</tr>
<tr>
<td>Supplies, services and drugs</td>
<td>4%</td>
</tr>
</tbody>
</table>

---

**Supplies, services and drugs**

- Establishment and travel
- Professional fees
- Redundancy
- Services from NHS bodies
- Supplies, services and drugs

---

**Capital spend in 2013/14**

- Adult acute wards: £2,727
- IM&T (including mobile working): £1,337
- Life cycle investment: £556
- Other new developments: £696
- Minor improvements: £562

---

**Scheme spend in 2013/14**

- Adult acute wards: £2,727
- IM&T (including mobile working): £1,337
- Life cycle investment: £556
- Other new developments: £696
- Minor improvements: £562

---

**Supplies, services and drugs**

- Depreciation and impairments
- Employees and directors pay
- Establishment and travel
- Other
- Premises and rental costs
- Professional fees
- Redundancy
- Services from NHS bodies
- Supplies, services and drugs

---

**Operating expenditure by type 2013/14**

- Depreciation and impairments
- Employees and directors pay
- Establishment and travel
- Other
- Premises and rental costs
- Professional fees
- Redundancy
- Services from NHS bodies
- Supplies, services and drugs

---

**Liquidity ratio**

The Liquidity ratio which measures the liquidity days based on net current assets (excluding inventories) divided by operating expenditure, multiplied by 360

The CoSRR replaces the former FRR compliance framework assessment which sets out to demonstrate the following:

1. **Achievement of plan** – has the Trust achieved its plans?
2. **Underlying performance** – did the Trust achieve its goals in the way it set out to, using planned resources?
3. **Financial efficiency** – did the Trust use its money wisely?
4. **Liquidity** – does the Trust have enough cash resources to carry on its day-to-day business?

The new CoSRR provides a Trust with a rating from 1 to 4, where 4 equals the highest score and the Trust is therefore considered low risk with no regulatory concerns. The old FRR rated from 1 to 5, with 5 being the lowest risk with no regulatory concerns.
The table below summarises the key metrics and the Trust’s performance during 2013/14.

<table>
<thead>
<tr>
<th></th>
<th>Annual plan 2013/14</th>
<th>Q1 2013/14</th>
<th>Q2 2013/14</th>
<th>Q3 2013/14</th>
<th>Q4 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Under the Compliance Framework</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial risk rating</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Governance rating</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Under the Risk Assessment Framework</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity of Service Rating</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Governance rating</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Annual plan 2012/13</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Under the Compliance Framework</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial risk rating</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Governance rating</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
</tr>
</tbody>
</table>
Statement on accounts preparation

The annual accounts have been prepared under direction issued by Monitor under the National Service Act 2006.

Going concern

The Trust has prepared its 2013/14 Annual Accounts on the basis of the Trust being a going concern. This preparation takes into account consideration of information available about the future prospects of the Trust and covers:

- Liquidity, being the ability to pay liabilities as they fall due
- Solvency, being the long-term financial viability of the operation
- Business model and customers
- Political factors within the NHS regionally and nationally

Additional risks such as the loss of key personnel and potential breach of borrowing facilities have also been examined.

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

Accounting policies and estimates

The Trust’s financial statements are prepared in accordance with IFRS. These policies are approved by the audit committee for use in preparing the accounts and are amended annually to reflect the changing circumstance, accounting regulation and guidance.

Pensions and other retirement benefits disclosure

The accounting policies for pensions and other retirement benefits are set out in note 5.6 to the accounts. The details of senior employees’ remuneration can be found in the remuneration report.

A look forward

The existence of short-term contracts with commissioners remains a risk for 2015/16 and beyond. The changing commissioner landscape has forced commissioners to proactively address procurement of commissioned services and resist commissioning based on a longer term models. To address this risk, the Trust has continued its strategy of communicating its vision with key commissioners of providing quality care through strategic partnering and integration, with the aim of mitigating against whole scale procurement and establishing long-term contracts.

Overall the Trust’s work with commissioners and the recent success in being awarded the Oldham community services, in addition to being awarded a three year contract for Trafford community services commencing in 2013/14, demonstrates the Trust’s ability to compete in a competitive environment which minimises the risk of loss of contracted income.
Our staff

Pennine Care has a diverse workforce of up to 6,000 staff including consultants, nurses, therapists and specialist practitioners, who work in a variety of places in the community and in hospitals.

We simply would not be able to deliver high quality care to our patients without their continuing hard work and dedication.

NHS Staff Survey

The Trust received a response rate of 38% in its 2013/2014 NHS staff survey, which is a decrease on the 2012/2013 response rate, which was 44%. The Trust will be communicating these results to staff including a high level summary of key findings, areas where the Trust had done particularly well and areas where we have shown deterioration compared to the previous year.

The results have been disseminated to the divisional management teams for local action.

<table>
<thead>
<tr>
<th>Response rate</th>
<th>Trust %</th>
<th>National average %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/2013</td>
<td>44%</td>
<td>50%</td>
</tr>
<tr>
<td>2013/2014</td>
<td>38%</td>
<td>49%</td>
</tr>
</tbody>
</table>

Performance in our top 5 ranking scores for this year was as follows:

<table>
<thead>
<tr>
<th>Top 5 ranking scores</th>
<th>2012/2013 Trust</th>
<th>National average</th>
<th>2013/2014 Trust</th>
<th>National average</th>
<th>Trust improvement/deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 5 Percentage of staff working extra hours</td>
<td>67%</td>
<td>70%</td>
<td>67%</td>
<td>71%</td>
<td>No change (Trust in the lowest (best) 20%)</td>
</tr>
<tr>
<td>KF 16 Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months</td>
<td>9%</td>
<td>20%</td>
<td>12%</td>
<td>19%</td>
<td>No change (Trust in the lowest (best) 20%)</td>
</tr>
<tr>
<td>KF 17 Percentage of staff experiencing physical violence from staff in the last 12 months</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
<td>4%</td>
<td>No change (Trust in the lowest (best) 20%)</td>
</tr>
<tr>
<td>KF 18 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>22%</td>
<td>30%</td>
<td>26%</td>
<td>30%</td>
<td>No change (Trust in the lowest (best) 20%)</td>
</tr>
<tr>
<td>KF 28 Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>8%</td>
<td>13%</td>
<td>10%</td>
<td>13%</td>
<td>No change (Trust below (better than) average)</td>
</tr>
</tbody>
</table>
Performance in our lowest 5 ranking scores was as follows:

<table>
<thead>
<tr>
<th>Bottom 5 ranking scores</th>
<th>2012/2013</th>
<th>2013/2014</th>
<th>Trust improvement/ deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 8 Percentage of staff having well structured appraisals in the last 12 months</td>
<td>46%</td>
<td>39%</td>
<td>Decrease (worse than 12) Above (worse than) average</td>
</tr>
<tr>
<td>KF 9 Support from immediate line manager</td>
<td>3.80</td>
<td>3.77</td>
<td>No change Trust below (worse than) average</td>
</tr>
<tr>
<td>KF 14 Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>91%</td>
<td>91%</td>
<td>No change Trust below (worse than) average</td>
</tr>
<tr>
<td>KF 21 Reporting good communication between senior management and staff</td>
<td>N/A</td>
<td>30%</td>
<td>Change to question (no 2012 comparison available) Trust below (worse than) average</td>
</tr>
<tr>
<td>KF 26 Percentage of staff having Equality and Diversity Training in the last 12 Months</td>
<td>54%</td>
<td>56%</td>
<td>No change Trust below (worse than) average</td>
</tr>
</tbody>
</table>

Plans to address identified areas of weakness

The Trust is committed to working with staff to address our areas of under-performance within the NHS staff survey. In order to further improve our understanding of what we need to focus on, we conduct staff roadshows, co-ordinate focus groups, hold meetings with key services and departments, and use staff champions to help with promotion and engagement activities.

The roadshows commencing in May 2014 are completely dedicated to the staff survey results and focusing on employee engagement and organisational culture. The aim of these roadshows is to obtain feedback and suggestions from staff on how improvements can be made. These actions help to encourage services to look at their specific results. This then informs the development of a Trust-wide plan to address the bottom ranking scores and to improve the employee experience within Pennine Care.

Specific actions against the five lowest scoring indicators in the survey are as follows:

Percentage of staff having well-structured appraisals in the last 12 months

In April 2013 the Trust implemented a new appraisal document alongside adopting the simplified knowledge skills framework (KSF) approach of assessment. The purpose of this new appraisal documentation was to harmonise and standardise the appraisal approach and supporting documentation and providing vital links between the appraisal objectives and the schedule of management supervision discussions.

There is continuing work to implement and embed the use of this appraisal document and process, the simplified KSF and the management and leadership development framework with supporting training in place for managers.

The Trust is currently reviewing the schedule of appraisals (which is currently at the anniversary in post date) with a view for this to take place in quarter 1 of the financial year. This has been piloted in the specialist service division, which has enabled the dissemination of the Trust and divisional objectives into individual appraisals and personal objectives and therefore supporting a better structured appraisal process.

The ongoing work to roll out this approach within the Trust is underway with a phased roll out starting with Band 7 and above employees having their appraisal in April 2015.

Support from immediate managers

The Trust has a dedicated learning and development package to support line managers in their roles to support employees and effectively manage services. This consists of leadership training for team leaders, first line managers, resilience training and coaching skills for managers. Managers can also access mediation to resolve workplace conflict and can personally access coaching and mentoring to support their leadership and management skills. The Trust has also been successful in obtaining places for its leaders on the national NHS leadership development programmes at postgraduate and masters level.

Clinical supervisor training is also commissioned annually to support managers who play both a role as a management supervisor and a clinical supervisor. The skills and knowledge developed in this training support the manager in skills in facilitating effective engagement with staff.

With the appointment of the new Chief Executive, the Trust has recognised employee engagement to be a key enabler to the delivery of excellent patient care. The Chief Executive is passionate about employee engagement and has provided support to events that will promote and progress employee engagement, such as the roadshows and service transformation briefings. Focus and progression with employee engagement in 2014 will be a driver for making Pennine Care a great place to work and upholding the 10 Principles of Care.

Percentage of staff reporting errors, near misses or incidents witnessed in the last month

The Trust’s performance remains unchanged from the 2012 results at 91% however this is slightly below the national average (92%) for staff reporting of errors, near misses or incidents.

In 2012/2013 the Trust implemented a series of proactive and targeted communications to raise awareness on the incident reporting procedures across the organisation. In 2013/2014 this was built upon by the refresh training schedule delivered, which covered incident reporting, investigations at different levels and the principles of being open.

This targeted campaign and supporting training schedule continued to raise awareness amongst employees about the importance of incident reporting and continuing to promote a strong focus on the implementation of electronic reporting.

Going forward the risk department will review the current approach and training provided with the aim to continue to provide a best practice approach and to further raise staff awareness.

Percentage of staff receiving diversity training in last 12 months

The Trust has performed below the national average for staff having received diversity training in the last 12 months, although there has been a slight increase in the Trust results for 2013/2014 (56%) compared to 2012/2013 (55%) the national average has increased from 59% to 67%. This is therefore reflecting that there remains a pressing priority to address this low reported completion rate for mandatory equality and diversity training.

A review of the core and essential skills training provided for staff has increased the compliance target from accessing training three yearly to annually. The impact of this increase will be seen during 14/15, although numbers of staff accessing equality and diversity training is already beginning to increase. This is supported by provision of e-learning for the introductory level programme.
Mandatory equality and diversity training will continue to be promoted across all levels of services and departments and training will be made accessible to all employees with a review and resolution of any areas of non-compliance. These actions will enable the Trust to meet its legal and moral obligations as a proactively diverse, conscious and legally compliant employer.

In 2013 we have continued to provide a range of courses and bespoke training in support of equality and diversity as a broad subject area. This training will continue in 2014 and completion rates will be monitored through local division management structures and the equality and diversity steering group. The monitoring of this mandatory training completion is enabled by the training record system which produces compliance data built up by the implementation of the new reporting process in 2013/14.

The new reports allow for tracking of training against agreed competencies for each staff group meaning reports will be produced on who needs training, who has completed, and who is out of date for specific training. This will allow better targeting of interventions where compliance levels are low by specific service area. Compliance reports are produced monthly being monitored and reported through the Trust Board, operational management groups and service directors. This will ensure the Board receives assurance that employees are up to date with the required core and essential training and is also notified of actions taken to address any compliance issues identified.

The Trust has seen stability in the result for overall staff engagement in the 2013/14 results. This indicator is calculated using the responses to questions where staff said they would recommend Pennine Care as a place to work or receive treatment, have the ability to contribute towards improvements at work and staff motivation at work. This result places the Trust in line with the national average in this area.

The areas where there has been a significant increase in results (staff in receipt of health and safety training and the availability of hand washing materials) were both included in the lowest scores in our 2012/2013 results. Through a focused approach to promoting awareness, robust monitoring and targeted actions these two areas have increased significantly. This approach will be continued by the Trust to ensure that this improved position is maintained and built upon.

The areas where there has been a significant decrease in results (work pressure felt by staff and receiving well-structured appraisals in the last 12 months) will be picked up in the roadshows and local divisional discussions to provide a wrap-around plan to improve on these results through appropriate promotion, training and monitoring.

Pennine Care recognises the importance of the NHS Staff Survey to fully understand the views and opinions of employees and to improve the working lives of our staff, which will ultimately deliver a better patient experience. The Trust is committed to obtaining a clearer understanding of the results from the survey by engaging with employees through staff forums and involving services in the development of plans to address both Trust-wide and local issues.

The health and wellbeing strategy for 2013-2015 promotes:

- The role that staff play in influencing the local health economy to improve their health and wellbeing by themselves, setting an example about health and wellbeing.
- Identifying specific KPI measures and indicators (e.g. workforce information, staff survey results, road show results) and capturing possible points of impact attributable to the health and wellbeing activity.
- Raising the profile of health and wellbeing through health awareness information, activities, achievements and awards.

Flu vaccination uptake

The Trust has achieved just under 60% uptake for the flu vaccination this year. The team worked exceptionally hard to achieve this and communications were regular throughout the programme encouraging staff to have the vaccination. It is thought that the milder weather and absence of a national campaign this year impacted on the numbers. The figures were still ahead of the UK national average uptake figure of 53.1%.

Sickness absence

The health and wellbeing strategy and supporting occupational health services are focused on improving the overall health of our workforce. There is an occupational health service in place that can be accessed by staff directly or through management referral.

In 2012, the Trust made improvements to the reporting and monitoring of sickness absence, which is now displayed in a joint dashboard detailing the Trust’s performance. In 2013 we have built on this improved reporting by implementing the monitoring of absence reasons. This will enable the Trust to proactively monitor the most common reasons for absence which will feed directly into the health and wellbeing strategy and will enable targeted awareness raising and health interventions with the emphasis on improving employees health and wellbeing in the workplace.

Summary of significant change since the 2012/2013 Staff Opinion Survey

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Where staff experience has improved</th>
<th>2012</th>
<th>2013</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Staff receiving health and safety training in the last 12 months</td>
<td>67%</td>
<td>74%</td>
<td>75%</td>
<td>Increase (better than 12) Trust result is average</td>
</tr>
<tr>
<td>12 Staff saying hand washing materials are always available</td>
<td>47%</td>
<td>54%</td>
<td>54%</td>
<td>Increase (better than 12) Trust result is average</td>
</tr>
<tr>
<td>3 Work pressure felt by staff</td>
<td>2.93</td>
<td>3.09</td>
<td>3.07</td>
<td>Increase (worse than 12) Trust above (worse than) average</td>
</tr>
<tr>
<td>8 Percentage of staff having well structured appraisals in the last 12 months</td>
<td>46%</td>
<td>39%</td>
<td>42%</td>
<td>Decrease (worse than 12) Trust below (worse than) average</td>
</tr>
<tr>
<td>Overall indicator</td>
<td>Overall staff engagement</td>
<td>3.73</td>
<td>3.72</td>
<td>3.71</td>
</tr>
</tbody>
</table>
The Trust’s 2013/14 overall sickness absence rate is 5.25%, which is a reduction in the absence rate from last year (5.5%) and a step closer towards the overall target of 5%.

Further work continues in partnership with our staff side colleagues to develop a consistent policy across the organisation and to ensure we develop our managers in this key area. We are currently reviewing our occupational health provision through a re-tender process to ensure that this service meets the needs of the organisation and offers high quality responsive support to both management and employees.

**Workforce demographics**

Analysis of workforce and membership according to age, gender, race and disability:

<table>
<thead>
<tr>
<th></th>
<th>Staff 2012-13</th>
<th>%</th>
<th>Staff 2013-14</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>17-20</td>
<td>4</td>
<td>0.1</td>
<td>6</td>
<td>0.1</td>
</tr>
<tr>
<td>21-30</td>
<td>682</td>
<td>13.2</td>
<td>764</td>
<td>12.8</td>
</tr>
<tr>
<td>31-40</td>
<td>1258</td>
<td>24.4</td>
<td>1397</td>
<td>23.5</td>
</tr>
<tr>
<td>41-50</td>
<td>1713</td>
<td>33.2</td>
<td>1907</td>
<td>32.1</td>
</tr>
<tr>
<td>51+</td>
<td>1500</td>
<td>29.1</td>
<td>1872</td>
<td>31.5</td>
</tr>
<tr>
<td>Total</td>
<td>5157</td>
<td>100</td>
<td>5946</td>
<td>100</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>4572</td>
<td>88.7</td>
<td>5239</td>
<td>88.1</td>
</tr>
<tr>
<td>Mixed</td>
<td>52</td>
<td>1</td>
<td>63</td>
<td>1.1</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>238</td>
<td>4.6</td>
<td>271</td>
<td>4.6</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>108</td>
<td>2.1</td>
<td>141</td>
<td>2.4</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>852</td>
<td>16.5</td>
<td>895</td>
<td>15.1</td>
</tr>
<tr>
<td>Female</td>
<td>4305</td>
<td>83.5</td>
<td>5051</td>
<td>85.0</td>
</tr>
<tr>
<td>Transgender</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Recorded Disability</td>
<td>218</td>
<td>4.2</td>
<td>237</td>
<td>4.0</td>
</tr>
</tbody>
</table>
The analysis section of this report excludes:

- 202 members of staff with no stated ethnicity and 30 classed as “other” ethnic background.

The breakdown at year end of the number of male and female staff members is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Senior managers</td>
<td>19</td>
<td>60</td>
</tr>
<tr>
<td>Employees</td>
<td>864</td>
<td>4983</td>
</tr>
<tr>
<td>Total</td>
<td>895</td>
<td>5051</td>
</tr>
</tbody>
</table>

### Equality and diversity

Throughout 2013/14, the Trust has continued to work towards being a provider and employer of choice for its diverse communities and individuals. In support of this, the Trust has ensured that services and employment opportunities are as accessible as possible. We aim to meet diverse needs, reduce health inequalities and improve patient experience and outcomes for our employees.

The Trust is committed to move beyond statutory compliance by embedding equality and human rights in all our operations. To achieve this, the Trust is in the process of implementing an equality improvement framework called Equality Delivery System (EDS2). This will involve listening to patients, carers, staff and the voluntary sector and measuring the Trust's performance against 18 key outcomes.

The assessment process will take place over the course of the coming year and will be used to refresh the Trust’s equality objectives.

#### Equality objectives

The Trust’s equality objectives were developed through consultation and cover the period from 2012 to 2016. The objectives are:

1. Information and monitoring - effectively monitoring to improve the usefulness of information.
2. Communication - improving communication between the Trust and service users and carers, voluntary and community groups, staff, and primary care.
3. Engagement - improving engagement with a range of stakeholders.
4. Learning and development - ensuring the Trust meets mandatory requirements and provides training that responds to the needs of staff.
5. Making the organisation more reflective of the communities we serve.

As part of these objectives, the Trust publishes equality and diversity data on the website to ensure accountability and transparency, as well as identifying the areas that it intends to prioritise.

Making information available and accessible provides our stakeholders with the means to measure our performance and progress on equality and diversity issues. We will remain responsive to our service users and staff needs, identifying equality and diversity issues whilst sustaining our existing commitments.

#### Supporting staff with disabilities

The Trust is committed to supporting employees who have a disability or develop a disability during their employment. Through the use of occupational health services, implementing reasonable adjustments or considering redeployment opportunities, we aim to support employees to maintain their attendance in work and employment.

We have a range of supportive policies that employees can use to meet their needs during employment, e.g. Flexible Working Policy and a range of policies that adopt a supportive approach to managing employees who have a disability e.g. Absence Management Policy, Capability Policy.

Penmore Care is an equal opportunities employer and as such operates the guaranteed interview scheme. The scheme offers candidates applying for posts a guaranteed interview if they disabled due to an impairment. We monitor the amount of applications that are received and how many people who identify as having a disability are interviewed and who are appointed. Whilst we have a good rate of success supporting people to interview, we aim to improve our rates of appointments to posts of candidates who identify as being disabled.

Managers are supported by the HR department throughout the recruitment process to address any access to work issues or reasonable adjustments needed.

Disability Awareness training is available to staff and managers and this supports the social model of disability. There is a disability staff network. We are currently working in partnership with Rochdale Disability Action Group to review and refresh the disability staff network and their terms of reference. The network aims to support staff who are disabled and to engage and address relevant issues and improvements. We have also worked with Breakthrough, a disability organisation, to promote ‘Aspire’ which is a peer support project for disabled employees.

#### Staff engagement and organisational development

A range of Organisational Development (OD) interventions have been provided during the year to support services with OD consultancy and advice. This also involved the design and facilitation of events and the provision of bespoke team development activity tailored to meet the needs of the team. In addition, a range of workshops continue to be provided which are valued by staff including resilience and change workshops. The work has contributed to learning, making links across projects and supporting change in practice and care pathways including:

- **Beginning work to develop a self-management/self-care toolkit to support services**
- **Facilitating an experience based design session involving staff and patients in contributing to inputting their experiences of the district nursing service**
- **Supporting the organisation with a review of the Oldham and Trafford tender review process to share learning**
- **Supporting service review work in community services and enabling staff to be engaged in identifying ideas for service development**

### Forums

Support for the Nurse Forum has continued in 2013-14 providing space for nurses to feedback directly on developments in the Trust and for the nursing profession and for senior managers to ask for nurses’ views. Work took place this year to understand what could be put in place to provide similar processes for all other Allied Health Professionals.

#### Knowledge management

The Trust has recognised the benefits of investing in a bespoke knowledge management service for the Trust. This has allowed us to make best use of technology to provide access to knowledge and library services across our large and diverse footprint. We have increased our library’s quality assurance framework score this year from 34% to 72% which highlights the excellent work that is taking place to meet this standard. At the heart of the service is disseminating research and evidence, and ensuring all staff have access to the best clinical evidence and research to help practice develop and benefit patients.

#### Compliance reporting and development of flexible access to core and essential skills

The Trust has improved its method of reporting of staff compliance against core skills supporting managers to plan and manage effectively the training required. We have also started to roll out e-learning as a flexible option to meet core skills needs. Additional work has taken place to provide training for the areas that are essential to individual professions or roles such as health visitors in a way that streamlines and reduces waste in time away from work.

#### Clinical and professional skills identification of need and meeting need

This year has seen us embed new processes to identify and prioritise the key clinical skills requirements for our professional staff. This has allowed us to place funding where it is most needed and provides the biggest impact in improving patient care.
Apprenticeship promise and supporting staff development

The Trust continues to provide development opportunities for staff through apprenticeship schemes and qualifications to develop a fully qualified workforce. To support and recognise this work, the Trust has signed up to the NHS North West Apprenticeship Promise and is working towards expanding the offer of qualifications to new starters and to provide fixed-term opportunities to young people through apprenticeship schemes. In addition, a range of internal programmes and training is offered to support staff to develop confidence and skills, for example assertiveness training.

Leadership and management development

The Trust continues to provide access to skills and knowledge to ensure that managers and leaders are competent and confident in their roles in leading services. To support this we have launched the Pennine Care Principles of Leadership and Management setting out the expectations of managers, supporting managers and leaders to self-assess and access appropriate development opportunities. A number of managers and leaders in the Trust have been provided with places on the National NHS Leadership programmes and a review of the content of the Pennine Care Team leaders programme has taken place to support managers in delivering their role with devolved autonomy.

We continue to provide a range of leadership development opportunities such as leadership workshops, 1-1 coaching, bespoke team interventions and 1-1 advice and support to senior leaders.
The NHS Constitution brings together, in one place, details of what staff, patients and the public can expect from the National Health Service. It also explains what you can do to help support the NHS, help it work effectively, and help ensure that its resources are used responsibly.

The Constitution sets out your rights as an NHS patient. These rights cover how you access health services, the quality of care you'll receive, the treatments and programmes available to you, confidentiality, information and your right to complain if things go wrong.

As part of the Constitution, there are seven principles that guide how all parts of the NHS, including Pennine Care, are expected to behave and make decisions.

**NHS Principles:**

1. The NHS provides a comprehensive service available to all, irrespective of gender, race, disability, age, sexual orientation, religion or belief.

2. Access to NHS services is based on clinical need, not an individual’s ability to pay. NHS services are free, except in limited circumstances sanctioned by Parliament.

3. The NHS aspires to the highest standards of excellence and professionalism in all that it does, including the development and support of staff, as well as the care and treatment of patients.

4. NHS services must reflect the needs and preferences of patients, their families and their carers. Patients should not be seen as passive recipients of treatment, but as partners whose individual needs and preferences should be taken into account.

5. The NHS works together across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population.

6. The NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources. As we live longer and scientific knowledge and technology advances, we have to use the NHS’s resources responsibly and fairly.

7. The NHS is accountable to the public, communities and patients that it serves – it takes most of its decisions locally and gives us the chance to influence and scrutinise its performance and priorities.

The NHS Constitution principles, rights and pledges are reflected in Pennine Care’s strategic goals, the Principles of Care and Trust policies. The Trust is fully compliant with all aspects of the NHS Constitution.
There is a clear need for the NHS to take a lead in energy reduction to reduce the impact that healthcare activities have on the environment, to improve health, to improve sustainability and to reduce our expenditure on energy. The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015, and reducing the amount of energy used in our organisation contributes to this goal.

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

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

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

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The Board of Directors approved our SDMP in the last 12 months, so our plans for a sustainable future are well known within the organisation and clearly laid out.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) tool. The last time we used the GCC self-assessment was on 1 April 2014 and we scored 41.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, and also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our board approved plans address the potential need to adapt the delivery the organisation’s activities and infrastructure to climate change and adverse weather events.

Pennine Care is committed to providing services in a way that is sustainable and supports our corporate and social responsibilities.
Performance
Since the 2007 baseline year, the NHS has undergone a significant restructuring process, which is still ongoing. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time:

<table>
<thead>
<tr>
<th>Context info</th>
<th>2007/08</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor space (m²)</td>
<td>60796</td>
<td>69917</td>
<td>69886</td>
<td>78677</td>
</tr>
<tr>
<td>Number of staff</td>
<td>2052</td>
<td>5007</td>
<td>5157</td>
<td>5952</td>
</tr>
</tbody>
</table>

As a part of the NHS, it is our duty to contribute towards the goal set in 2009 of reducing the carbon footprint of the NHS by 10% (from a 2007 baseline) by 2015. It is our aim to exceed this target by reducing our carbon emissions by 15%, by 2015/16 using 2007/08 as the baseline year.

Energy
Pennine Care has spent £1,672,143 on energy in 2013/14, which is a 18.4% increase on energy spend from last year. 0% of our electricity use comes from renewable sources.

<table>
<thead>
<tr>
<th>Resource</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas</td>
<td>Use (kWh)</td>
<td>1029437</td>
<td>10874340</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>2103.65</td>
<td>2222.171</td>
</tr>
<tr>
<td>Oil</td>
<td>Use (kWh)</td>
<td>95000</td>
<td>98000</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>30.29075</td>
<td>31.2473</td>
</tr>
<tr>
<td>Coal</td>
<td>Use (kWh)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Electricity</td>
<td>Use (kWh)</td>
<td>6341523</td>
<td>6419401</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>3553.789</td>
<td>3664.258</td>
</tr>
<tr>
<td>Total energy CO₂e</td>
<td></td>
<td>5687.73</td>
<td>5917.677</td>
</tr>
</tbody>
</table>

Waste breakdown

<table>
<thead>
<tr>
<th>Waste</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recycling</td>
<td>(tonnes)</td>
<td>259</td>
<td>259</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>5.439</td>
<td>5.439</td>
</tr>
<tr>
<td>Re-use</td>
<td>(tonnes)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Compost</td>
<td>(tonnes)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>WEEE</td>
<td>(tonnes)</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>0.063</td>
<td>0</td>
</tr>
<tr>
<td>High temp recovery</td>
<td>(tonnes)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>High temp disposal</td>
<td>(tonnes)</td>
<td>109</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>2.289</td>
<td>2.499</td>
</tr>
<tr>
<td>Non-burn disposal</td>
<td>(tonnes)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Landfill</td>
<td>(tonnes)</td>
<td>23</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>5.621606</td>
<td>8.310204</td>
</tr>
<tr>
<td>Total waste (tonnes)</td>
<td></td>
<td>394</td>
<td>412</td>
</tr>
<tr>
<td>% recycled or re-used</td>
<td></td>
<td>0.013805</td>
<td>0.013201</td>
</tr>
<tr>
<td>Total waste tCO₂e</td>
<td></td>
<td>13.41261</td>
<td>16.2482</td>
</tr>
</tbody>
</table>

Water breakdown

<table>
<thead>
<tr>
<th>Water</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mains</td>
<td>m³</td>
<td>70837</td>
<td>64478</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>65</td>
<td>59</td>
</tr>
<tr>
<td>Water and sewage spend</td>
<td>£</td>
<td>£257,665</td>
<td>£249,834</td>
</tr>
</tbody>
</table>
Carbon footprint
The information provided in the previous sections of this sustainability report uses the Environmental and Regulation Information Centre (ERIC) returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the NHS Sustainable Development Unit (SDU) in 2009/10.

Pennine Care’s total carbon emissions are the equivalent of 10257 tonnes.

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

In accordance with the General Companies Act (s416) the Trust is required to disclose the membership of its Board and its principal activities. As an NHS Foundation Trust, the principal purpose of the organisation, in accordance with its constitution, is the provision of goods and services for the purposes of the health service in England. The Trust’s principal activities are detailed in the strategic report from page 11.

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

As at 31 March 2014, membership of the Board of Directors was as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Schofield</td>
<td>Chairman</td>
</tr>
<tr>
<td>Robert Ainsworth</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Antony Berry</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Dr Dawn Edge</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Colin McKinless</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Alan Moran</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Michael McCourt</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Katy Calvin-Thomas</td>
<td>Executive Director of Planning, Performance and Information</td>
</tr>
<tr>
<td>Martin Roe</td>
<td>Executive Director of Finance/Deputy Chief Executive</td>
</tr>
<tr>
<td>Dr Henry Ticehurst</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Ian Trodden</td>
<td>Acting Executive Director of Nursing</td>
</tr>
</tbody>
</table>

Additionally there are three non-voting Board Directors, as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judith Crosby</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Richard Spearing</td>
<td>Director of Service Development and Partnerships</td>
</tr>
<tr>
<td>Bev Worthington</td>
<td>Director of Workforce and Organisational Development</td>
</tr>
</tbody>
</table>

The Board of Directors

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

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

The Board of Directors holds its formal meetings in public on a monthly basis, chaired by the Chairman, John Schofield.

Following the resignation of the former Chief Executive in April 2013, a number of interim arrangements were introduced to ensure leadership continuity pending the appointment of a new Chief Executive. From 1 April 2013 to 31 December 2013, the interim arrangements were as follows:

- Martin Roe – Acting Chief Executive
- Katy Calvin-Thomas – Director of Performance, Planning and Information
- Michael McCourt – Director of Operations and Nursing/Acting Deputy Chief Executive
- Dr Henry Ticehurst – Medical Director
- Judith Crosby – Acting Director of Finance (to 31 March 2014)

Additionally, the following non-voting Board level appointments were made:

- Richard Spearing – Acting Director of Service Development and Partnerships
- Ian Trodden – Acting Director of Nursing
- Bev Worthington – Director of Workforce and Organisational Development (from November 2013)

A robust and independent recruitment process to appoint a new Chief Executive commenced in May 2013, led by the NHS Leadership Academy, and in December 2013 the Council of Governors approved the recommended appointment of the Trust’s existing Director of Operations and Nursing, Michael McCourt, to lead the organisation from 1 January 2014. The recruitment process is outlined in more detail on page 58, where the work of the Appointment and Remuneration Committee is reported.

Meetings of the Board of Directors

From April 2013, meetings of the Board of Directors have been held in public on a monthly basis and the papers for each meeting are published on the Trust website. Additionally, the Governors are provided with a copy of the agenda prior to any meeting of the Board and a copy of the minutes once approved at the following meeting.

The Board of Directors met 12 times during the period 1 April 2013 to 31 March 2014. The table below shows the attendance of the individual directors:

<table>
<thead>
<tr>
<th>Member</th>
<th>Attendance (actual/eligible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Ainsworth</td>
<td>12/12</td>
</tr>
<tr>
<td>Antony Berry</td>
<td>12/12</td>
</tr>
<tr>
<td>Katy Calvin-Thomas</td>
<td>12/12</td>
</tr>
<tr>
<td>Judith Crosby</td>
<td>10/12</td>
</tr>
<tr>
<td>Dr Dawn Edge</td>
<td>10/12</td>
</tr>
<tr>
<td>Michael McCourt</td>
<td>11/12</td>
</tr>
<tr>
<td>Colin McKinless</td>
<td>10/12</td>
</tr>
<tr>
<td>Alan Moran</td>
<td>11/12</td>
</tr>
<tr>
<td>Martin Roe</td>
<td>11/12</td>
</tr>
<tr>
<td>John Schofield</td>
<td>12/12</td>
</tr>
<tr>
<td>Dr Henry Ticehurst</td>
<td>11/12</td>
</tr>
<tr>
<td>Ian Trodden</td>
<td>11/12</td>
</tr>
<tr>
<td>Bev Worthington</td>
<td>3/5</td>
</tr>
<tr>
<td>Richard Spearing</td>
<td>9/11</td>
</tr>
</tbody>
</table>
All our Non-Executive Directors are considered to be independent as they have not been employed by the Trust and do not have any financial or other business interest in the organisation. None have close family ties with Pennine Care NHS Foundation Trust’s advisers, directors or senior employees and none have served on the Board for more than six years following authorisation of the Foundation Trust.

Assessing the Board’s performance

In line with the Foundation Trust Code of Governance, the Executive Directors undertake annual individual performance evaluations led by the Chief Executive. Non-Executive Directors are appraised annually by the Chairman of the Trust following a process agreed with the Council of Governors, who have the power to re-appoint or remove them from post, following a procedure laid down in the Trust’s constitution.

Following the appointment of the new Chief Executive, and the introduction of an interim leadership structure, the Board identified the need to have an effective programme of Board development to ensure it had the right leadership skills to deliver the Trust’s vision and strategy over the next five years.

The Board received briefing papers at the December 2013 Board meeting and Board Development session on 12 February 2014 outlining proposed changes to the approach to Board development.

It was agreed that the focus of the twice-monthly development sessions would be split between ‘education and information’ sessions, which would provide Board members with the knowledge, information and expertise required to maintain its strategic focus, and ‘board development’ sessions, ensuring the Board received the time to consider its own collective and individual member development needs. These new arrangements were introduced from February 2014.

Furthermore, as part of its ongoing governance arrangements, the Board recognised the need to undertake regular evaluations of its performance to demonstrate it had the required skills, expertise and leadership qualities to drive the organisation forward and it was agreed that a phased approach to Board’s ongoing evaluation and development would be undertaken. This commenced with a self-assessment of the skills and experience each Board member contributes individually to the Board as a whole. This will help identify any areas that are broadly under-represented and help inform the recruitment of new Non-Executive Directors during 2014.

Working with the Council of Governors

The Board of Directors and Council of Governors work closely together. The Board of Directors is responsible for running the Trust’s services and developing strategies and plans for the future. It is also accountable for the organisation’s compliance with national standards, performance targets and financial requirements. The Council of Governors has a statutory responsibility to hold the non-executive directors of the Board individually and collectively to account for the performance of the Board of Directors and details on how this is undertaken are reported in the Council of Governors section of this report (page 66).

The Chairman of the Trust chairs the meetings of both the Board of Directors and the Council of Governors. A report on all items discussed and approved by the Board of Directors forms a standing agenda item at meetings of the Council of Governors, which are held on a quarterly basis. Additionally arrangements are in place for Governor representatives to observe monthly meetings of the Board of Directors and each meeting of the Audit Committee.

Non-Executive Directors’ Terms of Office

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

The aim of devolved autonomy is to establish clear leadership systems and processes that support operational services to adopt a more arm’s length approach to delivery. It is a move away from a centralised management approach to local leadership, through the development of a framework that allows a clear line of sight between Board and services, facilitating greater local decision-making rights and a stronger sense of local ownership for their own deliverables.

Devolved autonomy is also about empowering the Board by ensuring that members have access to timely, focused, and appropriate business intelligence. This allows the Board to function appropriately, focusing on the issues that matter rather than being distracted by issues that can be reasonably managed locally.

Following the decision to implement a more robust business planning and performance management framework, the Trust commissioned a review of the current governance structures and associated reporting mechanisms. The Terms of Reference, membership and reporting mechanisms for each of the existing sub-committees were reviewed and a decision made to replace the Integrated Governance Group with a Quality Governance and Assurance Committee, and replace the Service Development Group with a Service Development and Transformation Committee.

The revised committee structure, which will become effective from May 2014, will comprise five formal sub-committees of the Board of Directors, as follows:

- Audit Committee
- Appointment and Remuneration Committee
- Quality Governance and Assurance Committee
- Service Development and Transformation Committee
- Finance Strategy Committee

The work of the existing sub-committees is described below.

Audit Committee

Chaired by a Non-Executive Director, this group is responsible for:

- Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust’s activities (both clinical and non-clinical), that support the achievement of the Trust’s objectives.
- Ensuring the establishment of an effective internal audit function in line with mandatory NHS Internal Audit Standards, which provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- Reviewing the work, findings and implications of and responses to the work of the External Auditor, as appointed by the Council of Governors.

<table>
<thead>
<tr>
<th>Name</th>
<th>Appointment start date</th>
<th>Appointment expiry date</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Schofield</td>
<td>2 July 2008 (reappointed 1 November 2011)</td>
<td>31 October 2014</td>
</tr>
<tr>
<td>Robert Ainsworth</td>
<td>2 July 2008 (reappointed 1 January 2012)</td>
<td>31 December 2014</td>
</tr>
<tr>
<td>Antony Berry</td>
<td>1 April 2011</td>
<td>31 March 2014</td>
</tr>
<tr>
<td>Dr Dawn Edge</td>
<td>1 November 2008 (reappointed 1 November 2011)</td>
<td>31 October 2014</td>
</tr>
<tr>
<td>Colin McKIness</td>
<td>1 November 2008 (reappointed 1 November 2011)</td>
<td>31 October 2014</td>
</tr>
<tr>
<td>Alan Moran</td>
<td>1 August 2008 (reappointed 1 August 2013)</td>
<td>31 July 2014</td>
</tr>
</tbody>
</table>
Testing assurance processes and reviewing the findings of other significant internal and external assurance functions and their implications for the governance of the Trust.

It is also important that the independence of our external auditors in reporting to the Council of Governors, Non-Executive Directors and the Trust does not appear to be compromised but equally the Trust should not be deprived of expertise where it is needed and can be obtained from Price Waterhouse Coopers (PWC) as a whole. To this end, a policy has been developed that seeks to set out what threats theoretically exist and thus provide a definition of non-audit work that can be shared by the Trust and the external auditors. It then seeks to establish the approval process and corporate reporting mechanisms to be put in place for any non-audit work that the external auditors are asked to perform.

The policy was approved at the November 2008 Audit Committee.

Audit Committee membership:

- Alan Moran – Chair
- Robert Ainsworth
- Dr Dawn Edge
- Colin McKinless
- Antony Berry

There have been four meetings of the Audit Committee during the period 1 April 2013 to 31 March 2014 and the table below shows each member’s attendance:

<table>
<thead>
<tr>
<th>Member</th>
<th>Attendance (actual/eligible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan Moran (Chair)</td>
<td>4/4</td>
</tr>
<tr>
<td>Robert Ainsworth</td>
<td>4/4</td>
</tr>
<tr>
<td>Dr Dawn Edge</td>
<td>3/4</td>
</tr>
<tr>
<td>Colin McKinless</td>
<td>3/4</td>
</tr>
<tr>
<td>Antony Berry</td>
<td>3/4</td>
</tr>
</tbody>
</table>

Appointment and Remuneration Committee

Chaired by the Chairman, and with a membership comprising all Non-Executive Directors, this committee is responsible for reviewing the size, structure and composition of the Board and making recommendations with regard to any changes. It also decides and reviews the terms and conditions of office of the Trust’s Executive Directors in accordance with all relevant Trust policies.

It is for the Non-Executive Directors to appoint the Chief Executive and in May 2013, the Committee approved the establishment of a Task and Finish Group to progress the arrangements for recruiting a new Chief Executive. Chaired by the Trust Chairman, this group comprised two Non-Executive Directors, the People and Development Director, the Head of Corporate Governance and, in the interests of openness and transparency, the Lead and Deputy Lead Governors.

To ensure independence and objectivity in the recruitment process, the NHS Leadership Academy was appointed to lead the process and provide external, expert advice. Subject to the necessary confidentiality, the Governors were kept appraised of progress throughout and a number of them were involved in the assessment and interview panels in December 2012, through which the final selection was made. The Appointment and Remuneration Committee met on 12 December to formally approve the recommended appointment of Michael McCourt as the new Chief Executive, and this was in turn approved by the Council of Governors on 16 December 2013.

Michael McCourt commenced in post as new Chief Executive on 1 January 2014, and immediately reviewed the role and function of the Executive team, to fill the gap left when he vacated his former Director of Operations and Nursing role and to ensure the right leadership arrangements were in place to support the Trust’s objectives over the coming years. At a meeting of the Appointment and Remuneration Committee on 8 January 2014, the interim leadership arrangements, outlined on page 55, were approved. pending completion of a review of the whole Board composition.

There have been eight meetings of the Appointment and Remuneration Committee during the period 1 April 2013 to 31 March 2014 and the table below shows each member’s attendance:

<table>
<thead>
<tr>
<th>Member</th>
<th>Attendance (actual/eligible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Schofield (Chair)</td>
<td>6/8</td>
</tr>
<tr>
<td>Robert Ainsworth</td>
<td>7/8</td>
</tr>
<tr>
<td>Antony Berry</td>
<td>7/8</td>
</tr>
<tr>
<td>Dr Dawn Edge</td>
<td>4/8</td>
</tr>
<tr>
<td>Colin McKinless</td>
<td>6/8</td>
</tr>
<tr>
<td>Alan Moran</td>
<td>7/8</td>
</tr>
</tbody>
</table>

Integrated Governance Group

The Integrated Governance Group was originally established in 2009 and its form and function reviewed when, in 2011, under Transforming Community Services, the Trust began to provide community health in addition to mental health services.

During 2013, the Executive Directors commissioned a work stream to review the Trust’s strategic approach to quality and Board-level assurance. A number of meetings, workshops and Board development sessions were held and in June 2013, a decision was made to disestablish the Integrated Governance Group and replace it with a new committee that would also encompass Quality Assurance, which had previously been the responsibility of a separate Quality Group.

Meetings of the new Quality Governance and Assurance Committee will commence from May 2014. The Committee will be chaired by the Medical Director, and membership will comprise all members of the Board.

Service Development Group

The Service Development Group was originally established in 2008 with delegated authority from the Board of Directors to ensure the delivery of the Trust’s Integrated Business Plan (IBP), monitor the Service Development Strategy (SDS) and Long Term Financial Model (LTFM) to ensure that progress was made in line with agreed objectives and timescales;
and to provide assurance to the Board of Directors on the delivery of the Service Development Strategy and the range of mental health and community services programmes outlined in the IBP to deliver it. This group also managed the Trust’s business continuity plans and a range of developing future business schemes. As part of the review of the Trust’s governance structures, undertaken in 2013, a decision was made to disestablish the Service Development Group and replace it with a Service Development and Transformation Committee. This committee, which will meet from June 2014 onwards, will be chaired by the Chief Executive and membership shall comprise all Board members. In line with the move towards devolved autonomy, the Service Development and Transformation Committee will have delegated authority from the Board of Directors to ensure the delivery of the Trust’s Strategic Business Plan and associated Strategic Planning Work streams and structures; and will provide assurance to the Board of Directors on the delivery of the Trust’s strategic objectives through Divisional Assurance to the Board of Directors on the delivery of the Service Development Strategy and to provide assurance to the Board of Directors with the Council for some eight years, and in total worked for the Council for over 32 years.

Colin McKinless is currently an independent adult social care consultant, having taken early retirement from the post of Executive Director (Adult Social Care and Health) with Tameside Council in 2007. Prior to that Colin was Director of Social Services with the Council for some eight years, and in total worked for the Council for over 32 years.

Colin has also been a member of the NHS North West Commission on mental health services, which reported in October 2008. He feels that the experience gained from the Commission’s work and his long experience of social care and local government, will give him the opportunity to contribute positively to the future direction and success of Pennine Care NHS Foundation Trust. Colin has lived and worked in the area of the Trust all his life.

Alan Moran is a qualified accountant with experience in Chief Executive and Director of Finance posts in large, complex and successful health organisations. He has a thorough understanding of the culture and drivers of the health service, a proven, strong and successful track record of delivery, and of providing leadership within organisations that continuously achieved activity, financial and quality targets. He chairs the Audit Sub-Committee.

Michael McCourt was appointed as Chief Executive on 1 January 2014. He has been a director at Pennine Care since 2004 and has worked for the NHS for nearly 30 years. He is a qualified nurse and has worked in a range of clinical and non-clinical roles. Michael has led the Trust’s service development strategy and professional leadership of nursing and allied health professionals. He also has extensive experience of service transformation and frontline services have grown by £150 million during his tenure at Pennine Care.

Michael’s priorities are to empower staff to improve patient care, continue to foster the Trust’s partnerships and focus on delivering integrated, whole-person care close to home.

Martin Roe has expertise in NHS financial management and has been a Finance Director for over 15 years, for four different NHS Trusts and has ensured that all the statutory finance targets have been achieved during that period. An honours graduate in Business Studies, he qualified for the National General Management Training Scheme, is a qualified accountant and a qualified mentor. Martin was the project lead for the Trust’s Foundation Trust application, which culminated in the Trust being authorised as the 100th Foundation Trust on the 1 July 2008.

Katy Calvin-Thomas is Director of Planning, Performance and Information and joined the NHS in 1997 on the NHS General Management Training Scheme. She graduated from the scheme in 1999 and completed an MA in Managing Healthcare Organisations in 2001. She has also achieved PRINCE 2 Foundation Level. Katy was selected to undertake the Health Foundation Leadership Fellows Development Programme, which she completed in July 2006. Her portfolio includes responsibility for planning, performance, supporting new business developments and delivery of the Integrated Business Plan. She is a qualified coach on the Executive Stretch Programme, run by the NHS Academy.

Dr Henry Ticehurst, was appointed as interim Medical Director in November 2009, and substantively as the Trust’s Medical Director from 1 June 2010. Henry was previously Lead Consultant in Bury, leading a team of medical staff and driving forward improvements in one of our five boroughs. Before becoming Lead Consultant, Henry was a Consultant Psychiatrist in a number of our localities.

Judith Crosby, has been Deputy Director of Finance at Pennine Care since 2002 having previously worked with community, mental health and acute services in both Tameside and Stockport. A qualified accountant, she supported the Foundation Trust application in 2006 and acted as the finance lead on the transactions for the Transfer of Community Services in 2011 and 2013.

Judith was appointed Acting Director of Finance in April 2013.

Ian Tredden is the Acting Executive Director of Nursing and Allied Health Professionals. He is responsible for the professional leadership of nurses and allied health professionals, as well as the lead for infection, prevention and control, adult and children’s safeguarding, patient safety and patient experience.
ian became a Registered Mental Health Nurse in 1985 and has more than 25 years of clinical, managerial and leadership experience working across community and mental health services. He is also a Director on a Community Interest Board and retains a clinical case load using Cognitive Behavioural Therapy for Chronic Obstructive Pulmonary Disease.

Bev Worthington was appointed as Director of Workforce and Organisational Development in 2013. She had previously been Director of Organisational Learning and Development. She was also project director for the successful merger of three community provider services into the Trust in 2011 and for the integration of Trafford Community Services in 2013.

Bev qualified as a Registered Mental Health Nurse in 1981 and has more than 30 years of clinical, managerial and leadership experience working in Pennine Care and predecessor organisations, including working in partnership with local authorities.

Richard Spearing is Director of Service Development and Partnerships and has been at Pennine Care for seven years. He is responsible for the Trust’s Service Development Strategy, integration and partnerships, use of technology and Council of Governors and membership.

Richard completed an MA in Social Work Studies, a Masters in Business Administration and previously worked as a social worker for young people and also in palliative care services. He has worked as a manager in the voluntary sector, NHS and local authorities and a commissioner in health and social care and for the Greater Manchester Strategic Health Authority.

Statement of compliance with the NHS Foundation Trust Code of Governance

The Board of Directors and the Council of Members of Pennine Care NHS Foundation Trust recognise the importance of good corporate governance, as described in the NHS Foundation Trust Code of Governance published by Monitor. Work has been undertaken within the Trust this year to ensure compliance against the Code and determine action to address any areas of non-compliance. As at 31 March 2014, the Trust was compliant with the code’s provisions.

Please refer to the strategic report from page 11, the director’s report from page 54 and Council of Governors and membership section from page 66 for full disclosures.

Summary of the requirements of Schedule 7 to the Regulations

<table>
<thead>
<tr>
<th>Disclosure requirement</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any important events since the end of the financial year affecting the NHS Foundation Trust.</td>
<td>Refer to the strategic report from page 11</td>
</tr>
<tr>
<td>An indication of likely future developments at the NHS Foundation Trust.</td>
<td>Refer to the strategic report, future priorities and challenges from page 22</td>
</tr>
<tr>
<td>An indication of any significant activities in the field of research and development.</td>
<td>Refer to the quality account, from page 85</td>
</tr>
<tr>
<td>Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.</td>
<td>Refer to the our staff section from page 34</td>
</tr>
<tr>
<td>Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period.</td>
<td>Refer to the our staff section from page 34</td>
</tr>
<tr>
<td>Policies applied during the financial year for the training, career development and promotion of disabled employees.</td>
<td>Refer to the our staff section from page 34</td>
</tr>
</tbody>
</table>

Statement of Accounting Officer’s responsibilities

Statement of the Chief Executive’s responsibilities as the Accounting Officer of Pennine Care NHS Foundation Trust.

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts, Monitor.

Under the NHS Act 2006, Monitor has directed Pennine Care NHS Foundation Trust to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Pennine Care NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

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

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

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

Michael McCourt
Chief Executive
28 May 2014
Statement as to disclosure to the auditors

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

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

John Schofield
Chairman

Michael McCourt
Chief Executive

Dr Henry Ticehurst
Medical Director

Martin Roe
Director of Finance and Deputy Chief Executive

Katy Calvin-Thomas
Director of Planning, Performance and Information

Richard Spearing
Acting Director of Service Development and Partnerships

Ian Trodden
Acting Executive Director of Nursing

Bev Worthington
Director of Workforce and Organisational Development

Judith Crosby
Director of Finance

Robert Ainsworth
Non-Executive Director

Anthony Berry
Non-Executive Director

Dr Dawn Edge
Non-Executive Director

Colin McKinless
Non-Executive Director

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

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

There are now in excess of 20,000 members of the Trust, approximately 14,100 of whom are public members living, in the main, in the local areas receiving services from Pennine Care. The remainder of our membership comprises our staff across all disciplines and services, and across all geographical areas served by the organisation.

**Membership strategy**

The Trust’s Membership Strategy Group identified a number of target areas to try to ensure the membership reflected the communities it served and had prioritised engagement and recruitment in the constituency areas of Stockport and Trafford, aiming particularly at the ‘working age’ population.

In April 2013, the membership team employed Membership Engagement Services (MES) to recruit 500 new members in the newly formed Trafford constituency, ahead of the 2013 Governor elections. During the summer months various recruitment and engagement events were attended by the membership team and the newly-elected Trafford governors.
Member engagement

The Trust strives to engage with its membership across the whole of the Trust footprint and participates in a range of events in order to link with existing and potential new members.

Work continues to increase the involvement of younger people across the patch, with regular attendance at college and university events in Bury, Middleton, Rochdale and Stockport. Where possible, the Trust arranged to run stands at their respective health-related events but has also linked into Fresher’s Fairs and has explored opportunities for linking into health and wellbeing-related courses.

The Trust continued with its series of public engagement events to reach into the communities which aimed to promote health and wellbeing messages, signpost to services and link to partner and third sector organisations. A lifestyle market took place in Bury, attended by over 250 members. The Trust would like to thank all staff from within the organisation, along with those from partnership and voluntary organisations, who contributed to making this event enjoyable and informative.

In October 2013, a Stockport engagement event was held for members and local people to have their say on how Stockport’s mental health services would be developed in the future. The event was well attended by staff, members and governors.

The Trust’s Community Choir is still going strong, encouraging members of staff and the local communities to join together for uplifting and enjoyable practice sessions. The Choir has performed at a range of functions across the Trust footprint, including the Trust’s Annual General Meeting.

The membership team has worked with the volunteering team to open up volunteering opportunities to those members interested in getting more involved in the services delivered by the Trust. This has been of particular interest to members who have joined through local college events.

Council of Governors

The Trust’s Council of Governors has a range of statutory duties set out in the NHS Act 2006. These are:

- To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors.
- To represent the interests of the Trust’s members, the public and staff in the governance of the Trust.
- To regularly feedback information about the Trust, its vision and its performance to the members, public and stakeholder organisations that elected or appointed them.

In January 2014, the Council of Governors undertook an annual review of their collective performance as recommended in the Code of Governance and were found to be effective in fulfilling their required roles and responsibilities.

The Council of Governors comprises 46 members – 25 elected members of the public, 8 elected members of staff and 13 members appointed by the key Local Authority and PCTs with whom the Trust has links.

As at 31 March 2014, the Council of Governors was as follows:

### Elected public governors:

<table>
<thead>
<tr>
<th>Name</th>
<th>Constituency</th>
<th>Term of office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael Armstrong</td>
<td>Trafford</td>
<td>2 years from 1 July 2013</td>
</tr>
<tr>
<td>Ed Barber</td>
<td>Tameside and Glossop</td>
<td>2 years from 1 July 2013</td>
</tr>
<tr>
<td>Pauline Barnett</td>
<td>Rest of England</td>
<td>2 years from 1 July 2012</td>
</tr>
<tr>
<td>Norma Bewley</td>
<td>Oldham</td>
<td>3 years from 1 July 2012</td>
</tr>
<tr>
<td>Jan Caldwell</td>
<td>Bury</td>
<td>2 years from 1 July 2012</td>
</tr>
<tr>
<td>Paul Carter</td>
<td>Stockport</td>
<td>3 years from 1 July 2013</td>
</tr>
<tr>
<td>Ryan Cowan</td>
<td>Heywood, Middleton and Rochdale</td>
<td>1 year from 1 July 2013</td>
</tr>
<tr>
<td>Mary Foden</td>
<td>Stockport</td>
<td>3 years from 1 July 2011 (second term)</td>
</tr>
<tr>
<td>Joe Furness</td>
<td>Tameside and Glossop</td>
<td>3 years from 1 July 2013</td>
</tr>
<tr>
<td>Dr Michael Johnson</td>
<td>Oldham</td>
<td>3 years from 1 July 2013</td>
</tr>
<tr>
<td>Patricia Knight</td>
<td>Heywood, Middleton and Rochdale</td>
<td>3 years from 1 July 2013 (second term)</td>
</tr>
<tr>
<td>Dr Satinder Lal</td>
<td>Bury</td>
<td>3 years from 1 July 2012 (third term)</td>
</tr>
<tr>
<td>Geoff Lucas</td>
<td>Stockport</td>
<td>3 years from 1 July 2013 (third term)</td>
</tr>
<tr>
<td>Linda McGrath</td>
<td>Stockport</td>
<td>3 years from 1 July 2013 (third term)</td>
</tr>
<tr>
<td>Stephen Moss</td>
<td>Tameside and Glossop</td>
<td>3 years from 1 July 2013 (second term)</td>
</tr>
<tr>
<td>Irving Normie</td>
<td>Trafford</td>
<td>3 years from 1 July 2013</td>
</tr>
<tr>
<td>William Utley</td>
<td>Heywood, Middleton and Rochdale</td>
<td>3 years from 1 July 2012</td>
</tr>
<tr>
<td>John Reddy</td>
<td>Tameside and Glossop</td>
<td>3 years from 1 July 2011 (second term)</td>
</tr>
<tr>
<td>Derek Rowley</td>
<td>Bury</td>
<td>2 years from 1 July 2013</td>
</tr>
<tr>
<td>John Starkey</td>
<td>Oldham</td>
<td>3 years from 1 July 2012 (second term)</td>
</tr>
<tr>
<td>Margaret Stoneman</td>
<td>Heywood, Middleton and Rochdale</td>
<td>3 years from 1 July 2013</td>
</tr>
<tr>
<td>Lydia White</td>
<td>Bury</td>
<td>3 years from 1 July 2013</td>
</tr>
<tr>
<td>Beryl Whiteley</td>
<td>Oldham</td>
<td>3 years from 1 July 2011 (second term)</td>
</tr>
<tr>
<td>Vacancies x 2</td>
<td>Trafford</td>
<td></td>
</tr>
</tbody>
</table>
The Council of Governors has a statutory responsibility to hold the non-executive directors of the Board individually and collectively to account for the performance of the Board of Directors. There have been four full meetings of the Council of Governors between April 2013 and March 2014 and the table below shows the attendance of individual governors:

<table>
<thead>
<tr>
<th>Name</th>
<th>Attendance (actual/eligible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raquia Almas (until 20 November 2013)</td>
<td>1/2</td>
</tr>
<tr>
<td>Michael Armstrong (from 1 July 2013)</td>
<td>3/3</td>
</tr>
<tr>
<td>Ed Barber (from 1 July 2013)</td>
<td>3/3</td>
</tr>
<tr>
<td>Pauline Barnett</td>
<td>4/4</td>
</tr>
<tr>
<td>Brian Beecham (until 30 June 2013)</td>
<td>0/1</td>
</tr>
<tr>
<td>Norma Bewley</td>
<td>4/4</td>
</tr>
<tr>
<td>Jan Caldwell</td>
<td>4/4</td>
</tr>
<tr>
<td>Paul Carter (from 1 July 2013)</td>
<td>3/3</td>
</tr>
<tr>
<td>Ryan Cowan (from 1 July 2013)</td>
<td>2/3</td>
</tr>
<tr>
<td>Mary Foden</td>
<td>4/4</td>
</tr>
<tr>
<td>Joe Furness (from 1 July 2013)</td>
<td>1/3</td>
</tr>
<tr>
<td>Dr Michael Johnson (from 1 July 2013)</td>
<td>3/3</td>
</tr>
<tr>
<td>Patricia Knight</td>
<td>3/4</td>
</tr>
<tr>
<td>Dr Satinder Lal</td>
<td>4/4</td>
</tr>
<tr>
<td>Geoff Lucas</td>
<td>3/4</td>
</tr>
<tr>
<td>Linda McGrath</td>
<td>3/4</td>
</tr>
<tr>
<td>Susan McKenzie (until 30 June 2013)</td>
<td>1/1</td>
</tr>
<tr>
<td>Ray McLean (until 30 June 2013)</td>
<td>1/1</td>
</tr>
<tr>
<td>Margaret Miller (until 30 June 2013)</td>
<td>1/1</td>
</tr>
<tr>
<td>Stephen Moss</td>
<td>2/4</td>
</tr>
<tr>
<td>Sue Neilson (until 30 June 2013)</td>
<td>0/1</td>
</tr>
<tr>
<td>Irving Normie (from 1 July 2013)</td>
<td>3/3</td>
</tr>
<tr>
<td>William Utley</td>
<td>4/4</td>
</tr>
<tr>
<td>John Reddy</td>
<td>4/4</td>
</tr>
<tr>
<td>Derek Rowley (from 1 July 2013)</td>
<td>3/3</td>
</tr>
<tr>
<td>John Starkey</td>
<td>4/4</td>
</tr>
<tr>
<td>Anthony Stokes (until 30 June 2013)</td>
<td>0/1</td>
</tr>
<tr>
<td>Margaret Stoneman (from 1 July 2013)</td>
<td>2/3</td>
</tr>
<tr>
<td>Lydia White (from 1 July 2013)</td>
<td>1/3</td>
</tr>
<tr>
<td>Beryl Whiteley</td>
<td>3/4</td>
</tr>
</tbody>
</table>

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

As required by Section 156(1) of the Health and Social Care Act 2012, Governor expenses claimed can be found in the Remuneration Report on page 136.
also undertake additional duties such as chairing the closed governors’ meetings that are held in advance of each full Council of Governors meeting, and meeting regularly with the Chairman and Deputy Chairman/Senior Independent Director on behalf of the governors.

During the period 1 October 2012 to September 2013 the nominated Lead and Deputy Lead Governor posts were held by Mr John Starkey (Public Governor, Oldham) and Mrs Mary Foden (Public Governor, Stockport) respectively.

In September 2013 the existing Lead and Deputy Lead Governor expressed an interest in standing for election into their respective roles for a further 12 months. The proposal for reappointment was approved by the full Council of Governors and at the full meeting on the 17 September 2013 they ratified the appointment of Mr Starkey and Mrs Foden for a further 12 months from 1 October 2013.

Appointment and Remuneration Committee

In line with their statutory duties under the NHS Act 2006, the Council of Governors’ Appointment and Remuneration Committee was established as a formal sub-group of the Council of Governors in August 2008 to advise and/or make recommendations to the Council of Governors in all matters relating to the appointment (and reappointment) of the Chairman and Non-Executive Directors; their remuneration, allowances and other terms and conditions of office; and the structure, size and composition of the Board.

Throughout the course of the year we have continued to run regular development sessions for all our governors on a wide range of subjects, including:

- Annual Report and Annual Accounts
- Research and development
- Anti-stigma campaign – ‘Don’t Bottle It Up’
- Audit Committee Annual Report
- Mental Health Matters and Physical Health Matters
- Your statutory duties: A reference guide for NHS Foundation Trust governors
- Liverpool Care Pathway
- Francis Report
- Assessing the Collective Performance of the Council of Governors
- Quality Accounts
- Social media
- Service Development Strategy
- Joint Board and Governor Development Sessions

Nominated Lead Governor

The process for nominating a Lead Governor was established in September 2011, following a consultation exercise involving all elected and appointed governors. As a result, it was agreed to run an election to select a Lead and Deputy Lead Governor who would have a specific role to play in liaising with Monitor in ‘specific circumstances’. The consultation also determined that the role of Lead Governor should be restricted to elected public governors and time-limited to 12 months, after which time the positions would be opened up to a further election process. It was also determined that those governors who had previously held the position of Lead or Deputy Lead Governor should be eligible to stand for re-election to these roles if they so wished. Although not formally required as part of this role, it was agreed that the Lead and Deputy Lead would

The new cohort of Governors elected from 1 July 2013 were officially introduced to the Trust at a welcome session, where they met the Board of Directors and their fellow governors and were given an overview of how their induction to the Trust would be facilitated over the coming weeks.

Two induction workshops were held for the new governors during their first months with the organisation, to which invitations were also extended to any existing governors wishing to refresh their understanding of the Trust, the range of services provided and the role of the governor in Pennine Care.
The Appointments and Remuneration Committee met five times during the period 1 April 2013 to 31 March 2014 and the table below shows the attendance of the individual governors:

<table>
<thead>
<tr>
<th>Public governors</th>
<th>Attendance (actual/eligible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raquia Almas (from 1 July 2013 to 20 November 2013)</td>
<td>0/2</td>
</tr>
<tr>
<td>Michael Armstrong (from 1 July 2013)</td>
<td>3/3</td>
</tr>
<tr>
<td>Ed Barber (from 1 July 2013)</td>
<td>0/3</td>
</tr>
<tr>
<td>Pauline Barnett</td>
<td>1/5</td>
</tr>
<tr>
<td>Brian Beedham (until 30 June 2013)</td>
<td>2/2</td>
</tr>
<tr>
<td>Norma Bewley</td>
<td>2/5</td>
</tr>
<tr>
<td>Jan Caldwell</td>
<td>4/5</td>
</tr>
<tr>
<td>Paul Carter (from 1 July 2013)</td>
<td>0/3</td>
</tr>
<tr>
<td>Ryan Cowan (from 1 July 2013)</td>
<td>0/3</td>
</tr>
<tr>
<td>Mary Foden</td>
<td>3/5</td>
</tr>
<tr>
<td>Joe Furness (from 1 July 2013)</td>
<td>0/3</td>
</tr>
<tr>
<td>Dr Michael Johnson (from 1 July 2013)</td>
<td>1/3</td>
</tr>
<tr>
<td>Patricia Knight</td>
<td>2/5</td>
</tr>
<tr>
<td>Dr Satinder Lal</td>
<td>4/5</td>
</tr>
<tr>
<td>Geoff Lucas</td>
<td>4/5</td>
</tr>
<tr>
<td>Linda McGrath</td>
<td>5/5</td>
</tr>
<tr>
<td>Susan McKenzie (until 30 June 2013)</td>
<td>1/2</td>
</tr>
<tr>
<td>Ray McLean (until 30 June 2013)</td>
<td>0/2</td>
</tr>
<tr>
<td>Margaret Miller (until 30 June 2013)</td>
<td>1/2</td>
</tr>
<tr>
<td>Stephen Moss</td>
<td>1/5</td>
</tr>
<tr>
<td>Sue Neilson (until 30 June 2013)</td>
<td>0/2</td>
</tr>
<tr>
<td>Irving Normie (from 1 July 2013)</td>
<td>1/3</td>
</tr>
<tr>
<td>William Uttley</td>
<td>4/5</td>
</tr>
<tr>
<td>John Reddy</td>
<td>1/5</td>
</tr>
<tr>
<td>Derek Rowley (from 1 July 2013)</td>
<td>0/3</td>
</tr>
<tr>
<td>John Starkey</td>
<td>5/5</td>
</tr>
<tr>
<td>Anthony Stokes (until 30 June 2013)</td>
<td>1/2</td>
</tr>
<tr>
<td>Margaret Stoneman (from 1 July 2013)</td>
<td>1/3</td>
</tr>
<tr>
<td>Lydia White (from 1 July 2013)</td>
<td>0/3</td>
</tr>
<tr>
<td>Beryl Whiteley</td>
<td>3/5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff governors</th>
<th>Attendance (actual/eligible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steven Butterworth</td>
<td>0/5</td>
</tr>
<tr>
<td>Richard Cliff</td>
<td>2/5</td>
</tr>
<tr>
<td>Gill Dascombe (from 1 July 2013)</td>
<td>0/3</td>
</tr>
<tr>
<td>Dawn Hobson</td>
<td>1/5</td>
</tr>
<tr>
<td>Dr Bernadette Larkin (until 30 June 2013)</td>
<td>0/2</td>
</tr>
<tr>
<td>Claire Maguire (until 30 June 2013)</td>
<td>0/2</td>
</tr>
<tr>
<td>Elizabeth McCoy</td>
<td>0/5</td>
</tr>
<tr>
<td>Joanne McLeod</td>
<td>0/5</td>
</tr>
<tr>
<td>Dr Sivasubramoniam Meiarasu (from 1 July 2013)</td>
<td>2/3</td>
</tr>
<tr>
<td>Lynzi Shepherd</td>
<td>1/5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appointed governors</th>
<th>Attendance (actual/eligible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Cllr. Karen Barclay (until 17 December 2013)</td>
<td>0/4</td>
</tr>
<tr>
<td>Cllr. Jane Black</td>
<td>0/5</td>
</tr>
<tr>
<td>Cllr. Susan Dearden</td>
<td>0/5</td>
</tr>
<tr>
<td>Graham Foulkes</td>
<td>0/5</td>
</tr>
<tr>
<td>Cllr. Kevin Hogg (from 27 June 2013)</td>
<td>0/3</td>
</tr>
<tr>
<td>Karen Hurley (from 5 March 2014)</td>
<td>0/0</td>
</tr>
<tr>
<td>Cllr. Peter Johnson (from 10 May 2013)</td>
<td>0/4</td>
</tr>
<tr>
<td>Cllr. Jackie Lane</td>
<td>0/5</td>
</tr>
<tr>
<td>Cllr. Patrick McAuley (until 26 June 2013)</td>
<td>0/2</td>
</tr>
<tr>
<td>Claire Postlethwaite</td>
<td>0/5</td>
</tr>
<tr>
<td>Tim Ryley</td>
<td>0/5</td>
</tr>
<tr>
<td>Cllr. George Wharmby (until 4 July 2013)</td>
<td>0/2</td>
</tr>
<tr>
<td>Cllr. Ellie Wilcox (from 5 July 2013)</td>
<td>0/3</td>
</tr>
</tbody>
</table>
Working between the Governors and the Board

The Trust encourages close working between governors and the Board of Directors to ensure that each develops a clear understanding of their mutual roles and responsibilities and to facilitate clear lines of communicating the views of members to the Board and vice versa.

Members of the Board of Directors are invited to attend each meeting of the Council of Governors. Additionally, to allow the governors the opportunity to gain an understanding of and assurance on how the Board of Directors works collectively, nominated governors attend monthly meetings of the Board of Directors and each meeting of the Audit Committee and provide feedback to their fellow governors on their observations.

The Council of Governors has a number of sub-committees that mirror those of the Board of Directors. The Strategy and Development Committee was established in April 2013 and its function is to keep governors informed of issues of service delivery and the Trust’s strategic plans. The Performance and Assurance Committee was established from May 2013 and provides the governors with assurance that the Trust is meeting appropriate standards of healthcare. Standing invitations to the full meetings of the Council of governors and the sub-committees are extended to the Board Directors, where they are able to answer questions from the governors on the performance of the Trust’s functions or the performance of their respective duties.
ANNUAL
GOVERNANCE
STATEMENT

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

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise risks relating to the achievement of the Trust’s policies, aims and objectives, to evaluate the likelihood and impact of those risks being realised and, to manage them efficiently, effectively and economically. The system of internal control has been in place within Pennine Care for the year ended 31 March 2014 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk
The Trust has a Risk Management Strategy which clearly outlines the risk management process that is endorsed by the Board. The Trust has also an Integrated Business Plan which details risk issues in meeting short, medium and long-term business plans. The Integrated Business Planning Group monitors ongoing risks and takes appropriate steps to mitigate risks and lessen their impact.

Training and education are key elements of the Trust’s risk management development process. It provides staff with the necessary knowledge and skills to work safely and to minimise risks at all levels. The Trust provides training in all areas to staff and other agencies working with services to ensure the maintenance and continuous development of a risk management culture.

The purpose of the Trust’s Risk Management Strategy is to detail the Trust’s framework for setting objectives, providing assurance and managing risk, which enables:

• The Trust to maintain a risk register that details those risks that could prevent the achievement of Trust strategic and directorate objectives stated within the Corporate Plan.
• Risks to be reported to the risk department and entered onto the risk register.
• The risk register to be reported through to the Trust Board via the Integrated Governance Group. This identifies all significant current and future risks judged significant enough to warrant Board-level attention. Risks are also monitored via Divisional Integrated Governance Groups to ensure that all risks are managed and mitigated where possible. The Trust has identified a number of current and future risks, including service re-design, managing the challenging financial circumstances of the wider NHS and maintaining and enhancing relationships with commissioners. Plans are in place to mitigate these risks, which are monitored at Board level.

The Trust takes both proactive and reactive approaches to the identification and management of principal risks that may threaten the achievement of strategic and directorate objectives. This involves the following processes:

• Risk identification (principal risk)
• Risk identification (corporate risk)
• Evaluate the nature and extent of identified principal risks
• Confirming existing controls
• Assessing the level of risk
• Assessing residual risk
• Acceptable risk
• Unacceptable risk
• Significant risk
• Implementing an action plan
• Populating the risk register

The Trust risk register is reported monthly to the Integrated Governance Group. This identifies all current and future risks judged significant enough to warrant Board-level attention. Risks are also monitored via Divisional Integrated Governance Groups to ensure that all risks are managed and mitigated where possible. The Trust has identified a number of current and future risks, including service re-design, managing the challenging financial circumstances of the wider NHS and maintaining and enhancing relationships with commissioners. Plans are in place to mitigate these risks, which are monitored at Board level.

The table below indicates some of the identified risks, the outcomes of which are assessed at Divisional Integrated Governance Groups and escalated to the Board if appropriate.

<table>
<thead>
<tr>
<th>Principal Risks</th>
<th>Policies, Aims and Objectives</th>
<th>Performance Management</th>
<th>Quality Improvement</th>
<th>Patient Care</th>
<th>Staff Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk 1</td>
<td>Objective 1</td>
<td>Objective 2</td>
<td>Objective 3</td>
<td>Objective 4</td>
<td>Objective 5</td>
</tr>
</tbody>
</table>

“System of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives.”
Management of risk is embedded in the organisation by the development of systems and processes at all levels. However, the Integrated Governance Group is responsible for monitoring risks overall and ensuring that all significant risks are reported to the Board on a quarterly basis. The group co-ordinates the management of reported risks and supervises the operation of the risk register and the processes that support it.

The Integrated Governance Group receives a monthly Integrated Governance Report, which includes a high level risk register relating to:

- Clinical
- Non-clinical
- Finance
- Estates
- Complaints
- Serious and untoward incidents
- Root Cause Analysis Investigations
- Infection prevention/control
- Homicides
- Litigation
- Adult safeguarding
- Child safeguarding

### Board Assurance Framework

The Board Assurance Framework (BAF) provides the Board of Directors with a system of monitoring risks to the achievement of the organisation’s strategic objectives, which includes a link to any ‘significant’ (red RAG-rated) risks from the Trust’s Risk Register.

Additionally it provides a structure for evidencing the key controls and forms of assurance that risks are being managed, along with any gaps in controls or assurances and actions to address these.

The full BAF is reviewed by the Board of Directors on a quarterly basis, and from November 2013, the Board has received a monthly summary report outlining any changes made in the interim.

The BAF is subject to annual review by the Trust’s internal auditors, who provided a rating of ‘substantial assurance’ for 2013/14, confirming it was fully aligned to the Trust’s objectives and no significant gaps in control were noted.

### Information Governance

Responsibility for information governance in the Trust rests with the Medical Director who acts as the Caldicott Guardian and the Director of Planning Performance and Information who acts as the Trust’s Senior Information Risk Owner (SIRO).

The Trust’s information governance status is regularly reviewed by the Caldicott Guardian and SIRO and any exceptions reported to the appropriate committee.

The Trust has self-assessed against the Information Governance Toolkit which assesses performance with DH information governance policies and standards and scored 72% overall. The annual submission is reviewed by Internal Audit and there is a sound system of control. The Trust has achieved the target of overall compliance of Level 2 and above for the Information Governance Toolkit with some criteria achieving Level 3.

Information security incidents are managed as part of the Trust’s information governance processes and all information security incidents are reviewed by the information governance team. Incidents are investigated with lessons learnt shared throughout the organisation. The Trust has implemented the new national information governance incidents reporting requirements (June 2013) named as Serious Incidents Requiring Investigation (SIRI). 4 SIRI’s have been reported in total across 2013/14 Please see table overleaf.
The target setting process is linked closely to the work undertaken in creating the Trust’s Quality Strategy. This involved consultation with a wide variety of stakeholders including service users, carers, members (via the Council of Governors) clinicians and staff. The process also included the Trust’s Integrated Governance Group, who were consulted and heavily involved throughout.

Quality priorities were selected to reflect the wishes of leading operational staff, clinicians, and the Council of Governors, together with national priorities identified by Monitor and local and regional CQUIN priorities. Priorities cover the three domains of quality, being patient experience, patient safety, and clinical quality.

The Trust is confident that the involvement of stakeholders in the creation of the Quality Account means that the account is an accurate reflection of priorities.

Data used in the Quality Account has come from reliable and robust sources; subject to regular audit and the data quality policies of the Trust. Where available, the Trust has included external benchmarks to drive quality improvement. The Board has been presented with updates on work to improve data quality in the past and receives regular reports on the data metrics used in the Quality Account throughout the year.

As part of the assurance process, final drafts of the Quality Account have been shared with our commissioners, local Healthwatch organisations and Health and Wellbeing Boards and the local overview and scrutiny panels. They have been invited to submit their comments on the Quality Account and, where submitted, these are included at the end of the Quality Account itself.

The Annual Quality Account is structured according to detailed guidance set down by Monitor. It includes an update on performance against priorities reported on in 2012/13, a review of performance in 2013/14 and targets for 2014/15.

The Trust is confident that the involvement of stakeholders in the creation of the Quality Account means that the account is an accurate reflection of priorities.

The effectiveness of the system of internal control has been maintained and reviewed according to a well understood process involving the Board, Audit Committee and others. The involvement of the Board of Directors has included individual Executive and Non-Executive Directors who approve, review and monitor the Assurance Framework, risk register, and Key Performance Indicators and receive reports from sub-committees of the Board.

The Audit Committee reviews risks and gains assurance on controls from external and internal audit and approves the annual audit programme. If identified, significant internal control gaps would be managed, mitigated and improved using these processes.

Conclusion

No significant internal control issues have been identified.

Michael McCourt
Chief Executive
28 May 2014
Whilst financial pressures persist, providing quality care must and will remain our priority.

Part 1: Statement on Quality from the Chief Executive of the NHS Foundation Trust

As the recently appointed Chief Executive of the Trust it gives me great pleasure to introduce you to this year’s Quality Account.

This has been another exciting and productive year for the Trust, our members and partners, we have continued to develop services in response to the changing face of the health care system and have seen the organisation continuing to grow, welcoming Community Services from Trafford.

As a Trust, like other NHS organisations across the country, we have had to respond to a number of ongoing financial and other challenges, and in response to these challenges we have demonstrated a resolve and flexibility as to how we provide services. We have shown our commitment in providing quality care, with a focus on positive patient experience. This year, and in the years to come, providing quality care across all our Community and Mental Health Services will always remain central to our aims and goals as an organisation.

Our Quality Account for 2013/14 details quality improvement projects initiated in, and implemented throughout, the year across our Mental Health and Community Services and also sets out some of our key priorities for quality improvement as we move into 2014/15. The priorities for quality improvement have been chosen from the core areas of safety, clinical effectiveness and patient experience, reflecting emergent themes arising from consultation with clinical and operational staff, service users, carers, the Foundation Trust membership and the Council of Governors.

In addition to the quality initiatives detailed within the Quality Account we have initiated numerous additional service improvement projects throughout the year. We have worked closely with service users and carers to improve patient experience as part of the ‘Triangle of Care’ project. We are improving clinical effectiveness by introducing an improved...
integrated health record system ‘PARIS’. Under the direction of the Director of Nursing and Allied Health Professionals we have worked closely with all our staff to consider and act upon recommendations resulting from the Francis report to improve patient safety.

I and all our staff are committed to ensure that Quality will always be at the centre of the care we provide, and in partnership with our service users, carers, Commissioners and local communities, we will make sure that this continues to drive all service improvements.

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

Michael McCourt
Chief Executive
28 May 2014

Part 2:
Priorities for Improvement and Statements of Assurance from the Board relating to the Quality of Services Provided

Performance in 2013/14 against Quality Indicators identified in the 2012/13 Quality Report

The Trust identified the following quality priorities in 2012/13 which were detailed in last year’s Quality Report.

Priority 1: Rapid Assessment Interface Discharge (RAID, Year 2) Alcohol – Patient Safety

Priority 2: Telehealth – Patient Experience

Priority 3: Physical Health, Community Mental Health – Clinical Effectiveness

The Trust’s performance against each of these indicators in 2013/14 is indicated below.

Further details of our performance in each of these indicators, and a selection of others, is available in Part three of this report.

The priorities as listed above were chosen to represent quality indicators across both Mental Health and Community Services.

Priority 1 above (RAID, year 2 Alcohol – Patient Safety) builds upon the RAID priority and priority 2, Telehealth (patient experience) builds on work commenced as part of the Hospital in the Community initiative, both of which were outlined in last year’s Quality Account. There is no comparative data to report as the priorities examine different aspects of the original projects. Priority 3 was set as a new priority last year and as such no comparison data is available.

We are also pleased that our Council of Governors were again able to choose a performance indicator to be audited by our external auditor. The Council of Governors have chosen ‘patient experience – community mental health indicator score with regard to a patient’s experience of contact with a health or social care worker’ and as a result our processes relating to this indicator will be audited.

The Trust is confident that a high level of quality assurance in our 2013/14 priorities can be achieved through internal governance structures and processes, external auditor scrutiny and joint working with our community and mental health Commissioners.

Performance in 2013/14
Priority 1: RAID (Year 2) Alcohol – Patient Safety

The overarching aim of this priority is to reduce the attendances to hospital Accident and Emergency (A&E) departments and hospital admissions where alcohol is a key factor, in addition, to develop systems and processes to ensure patients are engaged in appropriate mainstream alcohol services i.e. NHS or 3rd sector.

In order to deliver on this indicator, a dedicated alcohol liaison function consisting of qualified and unqualified alcohol practitioners has been developed as part of the RAID project. These practitioners have worked with a small cohort of people who are high users of unscheduled hospital care, primarily as a result of alcohol dependency, in order to reduce high rates of alcohol-related hospital attendances and admissions.

This has been achieved through targeted support for identified frequent attenders including;

- Increasing the successful engagement of alcohol dependent patients who place most demand on urgent care resources into community-based treatment and recovery
- Improving engagement of this group of patients with community-based, assertive outreach, treatment and support approaches
- Increasing confidence of clinicians to discharge from hospital
- Providing intensive support to clients, to improve chances of successful treatment and recovery in the community.
Across our four boroughs with A&E departments, the team has undertaken assertive community outreach work with people who are recognised as ‘frequent flyers’ to the A&E department and people who have had a number of acute hospital admissions as a consequence of their alcohol dependency.

The quality outcomes are demonstrable through this case study:

**Sam**

(N.B this case study uses name changes to ensure confidentiality)

*Sam* is a 40-year-old single man, living in supported accommodation for people with mental health problems. He experiences auditory and visual hallucinations and has developed anxiety as a result; this increases if he needs to go out on his own in busy public places.

Sam reported that both his mother and grandfather had problems with alcohol. His grandfather’s death was directly attributable to alcohol misuse and Sam was always exposed to alcohol from a young age. As a child he also suffered incidents of abuse from a relative which he believes have impacted on his mental health and memories of this are a trigger for his drinking.

Sam was referred to the RAID Alcohol team in October 2012 via the RAID A&E team.

Sam had called an ambulance after self-harming whilst intoxicated. At that time Sam reported that he had no knowledge of taking himself to hospital, let alone any memory of the incident in question, until he woke up in a hospital bed the morning after. He then discharged himself.

The RAID practitioner worked intensively with Sam over a number of weeks and jointly they discussed various methods for reducing alcohol consumption, addressing his mental health issues and discussed methods for filling his day and occupying his time more productively. With support from the RAID practitioner, Sam started to access social activities and started to consider options around employment.

As Sam was fully occupied, alcohol consumption reduced to a minimum, only consuming the occasional drink at weekends. Hospital presentations also stopped and Sam did not make any presentations to A&E for the 3 months he was with the RAID team.

Since working with the team, Sam has accessed counselling for the abuse he experienced as a child. Prior to this, Sam had never felt ready to talk about it.

Sam now has a peer mentor to support his on-going recovery and he has now been discharged from the RAID service.

Since December 2011 Sam reported that he had presented to A&E with alcohol related issues approximately 182 times. This was later confirmed by hospital staff.

From hospital records it was reported that Sam was attending A&E sometimes twice daily. Sam’s Care Coordinator was not always aware of his A&E presentations, however this communication improved as a consequence of consistent mental health practitioners being present in A&E through the RAID A&E team. Presentations would be similar in nature characterised by intoxication and overdoses. Sam would always be admitted to the Medical Assessment Unit (MAU) overnight but when he had sobered-up would discharge himself.

Sam initially made light of the constant presentations and did not appear to consider his actions risky. When discussing risks to himself, Sam always denied intending to harm himself and would say that he never had any recollection of any of the incidents.

The quality outcomes are demonstrable through this case study:

**Priority 2: Telehealth – Patient Experience**

A key priority for 2013/14 was to increase the use of Telehealth within Pennine Care NHS Foundation Trust, in order to improve the quality of care provided to patients, their clinical outcomes, and their experience. This was enabled primarily through the Hospital in the Community (HiC) project, whereby introduction of new technology (to remotely monitor vital signs) was introduced for patients with long-term conditions, and a robust evaluation framework to demonstrate the benefits was set up. Different models of implementation were progressed, for example, in Bury patients with Heart Failure benefited, in Oldham patients with Chronic Obstructive Pulmonary Disease were selected, and in Heywood, Middleton and Rochdale (HMR) patients under the care of the integrated nursing service were able to access Telehealth.

Throughout the year, clinical teams have become much more confident in the selection of appropriate patients who could benefit from Telehealth, and the evaluation demonstrates benefits across a range of factors, in all the three boroughs measured (Bury, Oldham, and HMR). Two workshops have taken place enabling the clinical teams to share their experiences and good practice. The evaluation document is now being used by the Service Directors within each borough, as an evidence base to discuss further spread of the existing Telehealth technology, in addition to exploring other technologies that could support self-management and improved outcomes and experience.

**Quality outcomes evidence by the evaluation**

Overall there has been positive reporting, of patient satisfaction with the technology itself, confidence in their ability to manage their own condition effectively, and reports of increased knowledge and patient reassurance, as exemplified by the feedback below:-

- ‘It helps monitor my condition. Feel more confident, less anxious about condition. Able to carry on with normal life’
- ‘Loved to read my observations, gives me confidence’

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total during 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of referrals made to RAID team</td>
<td>347</td>
<td>333</td>
<td>281</td>
<td>238</td>
<td>1,199</td>
</tr>
<tr>
<td>Number of referrals who were signposted or referred into other services</td>
<td>113</td>
<td>107</td>
<td>71</td>
<td>56</td>
<td>347</td>
</tr>
</tbody>
</table>

**Cost savings (patient level example)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Presentations to A&amp;E</th>
<th>Cost saving (excluding overnight admissions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2012 to October 2012</td>
<td>182 presentations</td>
<td>£16,380</td>
</tr>
<tr>
<td>October 2012 to September 2013</td>
<td>36 presentations</td>
<td>£3,240</td>
</tr>
<tr>
<td><strong>Total cost saving</strong></td>
<td><strong>£19,620</strong></td>
<td></td>
</tr>
</tbody>
</table>
‘Gives me a sense that because I am on my own someone was monitoring my health’

‘More of a view of how my oxygen levels are and therefore reassures me’

‘Provided reassurance, helped me to manage my condition’

(Feedback received via patient survey returns)

Carers reported feeling very strongly about the benefits of Telehealth with many or all reporting satisfaction in relation to peace of mind, assisting condition management and helping both patient and clinician to understand changes in the patient’s condition.

GP practices were also very positive regarding the benefits of Telehealth with 91% (out of a total of 46 GPs) reporting they felt the technology had enabled early detection and intervention in exacerbations in the patient’s condition. The majority of GPs also reported that Telehealth offered peace of mind for the patients and encouraged better self-management of their condition.

Since implementation, the project has benefitted patients by achieving a 34% (215 to 142) reduction in hospital admissions, a 20% (883 to 710 days) reduction in lengths of stay, and 21% (157 to 124) less A&E attendances. Associated with this deflection from secondary care, to date the project has evidenced savings of £136,393 (£440,366 to £303,973) against hospital admissions and £3,301 (£17,560 to £14,259) in A&E attendances (reductions of 31% and 19% respectively). As the evaluation data only considers nine months of clinical data and there is less data for some patients, the estimated figure for the full year should be approximately £180,000 cost savings, in addition to improved, patient experience and outcomes.

Additionally, it is important to realise that Long Term Condition (LTC) patients experience natural disease progression and deteriorating health. Therefore, the frequency of admissions increases by 20% and the frequency of A&E attendances increases by 15%. Thus, in addition the project improves patient experience and outcome, whilst remaining financially viable.

Priority 3: Physical Health, Community Mental Health – Clinical Effectiveness

The following work has been undertaken to deliver this objective:

Information sharing with patients

Pennine Care in collaboration with a local user and carer group developed a standardised letter for service users explaining the importance of good physical health, the link between physical and mental health and also encouraging attendance at their GP practice for an annual physical health check. Care coordinators have the responsibility to distribute this letter to all service users at an appointment or review to facilitate further discussion, address issues and any anxieties and to offer support to the service user to attend the physical health check appointment at the GP surgery.

What we will do next

A physical health leaflet has been developed and will be distributed, this leaflet provides detailed information on what to expect at the annual physical health check and why it is beneficial to attend. The leaflet will be made available to all secondary care community based mental health services, including Early Intervention and Review and Recovery.

Medication monitoring

Pennine Care has developed and implemented a medication specific monitoring tool to be implemented for all service users who are on newly prescribed or changed antipsychotic medication. The medication monitoring tool will be accompanied with medication specific information sheets available from the Choice and Medication website.

A review of the implementation of the medication care plan was undertaken, however identifying the cohort of patients who had either commenced or changed antipsychotic medication during the audit sample period was problematic. The patient cohort was unobtainable via electronic systems and a number of methods were explored to identify the cohort including working with pharmacy colleagues.

What we will do next:

We will carry out a sample audit across our community mental health teams to evidence:

• Medication management care planning
• Provision of a Physical Health letter

This will be feedback to our Commissioners as part of the CQUIN and we will take forward any resultant improvement action plans as a result of this.

We have taken into account staff feedback that medication and medication side effect monitoring is already considered as part of a number of formal review processes’ (e.g. Care Programme Approach (CPA) review and wellbeing care plans). Staff felt that whilst information contained within the specific medication monitoring care plan is useful, adding an additional care plan can be confusing for both staff and patients (e.g. which care plan to follow). Therefore, it is proposed to formally integrate the medication and medication side effect aspects into the existing care plan structures and develop as supporting patient information.

Communication exchange with GPs

We have implemented a trial process for the exchange of information between Pennine Care and GPs to capture the patients who have a serious mental illness who have, or have not, accessed an annual physical health check, the community

cohort including working with pharmacy colleagues.

For those clients who are identified as not attending their GP for a physical health check, the community teams have a responsibility to encourage attendance.
and in exceptional cases undertake the physical health check using the agreed tool that has been developed and forward the results to the GP for further interpretation and action.

Pennine Care identified the patients in the cohort (patients with a diagnosis of schizophrenia or bi-polar affective disorder) under the care of community mental health teams (CMHT) and early intervention teams, through performance and information extracting data from the National Care Records System. This data was then cleansed by the community teams and electronically transferred to GP surgeries requesting them to identify those clients who had received an annual physical health check or were scheduled to receive one in the coming months.

This information was then distributed back to community mental health teams for care coordinators to actively work with patients who hadn’t attended the GP to support attendance at the GP practice or undertake the physical health check with the multi-disciplinary team (if appropriate). 193 GP surgeries across the Trust footprint were contacted referencing 2631 patients within the identified cohort. 358 patients were included in the responses from GPs identifying that 211 patients had or were scheduled to receive an annual physical health check or were scheduled to receive one in the coming months.

What next
As per the CQUIN requirements of the remaining patients within the cohort we have directly communicated with CMHT team managers who tasked the care coordinators with supporting and encouraging patients to attend their GP for an annual physical health check. We will continue to progress this workstream throughout 2014/15 with refreshed data and where non-attendance is identified care coordinators will offer for the subsequent year.

Our priorities for Quality Improvement for 2014/15

The Trust has undertaken wide ranging consultation to determine its quality priorities for the year, which have been discussed and put forward by the Trust’s Quality Group with Board agreement.

Consultation on our priorities has included discussions with the Board, clinicians, operational managers, Council of Governors, service users and carers, and our wider staff from both the Mental Health and Community Services. In addition to the above, the views of the wider public have been considered through a number of consultation and engagement events where an overview of the Quality Account has been presented including; the Trust’s AGM; Patient Advice Liaison Service (PALS) service user and carer consultation event and in liaison with Commissioners via CQUIN and our joint quality groups. The three priorities as set out below cover both mental health and community services and have been set out to align with agreed CQUIN indicators and Trust Quality Priorities. As per previous years, the quality priorities have been chosen to reflect areas addressing patient safety, clinical effectiveness and patient experience.

Priority 1: Quality Thermometer – Patient Safety

This year we have focused on three quality priorities for the coming year, in addition to those priorities, the Trust has set an ambitious programme of quality improvement which is set out in the Trust’s Quality Strategy and will be monitored through the Trust’s Quality Group.

Priority 2: Self Management – Patient Experience

This year we have focused on three quality priorities for the coming year, in addition to those priorities, the Trust has set an ambitious programme of quality improvement which is set out in the Trust’s Quality Strategy and will be monitored through the Trust’s Quality Group.

Priority 3: Skills Mix – Clinical Effectiveness

This year we have focused on three quality priorities for the coming year, in addition to those priorities, the Trust has set an ambitious programme of quality improvement which is set out in the Trust’s Quality Strategy and will be monitored through the Trust’s Quality Group.

Priority 1: Quality Thermometer

Current performance and rationale for prioritising

The Trust has extensive service line reports across both mental health and community services, each of which contain multiple performance indicators under a range of headings (such as Human Resources (HR) and Finance) the reports whilst extremely comprehensive and detailed were not specifically designed to allow frontline clinicians to directly consider quality of care.

The Trust’s Quality Group commissioned a piece of work to develop a tool which would promote consideration, interpretation and appropriate action planning in relation to quality: patient safety, patient experience, clinical effectiveness.

The central component of the Quality Thermometer is to provide services with an at-a-glance view of quality for their service at a team level. The model is based on service leads having identified and agreed three indicators for each quality domain (Safe Care, Effective Care and Experience of Care), which are then used to generate an overall score for quality.

We have already drafted and implemented a Quality Thermometer across Adult Acute Mental Health inpatient wards. Following the successful reception of this, the aim is to extend this to cover all clinical services across the organisation during 2014/15.

How will we track improvement?

The Quality Thermometer will be included as part of Service Line Reporting processes enabling services to review Quality, Performance, Financial and HR information together. This will provide a balanced view of the overall quality and performance within the service.

The Quality Thermometer will give an overall score for quality of service for the team or ward. The score will be calculated based on performance against each indicator in each of the three quality domains and allow individual teams to track quality indicators.

Areas for improvement

Following the initial development of the thermometers, there will be a process of review, which will enable each service to provide feedback and outline any improvements to be made.

There is also a general project improvement plan, which identifies key developments to improve the overall tool and increase assurance. This list will be developed and updated continually alongside the project, but includes:

- Automation of the report via Performance and Information
- Weighting of indicators
- Review of targets
- Development of an overall service line thermometer

Actions planned to improve performance

The quality reporting framework will allow identification of areas of best practice, identify opportunities for service improvement and highlight any areas that may require urgent attention.

How will we report this priority?

This priority will report into, and progress will be monitored by both internal and external groups. Internally this priority will be reported into the Trust’s Quality group; externally the priority will provide updates in to the Trust Community and Mental Health Joint Commissioner Provider Quality Groups.

Priority 2: Self Management

Current performance and rationale for prioritising

As a Trust our vision is ‘to deliver the best possible care to patients, people and families in our local communities by working effectively with local partners, to help people to live well’. This quality priority outlines our approach in supporting this vision through developing self-management options. There are a number of important considerations in the planning and delivery of care with our patients that reinforce the importance of developing a self-management ethos, these include:

- Around 15 million people in England have one or more long-term conditions. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years
• People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days
• Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budget in England
• Around 70-80 per cent of people with long-term conditions can be supported to manage their own condition

Source – Department of Health Statistics

Self-management has been identified as a key organisational priority and enables which contributes to achievement of the ambitions set out in the Trust Service Development Strategy.

A report will be submitted to the Service Transformation Group in April 2014, namely “Self-Management using an Organisational Development (OD) Approach”, which will:
• Define what is meant by self-management
• Summarise the outcomes from mapping of self-management activity and highlighting themes
• Review of progress on the pilot underway within the Oldham cluster
• Provide feedback from the recent Service User and Carer conference where self-management was the main focus
• Propose a framework for the coordination and development of a programme to support the Divisional Business Units with the delivery of this agenda

How will we track improvement?

Acceptance of the recommendations contained within the paper by the Service Transformation Group in April will result in a number of activities which will be tracked through the Group.

Areas for improvement

A wealth of work has been undertaken to support the development of a self-management culture, although at present these comprise a number of separate activities rather than an agreed strategic approach. Greater benefits will come from viewing self-management as a major cultural change and adopting a planned approach from this basis. The approach being proposed is detailed within the “Self-Management using an OD Approach” report, which will be proposed to the Service Transformation Group to agree and oversee.

Actions planned to improve performance

• Self-management vision workshop be facilitated for Executive Directors and Service Directors
• A project approach for self-management to be agreed with Service Directors to ensure the enabling work with teams and services is in place prior to the Living Well Academy roll out
• The Service Transformation Group to maintain an overview of this agenda
• Service Directors agree with their local Clinical Commissioning Groups (CCGs) the plans for joint working on self-management, and commission support from OD as required
• A patient experience strategy and delivery plan will be developed with a named organisational executive sponsor and operational lead to ensure this important agenda can deliver to its optimum potential

How will we report this priority?

Reporting mechanisms for this work stream will be identified and agreed by the Service Transformation Group and will be delivered and reported throughout the year.

Priority 3: Ward skill mix review

Current performance and rationale for prioritising

National concern regarding staffing levels and the skills of staff were highlighted through the series of enquiries concerning the failings of care at Mid-Staffordshire Hospital. In October 2013 the Government published its response, which included a number of requirements for the future monitoring and measurement of staffing levels in all care settings.

Simply determining the number of nurses, midwives or care staff required is only one part of the equation. The skill mix of the workforce should reflect patient care needs and local requirements, considering the experience and capabilities of the workforce employed.

There has been much debate as to whether there should be defined staffing ratios in the NHS, but the current view is that there is no single ratio or formula that can calculate the answers to such complex questions. The right answer will differ across and within organisations, and reaching it will require the use of evidence and evidence based tools.

There are a number of key requirements for all Trusts regarding the reporting and monitoring of staffing levels which will be included in the 2014/15 National Standard Contract.

The evidence base in relation to workforce planning and safe and effective staffing within mental health, learning disability and community settings is less established than that for acute care settings. The composition of the multi-professional team in mental health settings, for example the presence of occupational therapists and psychologists, will have a direct impact upon nurse staffing requirements. This forms the basis for current and future work nationally.

All Pennine Care wards are engaged in a Trust-wide ward skill mix review project, the initial phase is to gather baseline information required to inform the development of local action plans and a proposal to Trust Board regarding continuous improvement.

How will we track improvement?

The project has been commissioned and will be overseen by the Director of Nursing and Allied Health Professionals and improvements will be tracked by delivering actions identified in the agreed Trust-wide action plan. Each area will then be accountable to their Divisional Business Unit with regards to agreeing and tracking improvements against their local action plan in their service areas.

The Trust board will be kept abreast of delivery of the project through regular updates and ad hoc board development sessions.
Areas for improvement

The project is focusing on improving the skill mix on the Pennine Care inpatient wards. This improvement will be grounded on intelligence and evidence of the required skill mix based on average patient dependency profiles and experienced multi-disciplinary professional judgement.

The average dependency of patients will be mapped over a period of time and calculated using evidence based tools.

Each service area will undertake an exercise to develop the staffing mix for their ward based on experienced multi-disciplinary professional judgement supported by sound rationale.

Each service area will also review the staffing mix required to support the delivery of all clinical and non-clinical tasks identified through a patient journey.

The current staffing establishment and budget on each ward will be reviewed taking into consideration a number of factors:

- The type of inpatient ward e.g. Acute/Rehabilitation, single rooms
- Dependency of patients
- National changes to human resource law (e.g. maternity and paternity leave)
- Trust expected sickness levels
- Mandatory and additional (Care Quality Commission (CQC) required) training

Actions planned to improve performance

The project group will continue to gather the baseline information and local intelligence. All baseline information will be collated and analysed by the project team using the evidence based tools to produce a proposal for consideration by the Trust Board with regards to local level actions to improve the skill mix in each ward area (services will be grouped e.g. all adult acute inpatient wards).

The Board proposal will focus on areas such as:

- Developing the skill mix through robust training and education
- Identification of areas where there is a definite need to change the existing staffing model to facilitate the improved skill mix
- Ability of wards to develop the required skill mix within existing staffing establishment and budgets

Opportunities will be provided for staff to attend relevant courses and seminars related to the project to improve their skills and knowledge.

As of the 1st April 2014 all ward areas will clearly display the expected and actual ward staffing numbers for each shift on a display board outside of the ward area. Where there is a discrepancy between the actual and expected staffing numbers there will be a section to provide further information regarding actions being taken to address the shortfall.

How will we report this priority?

The priority will be reported on a quarterly basis to Trust board and also to Commissioners on a quarterly basis to support the achievement of the additional quality incentive for 2014/15.

Each service area will be required to report progress locally via their Divisional Business Unit in the spirit of devolved autonomy.

Statements of assurance from the Board

During 2013/14 the Pennine Care NHS Foundation Trust provided and/or sub-contracted one relevant health service.

The Pennine Care NHS Foundation Trust has reviewed all the data available to them on the quality of care in one of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100% of the total income generated from the provision of relevant health services by the Pennine Care NHS Foundation Trust for 2013/14.

The data is reviewed through Board’s monthly review of the Integrated Governance Report. The data reviewed covers the three dimensions of quality: patient safety, clinical effectiveness and patient experience.

Information on participation in clinical audits and national confidential enquiries

During 2013/14 six national clinical audits and one national confidential enquiries covered relevant health services that Pennine Care NHS Foundation Trust provides.

During 2013/14, Pennine Care NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

<table>
<thead>
<tr>
<th>Area</th>
<th>Time of audit</th>
<th>Applicable to Pennine Care?</th>
<th>Participation from Pennine Care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological conditions</td>
<td>Prescribing in mental health services (POMH)</td>
<td>Yes</td>
<td>Yes, (in 4 out of 4 topics)</td>
</tr>
<tr>
<td></td>
<td>National Audit of Schizophrenia</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Audit of Memory Clinics</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>National Confidential Enquiry into Suicide and Homicide by people with mental illness</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust participated in during 2013/14 are as follows: (all as detailed in the table above).
The national clinical audits and national confidential enquiries that Pennine Care NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

<table>
<thead>
<tr>
<th>Title of audit</th>
<th>Percentage of cases submitted</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Audit of Schizophrenia</td>
<td>N/A</td>
<td>External report not yet completed</td>
</tr>
<tr>
<td>National Audit of Memory Clinics</td>
<td>100%</td>
<td>All of the Trust’s 5 Memory Clinics participated</td>
</tr>
<tr>
<td>POMH Topic 4b: Prescribing anti-dementia drugs</td>
<td>N/A</td>
<td>External report not yet completed</td>
</tr>
<tr>
<td>POMH Topic 14a: Prescribing for substance misuse: alcohol detoxification</td>
<td>N/A</td>
<td>External report not yet completed</td>
</tr>
<tr>
<td>POMH Topic 10c: Use of antipsychotic medication in CAMHS</td>
<td>N/A</td>
<td>External report not yet completed</td>
</tr>
<tr>
<td>National Confidential Enquiry into Homicide and Suicide</td>
<td>N/A</td>
<td>Ongoing participation</td>
</tr>
</tbody>
</table>

The reports of one national clinical audits were reviewed by the provider in 2013/14 and Pennine Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

### Audit name: POMH Topic 7d, Lithium Monitoring

<table>
<thead>
<tr>
<th>Action</th>
<th>Coordinator</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Psychiatrists and their teams to be reminded in writing by the Medical Director that it is a Trust requirement for recording baseline lithium and related monitoring to be included in Trust medical notes of patients prescribed lithium</td>
<td>Medical Director/Chief Pharmacist</td>
<td>June 2014</td>
</tr>
<tr>
<td>Community Mental Health Teams to be reminded in writing by the Director of Nursing/Medical Director that it is a Trust requirement for recording of ongoing lithium and related monitoring to be included in Trust medical notes of patients prescribed lithium</td>
<td>Medical Director/Director of Nursing/Chief Pharmacist</td>
<td>June 2014</td>
</tr>
<tr>
<td>Report (including conclusion, recommendations and action plan) to be placed on the agenda of the Quality Group for discussion</td>
<td>Medical Director/Chief Pharmacist</td>
<td>June 2014</td>
</tr>
</tbody>
</table>

The reports of 48 local clinical audits were reviewed by the provider in 2013/14 and Pennine Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (these represent a selection of key actions from 3 of the audits):

### Audit name: Community Services Quality Monitoring Records Audit

<table>
<thead>
<tr>
<th>Action</th>
<th>Coordinator</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where alterations have been made to a health record, the date and time of alteration, and name and designation of the person making the alteration should be recorded</td>
<td>Clinical Lead/Team Manager</td>
<td>September 2014</td>
</tr>
<tr>
<td>Past medical history should be recorded in all cases, or a statement made if no past medical history</td>
<td>Clinical Lead/Team Manager</td>
<td>September 2014</td>
</tr>
</tbody>
</table>

### Audit name: Audit of Safeguarding Children processes in Health Visiting and School Nursing (Community Services)

<table>
<thead>
<tr>
<th>Action</th>
<th>Coordinator</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure staff maintain documentary evidence of child safeguarding supervision plans with the health record</td>
<td>Named Nurses</td>
<td>November 2014</td>
</tr>
<tr>
<td>Explore reasons why Looked After Children (LAC) Review documentation is not evident in the health records and identify ways to improve</td>
<td>Named Nurses</td>
<td>November 2014</td>
</tr>
<tr>
<td>Explore reasons why child protection conference and review documentation is not evident in the health records and identify ways to improve</td>
<td>Named Nurses</td>
<td>November 2014</td>
</tr>
</tbody>
</table>

### Audit name: Physical Health Audit

<table>
<thead>
<tr>
<th>Action</th>
<th>Coordinator</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased monitoring of documentation being used by inpatient teams. Increase awareness amongst staff of how to access Trust Approved Documentation (TAD) to ensure up to date documentation is in use</td>
<td>Modern Matrons/Ward Managers</td>
<td>March 2014</td>
</tr>
<tr>
<td>Increased monitoring of the completion of height, weight and BMI recordings on Trust Approved Documentation</td>
<td>Modern Matrons/Ward Managers</td>
<td>March 2014</td>
</tr>
<tr>
<td>Following the launch of the TPR/MEWS chart, additional support in embedding the use of this to be identified through monitoring of completion</td>
<td>Modern Matrons/Ward Managers</td>
<td>March 2014</td>
</tr>
</tbody>
</table>

The Trust undertakes a programme of local audit on clinical performance which is reported to the Board of Directors.
Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Pennine Care NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 162.

Participation in clinical research demonstrates Pennine Care’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Pennine Care was involved in conducting 48 clinical research studies during 2013/14.

There was approximately 200 clinical staff participating in research approved by a research ethics committee at Pennine Care during 2013/14. These staff participated in research covering five medical specialties.

In addition, in the last three years, three publications have resulted from our involvement in National Institute of Health and Research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates Pennine Care’s commitment to testing and offering the latest medical treatments and techniques.

Information on the use of the CQUIN Framework

Commissioner quality schedule

A proportion of Pennine Care NHS Foundation Trust’s income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between Pennine Care NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at: www.monitor-nhsft.gov.uk/sites/all/modules/txeditor/plugins/ktbrowser/_openTKFile.php?id=3275 or on request from the Trust at Pennine Care NHS Foundation Trust, 225 Old Street, Ashton-under-Lyne, OL6 7SR.

In 2013/14 £4,941,486 was contingent on performance against a range of National, Greater Manchester and Local indicators. The Trust has received the full value as a result of its performance. Further information on the financial performance of the Trust is available within the Annual Accounts. The monetary total for the associated payment in 2012/13 was £4,179,417.

These standards have been based on quality indicators outlined in the model contract and some locally driven indicators. Some of the areas of focus are outlined below:

- National Safety Thermometer
- Transfer of Care
- Physical Health Checks
- RAID
- Identification of problematic alcohol

In addition the Trust has worked to achieve a variety of quality indicators that are not income contingent, but nonetheless form part of an agreed quality schedule between the Trust and its Commissioners. The Quality Schedule has considered a range of indicators including the following:

- All Serious Incident investigations to be completed and issued to Commissioners within 45 working days from date of incident (60 days for homicides) – National Indicator
- % malnourished patients >60 years who have a treatment plan agreed with dietetics – Greater Manchester Indicator
- Provision of evidence of involvement and actions of AMH, CRT or EIT in the care planning of all 16 and 17 year olds admitted to the Hope/Horizon Unit – Local indicator

Information on registration with the Care Quality Commission

Pennine Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “Registered”. Pennine Care NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Pennine Care NHS Foundation Trust during 2013/14.

Pennine Care NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Response to regulators

Pennine Care NHS Foundation Trust is fully registered with the Care Quality Commission, without conditions.

Use of the Care Quality Commission’s registration and quality and risk profile

The Health and Social Care Act 2008 identifies a number of regulations which the CQC has interpreted into 28 outcomes. Pennine Care NHS Foundation Trust has been given registration to provide services for the regulated activities:

Mental health services

- Treatment of Disease Disorder and Injury
- Assessment or Medical Treatment of People Detained Under the Mental Health Act 1983
- Diagnostic and Screening Procedures

We have provided these activities within services registered at the following locations:

- Fairfield General Hospital, Rochdale Old Road, Bury
- Royal Oldham Hospital, Rochdale Road, Oldham
- Birch Hill Hospital, Union Road, Rochdale
- Tameside General Hospital, Fountain Street, Ashton under Lyne
- Stepping Hill Hospital, Poplar Grove, Stockport
- Heathfield House, Cale Green, Stockport
- Meadows, Offerton, Stockport
- Stansfield Place, Rochdale
- Rhodes Place, Oldham

Community healthcare services

- Diagnostic and Screening Procedures
- Surgical Services
- Sexual Health
- Treatment of Disease, Disorder or Injury
- Accommodation for Persons Who Require Nursing or Personal Care
- Nursing Care
- Personal Care

We have provided these activities within services registered at the following locations:

- Trust Headquarters, 225 Old Street, Ashton under Lyne
- Bealey Community Hospital, Durners Lane, Radcliffe
- Cambeck Close, Whitefield, Greater Manchester
- Moorgate Primary Care Centre, Derby Way, Bury
- Prestwich Walk in Centre, Fairfax Road, Prestwich
- Butler Green House, Wallis Street, Chadderton
- Grange View, Grange Road South, Hyde
- Whitehall Street Clinic, Rochdale
- Nye Bevan House, Rochdale
- Integrated Care Centre, Oldham
- Radcliffe Primary Care Centre, Radcliffe
- Mitrow Health Centre, Rochdale
- Phoenix Centre, Rochdale
We have had to register all of our services against the following regulations and assess our own compliance with the outcomes underpinning each of these.

**Section 1: Involvement and information**
- Respecting and involving people who use services
- Consent to care and treatment

**Section 2: Personalised care, treatment and support**
- Care and welfare of people who use services
- Meeting nutritional needs
- Cooperating with other providers

**Section 3: Safeguarding and safety**
- Safeguarding people who use services from abuse
- Cleanliness and Infection Control
- Management of medicines
- Safety and suitability of premises
- Safety, availability and suitability of equipment

**Section 4: Suitability of staffing**
- Requirements relating to workers
- Staffing
- Supporting staff

**Section 5: Quality and management**
- Statement of purpose
- Assessing and monitoring the quality of service provision
- Complaints
- Records

**Information on the quality of data**

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

We will continue to work with our Data Quality Governance Group that reports into the Trust’s management structure. The group has developed a Data Improvement Action plan to focus on outstanding areas for improvement.

The Data Quality Governance Group led by the Performance and Information Department have a duty to support operational services to ensure that all activity data is recorded timely, accurately and robustly on Pennine’s electronic clinical/patient systems. The Performance and Information Department work closely with operational services to ensure they take responsibility for the quality of data recorded on the clinical system. They engage and encourage our teams to improve both the level and quality of activity information recorded and ensure the teams understand the importance of this.

We feel the clinical record is an important tool for our practitioners to understand the care being provided to our service users. Having an accurate record ensures our staff have the most accurate information in which to work from.
DH Mandatory quality indicator set to be included in the 2013/14 Quality Accounts

In addition to the indicators detailed later in this report, the following additional indicators and statements are required to be reported in 2013/14.

<table>
<thead>
<tr>
<th>CRHT Gatekeeping</th>
<th>2012/13</th>
<th>2013/14</th>
<th>National range</th>
<th>Threshold/ national average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99.3%</td>
<td>99%</td>
<td>90.7 – 100%</td>
<td>95% – 98.3%</td>
</tr>
</tbody>
</table>

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reason: to show the percentage of admission to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by continuing to monitor adherence to the above target and to take any remedial action if required. (Figures reported as per compliance framework).

<table>
<thead>
<tr>
<th>CPA 7 day follow up</th>
<th>2012/13</th>
<th>2013/14</th>
<th>National range</th>
<th>Threshold/ National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>96.4%</td>
<td>95.1%</td>
<td>92.5 – 100%</td>
<td>95% – 97.4%</td>
</tr>
</tbody>
</table>

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reason: to show the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by continuing to monitor adherence to the above target and to take any remedial action if required. (Figures reported as per compliance framework).

<table>
<thead>
<tr>
<th>Mental health 28 day emergency readmission rates</th>
<th>Age range</th>
<th>2012/13</th>
<th>2013/14</th>
<th>National range</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Wards</td>
<td>18 – 65</td>
<td>11.3%</td>
<td>11.5%</td>
<td>N/A</td>
<td>10%</td>
</tr>
<tr>
<td>Older Adult Wards</td>
<td>Over 65</td>
<td>5.8%</td>
<td>8.5%</td>
<td>N/A</td>
<td>5%</td>
</tr>
<tr>
<td>CAMHS Wards</td>
<td>0 – 14</td>
<td>0.0%</td>
<td>0.0%</td>
<td>N/A</td>
<td>NK</td>
</tr>
<tr>
<td>CAMHS Wards Over 15</td>
<td>Over 15</td>
<td>5.8%</td>
<td>8.5%</td>
<td>N/A</td>
<td>NK</td>
</tr>
</tbody>
</table>

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons: to show the percentage of patients aged 0-14; and 15 or over, readmitted to a hospital which forms part of the Trust, within 28 days of discharge, from a hospital which forms part of the Trust, during the reporting period.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by continuing to monitor readmission rates to feed these back into operational services to look at systems and processes to make improvements (e.g. RAID).

* Averages taken from NHS Benchmarking MH Inpatient Report. Internally generated reported readmission percentages.

<table>
<thead>
<tr>
<th>Patient Experience – Community Mental Health</th>
<th>2012/13</th>
<th>2013/14</th>
<th>National range</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.8</td>
<td>8.3</td>
<td>8.0 lowest</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reason: to show the Trust’s “Patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by continuing to actively engage with our service users to capture patient experience through the use of satisfaction kiosks and other means to provide direct service feedback to inform any required actions.

Note: Scores are out of a possible ten, information obtained from CQC NHS National Patient Survey 2013.
DH Mandatory quality indicator set to be included in the 2013/14 Quality Accounts continued

<table>
<thead>
<tr>
<th>Patient Safety Incidents</th>
<th>2012/13 G1 + Q2</th>
<th>2012/13 G3 + Q4</th>
<th>*National range</th>
<th>National total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of incidents ***</td>
<td>2,350</td>
<td>2,103</td>
<td>405</td>
<td>6737</td>
</tr>
<tr>
<td>Rate per 1000 bed days</td>
<td>28.2</td>
<td>25.3</td>
<td>8.2</td>
<td>99.8</td>
</tr>
<tr>
<td>Number of incidents resulting in</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe harm</td>
<td>0</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>122 (1.8%)</td>
</tr>
<tr>
<td>Death</td>
<td>14 (0.6%)</td>
<td>15 (0.7%)</td>
<td>0 (0%)</td>
<td>59 (1.9%)</td>
</tr>
<tr>
<td>Total number of incidents resulting in severe harm or death</td>
<td>14 (0.6%)</td>
<td>15 (0.7%)</td>
<td><strong>N/A</strong></td>
<td><strong>N/A</strong></td>
</tr>
</tbody>
</table>

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons:

- To show the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number of percentage of such patient safety incidents that resulted in severe harm or death.

- The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by reviewing STF’s the Trust’s Patient Safety Improvement Group will identify learning to improve systems and the quality and safety of patient care.

Note: * Data filtered by Trusts reporting six months of activity. ** Different NHS Trusts, unable to combine to provide total *** This is not intended to indicate performance but instead to show the National range, the number of incidents will vary influenced by the size of the NHS organisation and differences in population.

2012/13 Data reflects six monthly reporting period Quarter 1 + Quarter 2 April – September 2012 and Quarter 3 + Quarter 4 October 2012 – March 2013 (updated figures not yet available).

Staff who would recommend the Trust as a place to work or receive treatment

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>National range</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.64</td>
<td>3.54</td>
<td>3.01 lowest 4.04 highest</td>
<td>3.55</td>
</tr>
</tbody>
</table>

The Pennine Care NHS Foundation Trust considers that this data is as described for the following reasons:

- To indicate the extent to which staff employed by the Trust during the reporting period would recommend the Trust as a provider of care to their family or friends.

The Pennine Care NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by implementing a Trust Quality Group which considers, oversees and develops actions concerned with and to ensure the quality of our services and the care we provide.

Note: Scale = 1 (unlikely to recommend) to 5 (likely to recommend). Information obtained from CQC NHS National Staff Survey (2012) and Picker Institute Europe (2013), page 20, KSF finding 24 available online at: http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2013_RT2_full.pdf

Other than the other data sources stated, the above information was obtained from the Health and Social Care Information Centre, via the Indicator Portal March 2014.

Part 3: Review of quality performance, involvement, and external statements

Working closely with commissioners to drive quality

Throughout 2013/14 we have continued to work closely with our Mental Health and Community Services Commissioners to ensure that providing quality care remains the central and most important aspect of how we develop and deliver services.

Our Joint Commissioner and Provider Quality groups provide challenge and scrutiny as to how we provide services and in doing so promote an ongoing culture of openness, transparency and collaborative working.

As providers and Commissioners we have a joint commitment and responsibility to ensure that our local communities receive high quality health services and we will continue to build and strengthen our focus on quality throughout 2014/15 and into the coming years.

Current view of the Trust’s position and status for quality

During 2013/14 the Trust has continued to drive service improvement schemes with a focus on quality. Part three of this Quality Account details nine of the quality improvement priorities chosen by the Board following ongoing consultation with our service users and carers, Commissioners, Trust membership, and our local communities and partner organisations.

In response to requests from our Commissioners we are pleased to introduce a review of our quality initiatives in 2013/14 by giving an overview of how we are taking an organisational approach towards:

- Our response to the Francis report
- Capturing Patient Experience
- Safeguarding Adults and Children
Our response to the Francis Report

The Francis report outlines serious failings in patient care which occurred at Mid Staffordshire NHS Trust. Detailed within the report are 290 recommendations for all NHS trusts, Commissioners and external regulators to ensure similar failings in care and safety are not repeated.

Led by the Director of Nursing and Allied Health Professionals, as a Trust, from frontline staff to our Trust Board, we have actively consulted on, and considered the recommendations contained within this and other reports (such as Keogh and Berwick), and developed a Trust-wide action plan to ensure that we keep quality care central to all we do. Our action plan outlines our commitment to providing safe and effective care, with a focus on positive patient experience across the following areas:

Putting the patient first

We will ensure that patients receive effective services from caring, compassionate and committed staff, working to a common culture. Patients must also be protected from avoidable harm and any deprivation of their basic rights.

Common culture

We have a commitment to a common set of values and accessible basic care and treatment standards, which we will embed through our Principles of Care.

Values and standards of service

Fundamental basic standards of care will be applied by all those who work and serve in healthcare.

Openness, transparency, candour and effective complaints system

We will work to ensure a culture of:

• Openness: enabling concerns to be raised and disclosed freely without fear
• Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public

• Candour: ensuring that where patients are harmed they are informed of that fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question raised about it

Leadership

We will provide common professional training on leadership and management to promote healthcare leadership and management as a profession and promote research best practice.

Nursing

The 6 Cs of nursing, as outlined in the national strategy: care, compassion, competence, communication, courage and commitment, will continue to underpin and direct our fundamental approach to how we deliver nursing care.

Performance management and information

We will work to ensure that detailed and essential information is available to frontline services, and progress with introducing an electronic integrated health records system through the implementation of the PARIS clinical information system.

We will continue to review our effectiveness in relation to our action plan throughout the coming year and where necessary will take any appropriate actions to ensure we continue to deliver high quality care across all our Mental Health and Community services.

Capturing patient experience to enhance quality

The Trust has continued to focus on the variety of mediums available to capture the experiences of service users and carers accessing services, whilst ensuring these methods are routinely available and promoted.

Listening to the voice of the patient whilst capturing their experiences enables us to identify areas for change, as well as driving service enhancements and improvements.

We aim to provide all service users and carers with the opportunity to comment on their experience whilst accessing Pennine Care services, using real-time initiatives which the Trust has employed, in the forms of the Elephant Kiosks and SMS texting. Where these methods have yet to be adopted, we have alternative methods available to capture feedback.

Introducing friends and family test

The Friends and Family test involves directly asking both service users and our staff:

“How likely are you to recommend Pennine Care NHS Foundation Trust to friends and family should they require similar care or treatment?”

In 2014/15 reporting the friends and family test will be fully rolled out across all our community and mental health services. However, during 2013/14 we began collecting this feedback resulting in 91%* of patients stating that they would be ‘extremely likely’ or ‘likely’ to recommend Pennine Care NHS Foundation Trust to friends and family should they require similar care or treatment.

The friends and family test is included on all Elephant Kiosks, SMS texting and is included in all bespoke paper based questionnaires which are developed.

*Based on 3253 responses out of a total of 3693

Our approach to safeguarding

As a leading healthcare provider Pennine Care NHS Foundation Trust recognises its requirements to demonstrate that we have safeguarding leadership and commitment at all levels of our organisation and that we are fully engaged and in support of local accountability and assurance structures, in particular via the Local Safeguarding Child and Adult Boards (LSCB, LSAB) and our Commissioners. Most importantly, we strive to ensure that a culture exists where safeguarding is ‘everybody’s business’ and poor practice is identified and tackled.

The Director of Nursing and Allied Health Professionals in collaboration with Divisional Directors has embarked upon a work stream to review the form and function of safeguarding within the organisation. The aim of the work stream is to define a model of safeguarding for the Trust in its changing form that will give a high level of ‘fit for purpose’ assurance both internally and externally.

Children’s safeguarding

Safeguarding children is underpinned by legislation, statute and best practice guidance and incorporates a clear framework outlining the roles and responsibilities for clinical safeguarding practitioners in terms of competency and training requirements.

Roles and responsibilities outside and within the Trust reflect current practice in the realm of safeguarding children taking into account the statutory guidance in ‘Working Together’. The guidance makes explicit the governing principles required for provider services and Foundation Trusts and states that NHS Trusts and NHS Foundation Trusts must demonstrate strong local leadership, work as committed partners and invest in effective co-ordination and quality assurance of safeguarding.

Key work streams – child safeguarding

• Trust staff working in borough based Multi-Agency Safeguarding Hubs (MASH)
• Trust representation at LSCB’s identified by the Chief Executive to be at Divisional Director Level. The strategic position that Directors hold will ensure that Pennine Care is represented at the highest level by the most appropriate people who hold accountability for service provision and can commit resources
• Embedding child sexual exploitation guidance in to pathways and processes
• Preparation and contribution to the new CQC inspection processes in respect of safeguarding and Looked After Children
• Working with OL&D Directorate to ensure accurate reporting on compliance with training requirements

Key achievements – safeguarding and looked after children

• 100% attendance of Health Visitors and School Nurses at case conferences
• Increase in the uptake of Level 2 safeguarding children training

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Annual Report and Accounts 109
Review of Quality Performance in 2013/14 against the three quality domains

Below is a review of various performance quality indicators in the year 2013/14. These indicators cover three examples each contained within the three quality domains of patient safety, clinical effectiveness and patient experience. Three of these indicators fully detail the Quality Priorities for 2013/14, identified in last year’s Quality Account and detailed in Part two of this report.

The following indicators have been chosen to represent the broad overview of service quality across the organisation; comparative data has been included to indicate continuity and progression where available.

Patient Safety Indicator 1 RAID (year 2) – Alcohol, is an extension of the RAID project described in last year’s Quality Account, however, this year’s indicator gives a different aspect of RAID and no comparative data is available. Clinical Effectiveness Indicator 1, Physical Health, Mental Health expands upon themes from previous Quality Accounts, aimed to address inequalities in physical health outcomes for those with a mental illness however no comparative data is available. Patient Experience Indicator 1, Telehealth builds on work commenced as part of the Hospital in the Community initiative, detailed in last years Quality Account, but no comparative data is available. The remaining indicators are new for 2013/14.

The rationale for changing the reporting in priorities in 2013/14 against those presented in 2012/13 is as follows: the remaining priorities are new initiatives commenced in 2013/14 and are presented with the intention to show that the Trust continues to introduce new and innovative service improvement projects to improve the quality of care for service users and carers across the organisation.

These initiatives have also been introduced in response to changes in the needs of local populations and in response to changes in commissioning priorities and national programmes; these reflect themes from previous Quality Accounts in relation to safety, effectiveness and experience.
Review of Quality Performance in 2013/14 against the three quality domains

Review of Patient Safety Indicators:

Patient Safety Indicator 1: RAID (Year 2) Alcohol

Description of issue and rationale for prioritising

The RAID practitioners continue to work with a small cohort of people who are high users of unscheduled hospital care, primarily as a result of alcohol dependency, in order to reduce high rates of alcohol-related hospital attendances and admissions.

The RAID alcohol approach aims to support the following:

- A focus on A&E ‘frequent flyers’
- To increase the successful engagement of alcohol dependent clients who place most demand on urgent care resources into community-based treatment and recovery
- To deliver intensive community support
- To improve engagement of this very complex group of clients
- To support a multi-agency approach – engaging with a wide range of partners including police, housing, citizen’s advice etc
- To support the fast-track of clients into mainstream alcohol services
- To work with clients to improve their chances of successful treatment and recovery in the community

Aim/goal

Identifying the most appropriate people for the RAID practitioners to work with is often challenging due to a number of factors. In some boroughs the teams receive referrals from Alcohol Liaison colleagues working within the A&E departments, who have a responsibility to screen and undertake brief interventions with people presenting with alcohol issues or where alcohol is a factor. Those identified as ‘frequent flyers’ can then be referred to the RAID team for assertive community outreach work in an attempt to address their alcohol issues and change their behaviour in terms of utilisation of urgent care services.

Not all acute Trusts have this specific liaison function available; where this is not in place the RAID practitioners are often reliant on local intelligence concerning the frequent attenders.

Clinical coding, in terms of alcohol also presents difficulties. Often, the primary reason for attendance is not coded as alcohol; even though alcohol misuse is frequently the contributing factor. Therefore, electronic searches of A&E presentations often do not identify the most appropriate people to work with. This also presents difficulties when evaluating the service if the evaluation utilises data from A&E systems, in terms of looking for a reduction in the number of people presenting where alcohol is a key factor.

Current status

Access to all data required has presented challenges in terms of the evaluation and in demonstrating to Commissioners the value of the service. Throughout the pilot project, the practitioners have collated numerous case studies which highlight the quality outcomes achieved with patients, however from a cost-saving evaluation factor. Therefore, Clinical coding, in terms of alcohol also presents difficulties. Often, the primary reason for attendance is not coded as alcohol; even though alcohol misuse is frequently the contributing factor. Therefore, electronic searches of A&E presentations often do not identify the most appropriate people to work with. This also presents difficulties when evaluating the service if the evaluation utilises data from A&E systems, in terms of looking for a reduction in the number of people presenting where alcohol is a key factor.

Identified areas for improvement

As a result, and as RAID moves into Year 3 of being in operation, the data collection and evaluation tool for the RAID Alcohol service is being reviewed. Starting from April 2014, each RAID practitioner will report monthly on the number of people they are actively working with. Each patient will be referenced (anonymously) on the reporting framework, together with the number of contacts made by the practitioner (in an attempt to demonstrate the level of community engagement). The RAID practitioners will also utilise A&E systems to record on the reporting framework, the patient’s history in terms of A&E attendances or admissions prior to working with the RAID team and this will be subsequently documented each quarter post-engagement. This process will rely on a manual recording process by the practitioners themselves, as in order to demonstrate the value of this service, it is essential that the Trust accesses data from the Acute Trust A&E systems.

Ultimately, through this approach, it is envisaged that cost-savings can be calculated against individual patients.

Current initiatives

This approach will be piloted through the month of March with a view to be implemented from April 2014 onwards.

New initiatives

CQUIN funding to support the RAID approach has been confirmed for 2014/15 in order for the project to be formally evaluated and further performance evidence to be collated. It is hoped this evaluation will inform and influence commissioning intentions regarding the provision of long-term funding for the RAID project.

Patient Safety Indicator 2: Caring for complex children at home: The work of the Childrens’ Long Term Ventilation Team

Description of issue and rationale for prioritising

The Childrens’ LTVT was set up in 1997 after it was noted that children requiring technology to maintain life were occupying beds on Paediatric Intensive Care Units in the tertiary centres. The service started with one child and a team of five care staff and a team leader. The team has increased year on year and the team now supports up to 11 children in their own homes with packages of support tailored to the child and family’s individual needs.

Each client has an individual assessment and all care plans are undertaken in partnership with clients and the family; parents sign the nursing assessment and nursing care plans, to indicate their participation. Care plans are evaluated on an ongoing basis in partnership with parents and families. All care plans are signed by parents. All care plans are annually reviewed and updated.

The service has an on call system from 06:30 to 22:30, where a paediatric nurse is available 365 days a year to answer any issues.

The CQC assessment completed in October 2013 highlighted many areas of good practice within the service.

Identified areas for improvement

The results of a recent CQC assessment were excellent with no areas noted for immediate improvement; however the team continually strives for the gold standards that it sets themselves.
The team has recently improved the training package that it uses to train new staff members. This package now gives the carers much more theory regarding why a procedure is carried out and what systems of the body are affected at any given time.

Staff skill core competencies have been improved, and are completed by staff for each child they work with at patient specific level.

The team also continually works with parents to achieve the best outcomes supporting families in a variety of inventive ways including supporting family holidays, taking children to school and on shopping trips, attending to all the child’s health needs during the trips.

**Current initiatives**

Current Initiatives include continuing to ensure all staff have competency checks each year regarding medical tasks and administration of medication. Ensure all mandatory training is up to date, and to ensure all staff receive managerial supervision on a 6-8 weekly basis.

**New initiatives**

The team is currently looking at working with OL&D and Salford University to develop the apprenticeship scheme being promoted by Pennine Care utilising the current teaching package. This will enable all Support Workers to have a recognised qualification.

The team is also looking at introducing medication reviews on a 6 monthly basis or sooner if required, following a recommendation from the CQC assessment.

**Patient Safety indicator 3: The development of Condition Orientated Groups (COGs) to enhance quality and patient safety**

**Description of issue and rationale for prioritising**

The Community Rehabilitation Teams operating within Trafford division consist of four teams of Occupational Therapists (OT), Physiotherapists and Support Workers providing home based interventions to adults with physical disabilities. We also have one outpatient service.

Each team, with the exception of the outpatient team, covers a different geographical area within Trafford and are therefore based separately. The majority of the caseloads consist of older adults.

We identified several issues across the teams which initiated the idea to draw together the recommended best practice for the conditions that our clients most commonly present with. There was a difference in skills across the four teams; one OT had a particular interest in treating people with Parkinson’s disease and another for people diagnosed with cancer, one OT had specialist knowledge of pain management and another within stroke rehabilitation. Whilst it is useful and expected that clinicians have their areas of expertise, this clearly led to inequalities of knowledge and skills across the localities.

**Aim/goal**

The aim of COG is to be able to clearly demonstrate equitable access to the quality, evidence based rehabilitation service that we provide and the skill level of the staff providing this across all teams.

**Current status**

We have developed multi-disciplinary team working groups for Falls, Oncology, Dementia and Parkinson’s disease (known as COG). We gathered together existing recommendations for best practise from a variety of sources including the College of Occupational Therapists, the Chartered Society of Physiotherapists, NICE, NSF and compiled a checklist of interventions for each profession and each condition. This list was not prescriptive but provided options of best practice and allowed for clinical reasoning.

We were then also able to identify which grades of staff would be expected to carry out which interventions, for example not all grades would be expected to be confident in splinting. The checklists are used as part of each client’s documentation.

**Benefits**

- Increased confidence that we are meeting best practice guidelines in areas which may not be our specialty. The checklist provides a quick way of doing this and ensuring that areas are not being overlooked

- Checklists of clinical competencies allowing each grade of staff to be able to sign off the areas they feel confident in and to identify their own training needs. A training programme has been completed and there has been a consequent increase in skills and knowledge

- The clients are receiving a more equitable service across the borough

- It has enabled some staff to develop an area of expertise by being involved in researching the best practice and delivering and organising training

**Identified areas for improvement**

Reviews are underway to ensure that the most appropriate guidelines are placed in the patient’s records, specifically when a patient has more than one condition.

**New initiatives**

The COGs are under review at present to enable the inclusion of the patient support workers in the signing of competencies. A Cardiovascular Accident COG is under development.

The format of the COGs is under review to enable each document to be printed in a user friendly way.

**Current initiatives**

We plan to run two events to promote awareness and share best practice:

- The first to take place within the Trust to raise awareness of the COGs and share their development and the transferable opportunities across other professions and services

- The second event will be available for clinicians outside of Pennine Care to attend and share the development of the COGs, their uses and potentially generate income
We have developed and implemented a medication specific monitoring care plan to be implemented for all service users who are newly prescribed or changed anti-psychotic medication. The medication monitoring care plan will be accompanied with medication specific information sheets available from the Choice and Medication website.

Pennine Care have implemented a process for the exchange of information between Pennine Care and GPs to capture the services users who have not accessed a health check.

The tables below demonstrate the outcome of the information exchange between Pennine Care and GPs across the five boroughs where mental health services are delivered by the Trust.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Number of GPs contacted</th>
<th>% of GPs responded</th>
<th>Total number of patients in the cohort</th>
<th>Number (%) of patients included in the response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oldham</td>
<td>44</td>
<td>22%</td>
<td>518</td>
<td>59 (11%)</td>
</tr>
<tr>
<td>HMR</td>
<td>35</td>
<td>22%</td>
<td>744</td>
<td>96 (13%)</td>
</tr>
<tr>
<td>Stockport</td>
<td>42</td>
<td>21%</td>
<td>500</td>
<td>69 (13.8%)</td>
</tr>
<tr>
<td>Tameside and Glossop</td>
<td>44</td>
<td>18%</td>
<td>428</td>
<td>72 (16%)</td>
</tr>
<tr>
<td>Bury</td>
<td>28</td>
<td>14%</td>
<td>461</td>
<td>60 (13%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CCG</th>
<th>Of those GPs responding the number of Patients who had not received a physical health check at the GP (%)</th>
<th>Of those GPs responding the number of Patients who had not received a physical health check at the GP but had a check scheduled (%)</th>
<th>Of those GPs responding the number of Patients who had not received a physical health check at the GP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oldham</td>
<td>32 (54%)</td>
<td>2 (4%)</td>
<td>25 (42%)</td>
</tr>
<tr>
<td>HMR</td>
<td>63 (64%)</td>
<td>9 (11%)</td>
<td>26 (26%)</td>
</tr>
<tr>
<td>Stockport</td>
<td>20 (28%)</td>
<td>5 (9%)</td>
<td>44 (63%)</td>
</tr>
<tr>
<td>Tameside and Glossop</td>
<td>44 (61%)</td>
<td>4 (6%)</td>
<td>24 (33%)</td>
</tr>
<tr>
<td>Bury</td>
<td>32 (53%)</td>
<td>0 (0%)</td>
<td>28</td>
</tr>
</tbody>
</table>

The method of exchange of information between us and local GPs was very labour intensive, both in identifying the patient cohort and in the information exchange methods. We could not do this via shared electronic retrieval systems. This may have contributed to the relatively modest returns received; we are committed to working with Commissioners to improve this as detailed below.

Review of Clinical Effectiveness Indicators

Clinical Effectiveness Indicator 1: Physical Health, Community Mental Health

Description of issue and rationale for prioritising

People with serious mental illness are at increased risk of developing cardiovascular and respiratory disease as a result of lifestyle factors and side effects of anti-psychotic medication. Evidence suggests that people with severe mental illness (SMI) die 15-20 years younger than people without a SMI. Research presented in the British Journal of Psychiatry suggests that people with schizophrenia have a mortality risk that is two to three times that of the general population. Most of the extra deaths are from natural causes, particularly cardiovascular disease, and in addition, people with schizophrenia appear to be missing out on the improved cardiovascular mortality of the general population.

Results from the CQC survey show that less than 60% of patients are asked about physical health needs, receive support for physical health needs or are told about the side effects of medication. Evidence suggests that people with schizophrenia and bipolar disorder are less likely to attend routine check-ups, and a survey found that only one in three people with mental illness had been offered a physical health check.

Surveys undertaken by Rethink suggest that people with schizophrenia and bipolar disorder are less likely to attend routine check-ups, and a survey found that only one in three people with mental illness had been offered a physical health check.

NICE Guidance states that GPs and other primary care professionals should monitor the physical health of people with schizophrenia at least once a year.

Evidences suggests that having a protocol in place and monitoring form is not enough to ensure physical health checks are completed but the use of education, visits, and media campaigns can help. The recent English Mental Health Strategy No Health without Mental Health has made a commitment to ‘parity of esteem between mental and physical health services’, and has a clear objective to improve the physical health of those with a mental disorder.

The more recent report, Whole-Person Care: From Rhetoric to Reality, highlights the significant inequalities that exist between physical and mental health care, including preventable premature deaths, lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems.

Aim/goal

The aim of this priority is to raise awareness of the importance of physical health checks for people with mental health problems.

Aim/goal

The aim of this priority is to raise awareness of the importance of physical health checks for people with mental health services, including Early Intervention and Review and Recovery.

Current status

The Tier 4 community group has overseen the delivery of the Physical Health CQUIN objectives of the initiative.

To date the CQUIN has proved beneficial in terms of delivering the aims and objectives.

The following work has been undertaken to deliver this objective:

Pennine Care in collaboration with a local user and carer group has developed a standardised letter to distribute this letter to all service users at an appointment/review to facilitate further discussion, address issues or anxieties and offer support to the service user to attend the physical health check appointment.

A patient information physical health leaflet has also been developed providing detailed information on what to expect at the annual physical health check and why it is beneficial to attend. This leaflet will be made available to all secondary care community based mental health services, including Early Intervention and Review and Recovery.
Areas of improvement moving forward include:
- In partnership with CCGs further develop strategies for timely communication with GPs with regards to patients who do not attend for their annual physical health check.
- Working with community teams to relook at the medication care plan to ensure this is fit for purpose.
- Continue to work with community mental health team staff to develop an approach to supporting patients to attend their GP for a physical health check or alternatively Pennine Care staff providing the physical health.

Current initiative

Community teams are now actively working with the patients who have not attended the GP for a Physical Health check nor have a scheduled appointment booked to attend, to encourage them to attend and in exceptional circumstances arrange for the physical health check to be undertaken by a member of the multi-disciplinary team.

The physical health check undertaken by the community mental health team will be documented using an agreed template which reflects the GP QOF requirements. These results will be forwarded to the GP for expert interpretation or further follow-up if required with the support of the mental health services acknowledging that these patients are often difficult to engage.

A review of community mental health service records is underway to review the implementation of the physical health letter and medication care plan; is underway to review the implementation of the physical health check and for 90% of patients audited, an up-to-date care plan has been shared with the GP including ICD codes for all primary and secondary mental and physical health diagnosis, medications prescribed and monitoring requirements, physical health conditions and ongoing monitoring and treatment needs.

The Trust will also consider the implications and plan appropriate actions in response to the 25 Good Practice Examples as outlined in “Improving physical health for people with mental illness: What can be done?” Published by the Royal College of Psychiatrists December 2013.

Clinical Effectiveness indicator 2: Learning Disability Directorate review of clinical care pathways

Description of issue and rationale for prioritising

Providing continuing quality assurance across all Community Learning Disability Services is a priority for Pennine Care Learning Disability (LD) Directorate Services. In April 2011 the establishment of Learning Disability Directorate brought together Community Learning Disability services from five boroughs across the Trust. The rationale for prioritising pathway development was to provide an evidence based framework for key areas of service delivery across all boroughs. The process of selecting areas of provision for pathway development was informed by the reporting of local priorities from Learning Disability Partnership Boards, referencing of guidance provided to emerging Clinical Commissioning Groups by the Improving Health and Lives (Public Health England Learning Disability Observatory) alongside a review of referral trends and activity from each Community Learning Disability service.

The areas for pathway development across the Learning Disability Directorate were identified as:
- Positive Behavioural Support (PBS)
- End of Life
- Psychological Wellbeing
- Physical Health
- Dysphagia

The development of evidence based pathways also contributes to the delivery of quality assurances for:
- Care Quality Commission – 5 Key Questions
- Compassion in Practice 6 Cs – Care, Compassion, Competence Communication, Courage, Commitment
- NHS Constitution – Commitment to Quality of Care
- Pennine Care – Principles of Care
- Winterbourn View – Transforming Care

Aim/goal

Our aim is to develop pathways across key areas of service provision, supporting the delivery of services that are underpinned by the Learning Disability Directorate principles
- Values driven
- Safe and effective
- Evidence Based
- Person/Child Centred
- Outcome Focused

Current status

Pathways have been developed for End of Life, Positive Behaviour Support while workshops have been established and produced draft pathways across all other areas of provision.

Identified areas for improvement

Upon the establishment of the Trust’s LD Directorate in April 2012, each borough-level community service developed unique service models in response to national drivers and local priorities. Working with local partners the Trust have identified opportunities for borough-level services to build upon existing expertise and mitigate potential gaps in knowledge and experience through the delivery of specialist training which supports the implementation of pathways.

Current initiatives

The LD Directorate have supported the implementation of the PBS Pathway by delivering PBS training to over 60 staff across the footprint. This pathway included the review and harmonisation of approaches to psychical intervention resulting in a new policy document.

The ongoing development of expertise in the area of PBS is supported through the delivery of a Learning Disability Supervision Framework offering practitioners a range of options for clinical supervision designed to support competent and motivated teams offering person centred support.

New initiatives

2014/15 will see Pennine Care’s LD Directorate pilot the Health Equalities Framework (HEF); an outcomes framework based on the determinants of health inequalities.

HEF provides a way for all specialist learning disability services to consistently agree and measure outcomes with people with learning disabilities; it can be used by all services with regard to demonstrating effectiveness in tackling a range of...
Health and social determinants of health inequalities. The HEF will provide the Trust with the opportunity to demonstrate outcomes across services and pathways from individual caseloads aggregated up to whole service areas.

**Clinical effectiveness indicator 3: Piloting a comprehensive stroke rehabilitation service in Bury**

**Description of issue and rationale for prioritising**

The Early Supported Discharge Team (ESDT) in Bury provides a co-ordinated high quality, stroke specialist, multi-disciplinary, rehabilitation service to enable people to be discharged from hospital earlier than if the service was not provided.

The nationally recognised and supported criteria for Early Supported Discharge are robust, and as such a large cohort of stroke survivors do not meet the remit for admission to this team.

Providing a service for patients who do not meet these criteria but who still have rehabilitation needs became a priority as these patients were being seen by uni-disciplinary teams who were not able to co-ordinate input due to varying waiting times and service pressures. This fell short of the Royal College of Psychiatry guidelines, Stroke strategy (2007) and best practice guidelines, and meant that some patients were waiting up to 12 weeks for rehabilitation post hospital discharge.

Stroke patients who had received ESD rehabilitation, which is provided with the level of intensity of inpatient rehab, were referred onto waiting lists, often losing the functional gains they had made while with ESD. In addition, stroke patients who had identified new problems post discharge or some time following hospital discharge, were not able to re-access a co-ordinated service which was highlighted in the CQC audit of 2010 as a shortcoming of the Bury service.

**Aim/goal**

The aim of the pilot project was to extend the stroke service to include all people with stroke related rehabilitation needs. This would ensure an equitable service for all Bury patients and ensure the service met best practice and Royal College of Psychiatry guidelines.

In addition it is hoped that this service will impact on length of stay, ensuring a timely discharge for more patients and allow work on longer term functional goals to assist towards integration into community life.

**Current status**

The extended service has been in place since September 2013 with a slight increase in resource.

We have been able to see an additional 62 patients with this small increase in resource, which is a 122% increase for the five month period compared to the five months previously; because we are able to target our resource more efficiently. Knowing that patients will receive a timely follow on service after ESD means we step them down from ESD when they are ready, and continue to see them less intensively as their condition improves. This also stops the ‘cliff edge’ scenario whereby patients reported (following our intensive input), that they felt ‘abandoned’, whilst waiting for the services to pick them up.

**Referrals for stroke team (pilot commenced September 2013)**

![Referrals for stroke team graph](image)
Identified areas for improvement

We have increased our capacity by over 100%; however, we are still working on systems to ensure that administration keeps pace with the workload. For example, a new national database for all stroke patients has been commenced since the extended service began. This has increased the administration workload, and with higher volumes of patients, the administrative burden is felt more keenly. We are currently reviewing the data collection methods to enable us to collect the relevant data in a way which enables us to efficiently input into the national database.

Current initiatives

We recognised that we needed to reduce dependency on the service and the goal of rehabilitation is to promote independence. We therefore successfully bid for one-off funding from the Greater Manchester Cardiac and Stroke Network to implement the Bridges Stroke Self-Management Programme.

Our method of implementing this has won us recognition nationally, resulting in an invitation to speak at the UK Stroke Forum. More importantly, patients are identifying their own goals, allowing us to work on things which are relevant to them and therefore ensuring we target resources appropriately.

New initiatives

Should we be successful in securing continued funding for this service, we have several new initiatives we would like to take forward:

• Multi-disciplinary clinics to enable rapid assessment of patients, particularly those who have been referred some time post stroke, to ensure resources are targeted appropriately and patients are seen at their convenience as quickly and with as little disruption as possible

• Group work. Many of our patients would benefit from group work as they share similar rehabilitation needs and goals, and stroke often contributes to social isolation. Group work would enable more patients to be seen, but would also help to increase confidence and decrease the social isolation frequently felt

We plan to work with Speakeasy, a local aphasia charity, to scope a befriending service to provide peer support for people after stroke

Our assistant practitioners are currently taking part in the ‘Help yourself to health’ training, with a view to implementing stroke specific self-care and health promotion training. This will complement our Bridges ethos and further promote independence, self-management and shared decision making

Review of Patient Experience Indicators

Patient Experience Indicator 1: Telehealth

Description of issue and rationale for prioritising

The vital role of innovation in the modern NHS is emphasised by both the Department of Health paper ‘Innovation, Health and Wealth’ and the 2012/13 NHS Operating Framework, which highlight the importance of implementing innovative technologies to improve outcomes for patients and deliver value for money.

The importance of assistive technologies are underpinned by national findings from the Whole System Demonstrator Programme and the ‘Three Million Lives’ campaign, whereby delivering care closer to home is reported to be essential in order to improve quality of life for patients with long-term conditions and respond to the financial challenges currently faced by the NHS.

Furthermore, the emphasis and importance placed on development and implementation of assistive technologies, to support an increase in quality, and realise efficiencies has been reiterated by the adoption of ‘Three Million Lives’ as a pre-qualification requirement for Commissioning for Quality and Innovation payments.

Aim/goal

Through the Hospital in the Community project, existing expertise in the utilisation of Telehealth technology was spread across Bury and HMR boroughs. By the introduction of new models of care delivery incorporating remote monitoring of vital signs, with a fully monitored back-up system for patients who show signs of deterioration and need support from the health teams involved in their care. A robust evaluation framework was devised to capture the benefits across the range of quality domains: experience, effectiveness and safety.

The evaluation phase has now been concluded and positive findings have been reported, with the potential to further develop the scope of the existing technology, as well as introduce new Telehealth technologies to further enhance the patient experience and outcomes.

Current status

All three boroughs are continuing to use the existing model of Telehealth, with ‘next steps’ plans emerging in each borough, to support the further development of other models of implementation, using existing and new assistive technologies.

Identified areas for improvement

It has been recognised by the clinical teams that implementation of Telehealth requires a culture change in how care pathways are delivered, and that there is a significant learning curve when moving to the new ways of working. For example, in Bury, patients were signed up to receive Telehealth for a one-year period, however now clinicians are recognising that patients can use Telehealth to support their knowledge, skills, and self-management abilities over approximately three months, and are now considering amending the model of implementation to use the Telehealth as a learning tool, rather than creating a new long-term dependency for their patients.

As another example, in Oldham, initially patients who were at highest risk of hospitalisation as identified by risk stratification were selected for Telehealth.

Clinicians now recognise that although there are benefits for these patients, the impact of Telehealth can be strengthened by selecting patients who are earlier in their disease process, and using Telehealth as a tool to support the patient to recognise deterioration of their symptoms at a much earlier point in time, thereby maintaining optimal health and preventing avoidable hospital attendances or admissions.

Current initiatives

To further develop Telehealth, and as a part of the pre-qualification CQUIN scheme around 3 Million Lives, Pennine Care has hosted two workshops, spanning its footprint (Stockport, Tameside and Glossop, Trafford, Bury, Oldham, and HMR), to stimulate the development of local joint strategies and delivery plans around assistive technologies. The events have been well received across all agencies, with clear aims and action plans being identified by attendees from CCGs, local authorities, third sector, and provider organisations. Within the workshops it has been identified that a joint approach across health and social care can enhance patient benefits, and local boroughs are working together across organisational boundaries to develop this agenda further.

New initiatives

As part of the horizon scanning function of the Implementation Group, Flo Simple Telehealth (a text-based Telehealth solution) was identified as another Telehealth solution that warranted further exploration. Pennine Care has now implemented three pilot projects to test out Flo within health (diabetes management), mental health (stress and anxiety management) and public health (smoking cessation) pathways. It is expected that these pilots will provide recommendations for further roll-out if it demonstrates effectiveness.

Furthermore, the Drug and Alcohol service within Rochdale borough will soon be implementing a text-based Telehealth solution, which will identify people at risk of relapse and ensure timely interventions are delivered to support those individuals appropriately.

Patient Experience Indicator 2: Patient Advice Liaison Service

Description of issue and rationale for prioritising

In the wake of the failings at Mid-Staffordshire NHS Foundation Trust, a key focus for care quality policy and practice is responding to recommendations made by the Francis Enquiry reports. As a result of this, the scrutiny around the quality of user and carer experience and engagement has intensified markedly in the last 18 months.
It is crucial for Trusts to have confidence in the internal systems and processes they have in place around measuring, understanding, monitoring and improving patient experience and engagement.

**Areas for improvement**
The Trust faces technical challenges in inputting all patient experience data into the enhanced Safeguard system alongside information from PALS, Complaints etc. The patient experience information constitutes a large volume of data which would be inappropriate for manual input into Safeguard.

Trust-wide engagement activities are organised primarily by the PALS team. However there are a variety of informal engagement activities taking place at all levels of the Trust and across all service lines. These are outside the control, and in some instances, the knowledge of the PALS team. Because of this fact, there is a risk that important feedback is gathered from service users on an informal basis that is not formally recorded or reported internally.

**Current initiatives and activity**
PALS host a monthly Service User and Carer Mental Health Involvement Forum, which is attended by the Trust Chair, alongside 20 service user and carer members. This group is used to monitor involvement activities, with an emphasis on the view of the service users and carers.

Forum members have been regularly consulted and engaged in developing Patient Information literature for the CQUIN target relating to the physical health needs of those with serious mental illness. Members are currently reporting personal experience of this service development as recipients of Trust services relating to their serious mental illness.

The Trust has built up a database of over 250 individuals consisting of current service users, former service users and carers, who have declared their interest in the Trust’s involvement initiatives. This database is used for a variety of purposes including acting as a conduit between the Trust and its service users, volunteering in the Trust’s involvement activities, and being involved in working groups and panels covering a wide range of Trust operations.

Individuals from the database described above are involved in a number of involvement initiatives, including:

- **Co-training:** service users and carers from the involvement database have assisted the delivery of ‘customer care’ training to over 2,000 members of Trust staff in recent years. The next step is that bespoke training for specific services will also be delivered in various areas, with participation of service user or carer volunteers.
- **Mens’ Mental Health Awareness training:** service users and carers have worked with PALS to develop and deliver training to the male workforce of local businesses and are currently working with Greater Manchester Fire and Rescue Service to deliver the training to all 1,500 of its frontline fire-fighter staff.
- **Interview panels:** service users and carers have historically participated in interviews for staff positions at the Trust. This did not, however, take place across the board and momentum for service user involvement in interview/recruitment panels has diminished in recent months.
- **Research projects:** service users have been involved in the Personal Social Services Research Unit, which is run by the University of Manchester with support from Pennine Care.
- **PALS hosts an annual service user and carer conference which this year focused on how the Trust approaches those with Long Term Conditions (LTC), this was co-facilitated by the Organisational Learning and Development department and the Trust LTC Strategic Lead.** The event was held at The Queen Elizabeth Hall in Oldham, and was attended by approximately 100 people, filling the room to capacity. A significant number of staff were involved in setting up, facilitating and also evaluating the huge volume of outputs from the day. This was a whole day event, comprising two key elements:
  - Presentations providing background and context in relation to both self-management and the Principles of Care.
  - Interactive facilitated workshops to explore each of the Principles of Care and identify behaviours that would support the achievement of the principles of care in relation to behaviours from service users, carers and staff.

A working group of service users, carers and staff has been established to identify key priorities and actions generated at the event.

**New initiatives**
The initiative has a number of priorities:

- Engagement and involvement of carers in the Living Well Academy initiative, which aims to provide resources and educational packages for carers of those with Long Term Conditions.
- To establish steering and reference groups as well as engagement events with the wider LTC service user and carer population.
- Exploring Experience Based design and its components to ensure systematic engagement and involvement of service users and carers in service design.
- To implement the Safeguard system to capture and record involvement activity.

**Patient Experience Indicator 3: National Early Warning Scores (NEWS)**

**Description of issue and rationale for prioritising**

Early warning scores are frequently used in the assessment of patients presenting as unwell. Patients within both hospital and community settings can experience unexpected physiological deterioration that, if not identified and managed, can lead to hospital admission, critical illness requiring intensive management; cardiac arrest and even death. Deterioration can be detected in physiological signs i.e. pulse, blood pressure, pulse oximetry, or symptoms such as deterioration in mental state.

Various United Kingdom government agencies have recommended implementing early warning score systems: (National Patient Agency (2007) NICE (2007) National Confidential Enquiry into Patient Outcome and Death (2005)).

Studies within secondary care e.g. by the National Patient Safety Agency (2007), reported that a number of patients had died as their deterioration was not identified or acted upon. It is essential to have standard operating procedures and competency frameworks in place to underpin the use of any early warning score to ensure that the scores are thoroughly completed and actions on results are timely and clinically effective.
Community services can utilise the National Early Warning Score effectively if underpinned by strong governance and the clinical frameworks are in place; patients placed within community beds can be monitored frequently and staff can be trained to recognise the clinical signs, changes in patient presentation and objective measurement changes which herald deterioration.

**Aim/goal**

The aim and goal of using the National Early Warning Score (NEWS) is to enable community teams who manage patients with acute needs, or who are in crisis, to make effective and accurate clinical decisions for ongoing management from the calculations delivered by the NEWS. Non-registered staff who collate results will be able to feedback findings to registered staff who will make clinically reasoned decisions regarding patient management; registered staff will also collate, and act directly on results.

It is important to highlight that the NEWS is a supportive tool and does not replace the clinical reasoning of clinicians.

The tool will enable the improved quality of baseline patient observations and monitoring and allow for timely intervention or hospital admission if required. The tool will enable support of clinical judgment and aid in securing timely response by the right professional.

The ultimate goal would allow the whole system to engage with the use of the early warning score i.e. primary care, community services and secondary care, consequently allowing a seamless transition of care for patients placed within community beds or within their own home.

**Identified areas for improvement**

- The Trust plans to engage with the CCGs to enable the tool to be implemented more broadly for example within primary and secondary care and also North West Ambulance Service, ensuring the “whole system” communicates patient status in the same format.
- Implementing the use of the tool across other boroughs within the organisation
- The use of audit to monitor, evaluate and modify the use of the tool across services as required i.e. to ensure use of the tool dovetails with hospital avoidance schemes and ensures quality and effectiveness of care.

**Current initiatives**

The use of the NEWS will be monitored as part of the Greater Manchester CQUIN, relating to clinical effectiveness, across community services, specifically focusing on those services who are required to avoid admission for acute on chronic/acute crisis episodes.

**New initiatives**

The Trust will ensure the standardisation of the use of the tool via a clinical guideline and its related guidance on the accurate reading and clinical reasoning of vital signs.

Detecting the deterioration of a person’s status is more robust if the patient’s norm is known. It is recognised that the knowledge of families and carers cannot be overlooked in identifying a patients decline from their norm. There is value in pursuing new mechanisms of reporting timely carer feedback to health care professionals as part of this scheme.

**Performance against key national priorities and national core standards**

We have chosen to measure our performance against the following metrics, in line with last year. Please note, some indicators have been added and some have been removed from what we are required to report as part of the compliance framework.

<table>
<thead>
<tr>
<th>Monitor Compliance Framework Key Indicators</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions to inpatient services had access to CRHT (Gatekeeping)</td>
<td>99.3%</td>
<td>99.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Care Programme Approach (CPA) Adults</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>receiving follow up contact within 7 days</td>
<td>95.1%</td>
<td>95.0%</td>
<td>95%</td>
</tr>
<tr>
<td>having a formal review within 12 months</td>
<td>95.3%</td>
<td>0.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Minimising mental health delayed transfers of care</td>
<td>2.9%</td>
<td>1.3%</td>
<td>&lt;=7.5%</td>
</tr>
<tr>
<td>Mental Health: Meeting commitment to serve new cases of psychosis by Early Intervention Teams (Based on VSMR Target Line 5378)</td>
<td>103.4%</td>
<td>205</td>
<td>95% (quarterly target)</td>
</tr>
<tr>
<td>Mental Health data completeness: identifiers (MH MDS)</td>
<td>99.0%</td>
<td>99.3%</td>
<td>97%</td>
</tr>
<tr>
<td>Mental Health data completeness: outcomes for patients on CPA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td>98.9%</td>
<td>98.9%</td>
<td>50%</td>
</tr>
<tr>
<td>Accommodation status</td>
<td>98.6%</td>
<td>98.6%</td>
<td>50%</td>
</tr>
<tr>
<td>Having HoNOS assessment in last 12 months</td>
<td>89.1%</td>
<td>89.1%</td>
<td>50%</td>
</tr>
<tr>
<td>Overall – combined results of above</td>
<td>96.0%</td>
<td>96.0%</td>
<td>50%</td>
</tr>
<tr>
<td>Certification against compliance with requirements regarding to health care for people with learning disability</td>
<td>Achieved</td>
<td>Achieved</td>
<td>N/A</td>
</tr>
<tr>
<td>A&amp;E: maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>100%</td>
<td>99.9%</td>
<td>95%</td>
</tr>
<tr>
<td>Data Completeness: Community Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community care – referral to treatment information</td>
<td>57.8%</td>
<td>65.4%</td>
<td>50%</td>
</tr>
<tr>
<td>Community care – referral information</td>
<td>82.8%</td>
<td>51.7%</td>
<td>50%</td>
</tr>
<tr>
<td>Community care – treatment activity information</td>
<td>78.9%</td>
<td>79.2%</td>
<td>50%</td>
</tr>
<tr>
<td>Trust-wide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA bacteraemias</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Clostridium Difficile toxin positives</td>
<td>0</td>
<td>1*</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Classified Unavocatable
Other additional content relevant to the quality of NHS Services

As Pennine care NHS Foundation Trust has expanded to comprise services across mental health and community settings, the delivery of quality care remains at the forefront of the organisation. The Board has reviewed the quality of care and the results have led to numerous service improvement initiatives detailed in this year’s Quality Account.

The Trust continues its commitment to improving the services we provide and positive patient experience and provision of quality care remains central. We have continued to ensure that as services develop, quality is maintained and against any Cost Improvement Programmes, the Trust has a clear governance and accountability framework in place to manage these. All relevant service redesign schemes are subject to a quality impact assessment and are measured in terms of patient experience, patient safety and clinical effectiveness. Schemes are assigned a risk rating and are monitored closely through identified corporate structures.

Complaints

As an organisation we place high emphasis on positive patient experience, however, we have seen a 36% increase in the number of complaints received in mental health services during 2013/14 (from 142 in 2012/13 to 194 in 2013/14).

Although there are small pockets of trends within the complaints received, there is no overall theme emerging, clinical care remains the top reason for a complaint being reported but this is consistent across all organisations.

We report all complaints and respond to our Commissioners on a monthly basis. Moving in to 2014/15 we will report progress against monitoring and responding to complaints received in to the Trusts’ Quality Group and continue to work with our service users, carers, families and Commissioners. We will also be reviewing the complaints process to ensure that it delivers resolution for complainants and learning for the Trust in a robust and efficient manner alongside the consideration of other sources of patient feedback as referenced in other areas of the Quality Account.

Following releasing the draft Quality Account for external consultation, the following was added to Part 2 Indicator 1 RAID (Alcohol, year 2):

Overall, the RAID team has had 3430 contacts in 2013/14. This resulted in over 2100 hours of engagement. 1199 referrals were made to the team with 29% (347) of these referrals being signposted or referred on to other teams etc.

This is broken down by quarter in the table below:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total (2013/14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of referrals made to RAID team</td>
<td>347</td>
<td>333</td>
<td>281</td>
<td>238</td>
<td>1199</td>
</tr>
<tr>
<td>Number of referrals who were signposted or referred on to other services</td>
<td>113</td>
<td>107</td>
<td>71</td>
<td>56</td>
<td>347</td>
</tr>
</tbody>
</table>

Annex

Statement from Commissioners, Local Healthwatch organisations and Overview and Scrutiny Committee

Statement from Clinical Commissioning Groups (CCGs) CCG commentary on Pennine Care NHS Foundation Trust Quality Account 2013/14 (mental health and community services)

NHs Heywood, Middleton and Rochdale CCG (HMRC CCG) is the lead commissioner for Pennine Care NHS Foundation Trust mental health services. We are pleased to respond to Pennine Care Foundation Trust’s Quality Account 2013/14 on behalf of the following CCGs:

- NHS Bury CCG
- NHS Oldham CCG
- NHS Stockport CCG
- NHS Tameside and Glossop CCG
- Nine other associate CCGs

Bury CCG leads in seeking assurance for the quality and safety of Pennine Care Foundation Trust community services on behalf of NHs Heywood, Middleton and Rochdale CCG and NHS Oldham CCG.

Quality and safety of services is of paramount importance to the CCGs. As such we welcome the continued commitment of Pennine Care to implement the recommendations of the Francis Report, Winterbourne View Report and to embed the six C’s (Compassion, Courage, Commitment, Competency, Care and Communication) into practice. The CCGs will work with Pennine Care to ensure that this commitment is realised in 2014/15, so that patients and service users can be confident that they will be treated with dignity and respect.

The information presented in this Quality Account reflects the performance on quality reported to the CCGs through its contract monitoring processes.

PENNINE CARE and the CCGs meet monthly to review its performance in relation to quality and safety, including monitoring progress against CUQN schemes and quality indicators, for both mental health and community services. The CUQNs are not responsible for verifying data contained within the Quality Account that is not part of these contractual or performance monitoring processes.

We acknowledge the improvements achieved by Pennine Care against its priorities for 2013/14, as described in the Quality Account.

We support the priorities identified across the mental health and community services for 2014/15 to promote service improvement, patient experience and to ensure the implementation of the Francis and Winterbourne View recommendations. These priorities are also supported by the CUQN schemes for 2014/15. We will monitor the implementation and outcomes of such plans to further improve patient safety.

We are pleased with the progress to ensure appropriate and safe staffing in mental health in patient services, and would like to see the skill mix reviews extended into all services to focus on improving effectiveness and safety of care for service users.

We welcome the actions identified following audit programmes; of note is safeguarding in community services and the importance of improving these areas. We will be seeking further assurance in 2014/15 of good practice in safeguarding being demonstrated across community and mental health services. Last year we asked for the important role of safeguarding to be included in the Quality Account so are pleased to see this has been reflected this year.

The inclusion of the service user stories brings to life the reality of living with mental health or long-term conditions for people, and how improvement to health outcomes and experiences are being achieved through effective services.

We recognise the extensive good practice already underway to engage patients and service users, and welcome the improvement plans for learning from PALS and complaints; we will look for the outcomes of improved systems to capture patient experience effectively through quality monitoring processes.
Last year we also asked for further focus on lessons learned across services; whilst this work stream is not fully reflected in this Account we will continue to work with PCFT to realise this using a CQUIN scheme in 2014/15.

We recognise the challenge to present the breadth of the quality improvements across the mental health and community services, and as such consider this Account provides a snapshot of the extensive programme for quality improvement that has been undertaken. To further demonstrate this we would like to see more reflection of the outcomes we know have been achieved in localities across the mental health service footprint.

Overall, we support the significant quality improvements achieved and look forward to working with Pennine Care to further develop high quality services for our populations in 2014/15.

Yours sincerely

Dr Chris Duffy
Chair – NHS HMR CCG
Chair – North East Sector Commissioning Board

Feedback from Tameside Health and Wellbeing Board

Comments from Dr Gideon Smith, Consultant in Public Health, Tameside MBC:

- Very clearly presented summary of a very useful set of projects
- Would be interested to understand whether the Health Improvement Teams are in scope for this work
- Pleased with commitment to ‘Physical Health, Community Mental Health – Clinical Effectiveness’ workstream. Disappointed that only 18% of T&G GPs have engaged with the project to date, but also pleased that this piece of work will be continuing going forward. The client group experience significant disadvantage in terms of life expectancy, and this project will help to address an important local health inequality

Joint Health Overview and Scrutiny Committee for Pennine Care – Response to the Quality Account 2013/14

The Joint Health Overview and Scrutiny Committee discussed the Trust’s Quality Account at two meetings of the Joint Committee, in September 2013 and April 2014.

The primary aim of the Quality Account is to support the NHS in improving the quality of healthcare services, while at the same time enhancing public accountability. Members of the Joint Committee have scrutinised the three priorities identified as well as additional data provided by the Trust.

The Joint Committee supports the declared levels of compliance in relation to Priority one and two. With regards to Priority three, “Physical Health, Community Mental Health – Clinical Effectiveness”; members of the Joint Committee wish to commend the Pennine Care NHS Foundation Trust on the work undertaken in this area, but would like to place on record their disappointment at the lack of engagement from some GPs in relation to this priority area.

ThePennine Care NHS Foundation Trust has continued to demonstrate on numerous occasions a commitment to openness and transparency. Trust Executives have attended every meeting of the Joint Committee during this municipal year and the desire to provide high quality service for mental health patients, as well as those it serves in the community, has been well evidenced.

Members of the Joint Committee are mindful of the ongoing financial challenges faced by the Trust, and want to ensure that the Trust’s commitment to high quality service provision would continue to underpin all areas of service development.

All Members of the Joint Health Overview and Scrutiny Committee April 2014

Statement of Director’s responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes for the period April 2013 to March 2014;
  - Papers relating to Quality reported to the Board over the period April 2013 to March 2014;
  - Feedback from Heywood, Middleton, and Rochdale Clinical Commissioning Group dated 23/04/2014;
  - The Trust’s complaints and compliments quarterly reports for 2013/14 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
  - Feedback from other stakeholders involved in the sign-off of the Quality Report. Joint Health Overview and Scrutiny Committee for Pennine Care dated April 2014; and Tameside Health and Wellbeing Board dated April 2014;

- The national patient survey 2013;
- The national NHS staff survey 2013;
- Care Quality Commission quality and risk profiles dated 31/05/13, 30/06/13, 31/07/13, 31/10/13, 30/11/13, 31/01/14, 28/02/14, and 31/03/14;
- The Head of Internal Audit’s annual opinion over the Trust’s control environment dated 23/05/2014;
- The Quality Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/sites/all/modules/tckeditor/plugins/kbtreeview/_openTKFile.php?id=3275);

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

John Schofield
Chairman
28 May 2014

Michael McCourt
Chief Executive
28 May 2014
Independent Auditors’ Limited Assurance Report to the Council of Governors of Pennine Care NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Pennine Care NHS Foundation Trust to perform an independent assurance engagement in respect of Pennine Care NHS Foundation Trust’s Quality Report for the year ended 31 March 2014 (the “Quality Report”) and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the “specified indicators”) consist of the following national priority indicators as mandated by Monitor:

<table>
<thead>
<tr>
<th>Specified indicators</th>
<th>Specified indicators criteria (exact page number where criteria can be found)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital</td>
<td>Page 104</td>
</tr>
<tr>
<td>Admissions to inpatient services had access to crisis resolution home treatment teams</td>
<td>Page 104</td>
</tr>
</tbody>
</table>

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the “Criteria”). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual (“FT ARM”) and the “Detailed requirements for quality reports 2013/14” issued by the Independent Regulator of NHS Foundation Trusts (“Monitor”).

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

• The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the “Detailed requirements for quality reports 2013/14”;  
• The Quality Report is not consistent in all material respects with the sources specified below, and;
• The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the “2013/14 Detailed guidance for external assurance on quality reports”.  

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

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

• Board minutes for the period April 2013 to March 2014;
• Papers relating to Quality reported to the Board over the period April 2013 to March 2014;
• Feedback from Heywood, Middleton, and Rochdale Clinical Commissioning Group dated 23/04/2014;
• The Trust’s complaints and compliments quarterly reports for 2013/14 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
• Feedback from other stakeholders involved in the sign-off of the Quality Report; Joint Health Overview and Scrutiny Committee for Pennine Care dated April 2014; and Tameside Health and Wellbeing Board dated April 2014;
• The national patient survey 2013;
• The national NHS staff survey 2013;
• Care Quality Commission quality and risk profiles dated 31/05/13, 30/06/13, 31/07/13, 31/10/13, 30/11/13, 31/01/14, 28/02/14, and 31/03/14;
• The Head of Internal Audit’s annual opinion dated 23/05/2014, and;  
• Care Quality Commission inspection reports dated 09/05/2013 and 05/03/2014.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (“ICAEW”) Code of Ethics. Our team is independent of the entity and free from any relationships or other circumstances that could reasonably be thought to impair our objectivity.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Pennine Care NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

• Reviewing the content of the Quality Report against the requirements of the FT ARM and “Detailed requirements for quality reports 2013/14”;  
• Reviewing the Quality Report for consistency against the documents specified above;
• Obtaining an understanding of the design and operation of the controls in place in relation to the collection and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
• Based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
• Making enquiries of relevant management, personnel and, where relevant, third parties;
• Considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
• Performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and;
• Reading documents.
A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Pennine Care NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the “Detailed requirements for quality reports 2013/14”;
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the “2013/14 Detailed guidance for external assurance on quality reports”.

PricewaterhouseCoopers LLP
Chartered Accountants
Manchester
29 May 2014

The maintenance and integrity of the Pennine Care NHS Foundation Trust’s website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.
Salary and pension entitlements of senior managers in 2013 – 2014 and comparative figures.


<table>
<thead>
<tr>
<th>Remuneration 2013 – 2014</th>
<th>Salary and fees (Bands of £5,000)</th>
<th>Taxable benefits</th>
<th>Annual performance related bonuses (Bands of £5,000)</th>
<th>Long-term performance related bonuses (Bands of £5,000)</th>
<th>Pension related benefits (Bands of £5,000)</th>
<th>Total (Bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Directors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr M McCourt, Director of Operations and Nursing/Acting Deputy Chief Executive (1 April 2013 to 31 December 2013), Chief Executive (from 1 January 2014)</td>
<td>135 – 140</td>
<td>35</td>
<td>145 – 150</td>
<td>285 – 290</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr M Roe, Acting Chief Executive (1 April 2013 to 31 December 2013), Executive Director of Finance/Deputy Chief Executive (from 1 January 2014)</td>
<td>160 – 165</td>
<td>35</td>
<td>5 – 10</td>
<td>175 – 180</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms K Calvin-Thomas, Executive Director of Planning, Performance and Information</td>
<td>120 – 125</td>
<td></td>
<td>20 – 25</td>
<td>140 – 145</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr H Ticehurst, Medical Director</td>
<td>160 – 165</td>
<td>(65) – (70)</td>
<td>90 – 95</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms J Crosby, Acting Director of Finance (1 April 2013 to 31 March 2013)</td>
<td>100 – 105</td>
<td>120 – 125</td>
<td>220 – 225</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms B Worthington, Director of Workforce and Organisational Learning and Development (from 24 November 2013)*</td>
<td>85 – 90</td>
<td>5 – 10</td>
<td>95 – 100</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Remuneration 2013 – 2014

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Salary and fees (Bands of £5,000)</th>
<th>Taxable benefits</th>
<th>Annual performance related bonuses (Bands of £5,000)</th>
<th>Long-term performance related bonuses (Bands of £5,000)</th>
<th>Pension related benefits (Bands of £5,000)</th>
<th>Total (Bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Directors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| | Mr I Trodden, Acting Executive Director of Nursing  
(from 1 April 2013) | 100 – 105 | 95 – 100 | 195 – 200 | | |
| | Mr R Spearing, Acting Director of Service Development and Partnerships  
(from 1 April 2013) | 100 – 105 | 60 – 65 | 165 – 170 | | |
| | Mr J Archer, Chief Executive  
(to 12 April 2013)** | 20 – 25 | 0 | 20 – 25 | | |
| **Chairman** | | | | | | | |
| | Mr J Schofield | 45 – 50 | | | | | |
| **Non-Executive Directors** | | | | | | | |
| | Mr A Moran, Non-Executive Director | 15 – 20 | | | | | |
| | Mr R Ainsworth, Non-Executive Director | 15 – 20 | | | | | |
| | Dr D Edge, Non-Executive Director | 10 – 15 | | | | | |
| | Mr A Berry, Non-Executive Director | 10 – 15 | | | | | |
| | Mr C McKinless, Non-Executive Director | 10 – 15 | | | | | |

*Note: Ms Worthington was employed by Pennine Care NHS Foundation Trust in another role prior to appointment to the Board. Remuneration is disclosed for the full year.*

**Note: Mr Archer’s final salary included payments accrued for outstanding annual leave. No severance payment was made.*
<table>
<thead>
<tr>
<th>Executive Directors</th>
<th>Salary and fees (Bands of £5,000)</th>
<th>Taxable benefits</th>
<th>Annual performance related bonuses (Bands of £5,000)</th>
<th>Long-term performance related bonuses (Bands of £5,000)</th>
<th>Pension related benefits (Bands of £5,000)</th>
<th>Total (Bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr M McCourt, Director of Operations and Nursing/Acting Deputy Chief Executive</td>
<td>120 – 125</td>
<td>35</td>
<td>90 – 95</td>
<td></td>
<td>220 – 225</td>
<td></td>
</tr>
<tr>
<td>(1 April 2013 to 31 December 2013), Chief Executive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(from 1 January 2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr M Roe, Acting Chief Executive</td>
<td>130 – 135</td>
<td>35</td>
<td>90 – 95</td>
<td></td>
<td>225 – 230</td>
<td></td>
</tr>
<tr>
<td>(1 April 2013 to 31 December 2013), Executive Director of Finance/Deputy Chief Executive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(from 1 January 2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms K Calvin-Thomas, Executive Director of Planning, Performance and Information</td>
<td>95 – 100</td>
<td>25 – 30</td>
<td></td>
<td></td>
<td>120 – 125</td>
<td></td>
</tr>
<tr>
<td>(Maternity leave from 31 December 2011 to 18 June 2012)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr H Ticehurst, Medical Director</td>
<td>155 – 160</td>
<td></td>
<td></td>
<td></td>
<td>215 – 220</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr J Archer, Chief Executive</td>
<td>175 – 180</td>
<td></td>
<td></td>
<td></td>
<td>175 – 180</td>
<td></td>
</tr>
<tr>
<td>(to 12 April 2013)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms J Crouch</td>
<td>15 – 20</td>
<td></td>
<td></td>
<td></td>
<td>15 – 20</td>
<td></td>
</tr>
<tr>
<td>(from 3 January 2012 to 18 June 2012 – covering Ms Calvin-Thomas Maternity Leave)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Remuneration 2012 – 2013

<table>
<thead>
<tr>
<th></th>
<th>Salary and fees (Bands of £5,000)</th>
<th>Taxable benefits</th>
<th>Annual performance related bonuses (Bands of £5,000)</th>
<th>Long-term performance related bonuses (Bands of £5,000)</th>
<th>Pension related benefits (Bands of £5,000)</th>
<th>Total (Bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chairman</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr J Schofield</td>
<td>45 – 50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>45 – 50</td>
</tr>
<tr>
<td><strong>Non-Executive Directors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr A Moran, Non-Executive Director</td>
<td>15 – 20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15 – 20</td>
</tr>
<tr>
<td>Mr R Ainsworth, Non-Executive Director</td>
<td>15 – 20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15 – 20</td>
</tr>
<tr>
<td>Dr D Edge, Non-Executive Director</td>
<td>10 – 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10 – 15</td>
</tr>
<tr>
<td>Mr A Berry, Non-Executive Director</td>
<td>10 – 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10 – 15</td>
</tr>
<tr>
<td>Mr C McKinless, Non-Executive Director</td>
<td>10 – 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10 – 15</td>
</tr>
</tbody>
</table>

*Note: Comparative figures have been updated and re-presented to comply with the updated requirements of the Foundation Trust Annual Reporting Manual. Further detail of the changes is provided in Section D of the Remuneration Report.*
### Section B: Pension Benefits 2013 – 2014

<table>
<thead>
<tr>
<th>Executive Directors</th>
<th>Real increase in pension at age 60</th>
<th>Real increase in pension lump sum at age 60</th>
<th>Total accrued pension at age 60 at 31 March 2014</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2014</th>
<th>Cash Equivalent Transfer Value at 31 March 2013</th>
<th>Cash Equivalent Transfer Value at 31 March 2014</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(bands of £2,500)</td>
<td>(bands of £2,500)</td>
<td>(bands of £5,000)</td>
<td>(bands of £5,000)</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Executive Directors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr M McCourt, Director of Operations and Nursing/Acting Deputy Chief Executive (1 April 2013 to 31 December 2013) Chief Executive (from 1 January 2014)</td>
<td>5.0 – 7.5</td>
<td>20.0 – 22.5</td>
<td>50 – 55</td>
<td>160 – 165</td>
<td>762</td>
<td>926</td>
<td>146</td>
</tr>
<tr>
<td>Mr M Roe, Acting Chief Executive (1 April 2013 to 31 December 2013), Executive Director of Finance/Deputy Chief Executive (from 1 January 2014)</td>
<td>0 – 2.5</td>
<td>2.5 – 5.0</td>
<td>50 – 55</td>
<td>160 – 165</td>
<td>1,055</td>
<td>1,133</td>
<td>54</td>
</tr>
<tr>
<td>Ms K Calvin-Thomas, Executive Director of Planning, Performance and Information</td>
<td>0 – 2.5</td>
<td>2.5 – 5.0</td>
<td>20 – 25</td>
<td>70 – 75</td>
<td>310</td>
<td>349</td>
<td>32</td>
</tr>
<tr>
<td>Dr H Ticehurst, Medical Director</td>
<td>(2.5) – 0</td>
<td>(7.5) – (5.0)</td>
<td>35 – 40</td>
<td>105 – 110</td>
<td>624</td>
<td>617</td>
<td>(21)</td>
</tr>
<tr>
<td>Ms J Crosby, Acting Director of Finance (1 April 2013 to 31 March 2013)</td>
<td>5.0 – 7.5</td>
<td>15.0 – 17.5</td>
<td>30 – 35</td>
<td>100 – 105</td>
<td>508</td>
<td>641</td>
<td>122</td>
</tr>
<tr>
<td>Ms B Worthington, Director of Workforce and Organisational Learning and Development (from 25 November 2013)*</td>
<td>0 – 2.5</td>
<td>2.5 – 5.0</td>
<td>40 – 45</td>
<td>130 – 135</td>
<td>806</td>
<td>877</td>
<td>54</td>
</tr>
<tr>
<td>Mr I Trodden, Acting Executive Director of Nursing (from 1 April 2013)</td>
<td>2.5 – 5.0</td>
<td>12.5 – 15.0</td>
<td>30 – 35</td>
<td>95 – 100</td>
<td>465</td>
<td>573</td>
<td>98</td>
</tr>
<tr>
<td>Mr R Spearing, Acting Director of Service Development and Partnerships (from 1 April 2013)</td>
<td>2.5 – 5.0</td>
<td>10.0 – 12.5</td>
<td>20 – 25</td>
<td>70 – 75</td>
<td>338</td>
<td>411</td>
<td>67</td>
</tr>
<tr>
<td>Mr J Archer, Chief Executive (to 31 March 2013)**</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Note 1: Ms Worthington was employed by Pennine Care NHS Foundation Trust in another role prior to appointment to the Board. Remuneration is disclosed for the full year.
**Note 2: Mr Archer was not a member of the NHS Pension Scheme*
**Section C: Pay multiples 2013 – 2014**

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

The rounded remuneration of the highest-paid director in Pennine Care is the financial year 2013 – 2014 was £162,500 (2012 – 2013: £177,500). This was 6.1 times (2012 – 2013: 6.9) the median remuneration of the workforce, which was £26,822 (2012 – 2013: £25,800). The remuneration of the highest paid director in 2013 – 2014 is lower than in 2012 – 2013 due to the interim arrangements for the post of Chief Executive that were in place for nine months of the year.

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

**Section D: Expenses of Directors and Governors**

Members of the Board of Directors and members of the Council of Governors are entitled to reclaim expenses incurred in the execution of their duties for Pennine Care.

<table>
<thead>
<tr>
<th>Expenses claimed 2013 – 2014</th>
<th>Number in post</th>
<th>Number claiming expenses</th>
<th>Total expenses claimed £00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governors</td>
<td>23</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Executive and Non Executive Directors</td>
<td>14</td>
<td>11</td>
<td>117</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses claimed 2012 – 2013</th>
<th>Number in post</th>
<th>Number claiming expenses</th>
<th>Total expenses claimed £00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governors</td>
<td>19</td>
<td>16</td>
<td>35</td>
</tr>
<tr>
<td>Executive and Non Executive Directors</td>
<td>12</td>
<td>8</td>
<td>87</td>
</tr>
</tbody>
</table>

**Section E: Notes to the remuneration report**

**Changes in requirements for 2013 – 2014**

Chapter 7 of the Annual Reporting Manual (ARM) for foundation trusts has been updated in 2013 – 2014 to require several changes to the format and content of reporting the remuneration of senior managers. The information presented in Section A of the Remuneration Report reflects these changes, which have also been applied to the prior year figures to give consistent comparable information. The definitions of salaries and taxable benefits have been amended, and two new requirements added. The first is that a pension benefits figure is to be calculated and reported, the second that a total remuneration figure is to be reported.

The basis for calculating the pension benefits in section 7.62 of the ARM, and follows the ‘HMRC method’ which is derived from the Finance Act 2004 and modified by Statutory Instrument 2013/1981. The calculation required is:

\[
Pension\ Benefit\ Increase = (20 \times PE) + LSE - (20 \times PB) - LSB - EC
\]

Where:
- PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year;
- PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;
- LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year;
- LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;
- EC is the employee’s contribution paid during the year.

**Notes on changes to directors and comparative figures for Section A**

In 2013 – 2014 Pennine Care had a period of time during which interim arrangements were in place pending the appointment of a new Chief Executive. During the year four additional members of staff were appointed to the executive. The relevant dates for interim arrangements and new appointments are all shown in Sections A and B.

All of the newly appointed directors had previous service with Pennine Care directly preceding their appointment. It is not possible to obtain reliable figures for pensions data at mid-year points, therefore the full year remuneration for all areas (including salaries) is in 2013 – 2014 has been disclosed in Section A. However it is not considered relevant to provide equivalent data for 2012 – 2013 as none of the four new additions to the Board were serving in this capacity during the previous financial year.

In 2013-14 the negative movement in pension benefits shown in Sections A and B is due to a change in the assessment of whether certain elements of pay are pensionable under the NHS scheme rules. The change results in a decrease in pension value compared to prior year. All annual pension contributions have been paid in line with service arrangements.

**Notes on Cash Equivalent Transfer Value for Section B**

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

Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation (2.2% in 2013 – 2014, 5.2% in 2012 – 2013), contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.
Section F: Off-payroll arrangements
The Trust is required to report on any arrangements where staff earning more than £220 per day have been engaged via an off-payroll arrangement for more than six months.

Table 1: For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last for longer than six months

<table>
<thead>
<tr>
<th>Number of existing arrangements at 31 March 2014</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which:</td>
<td></td>
</tr>
<tr>
<td>Number that have existed for less than one year</td>
<td>0</td>
</tr>
<tr>
<td>Number that have existed for between one and two years</td>
<td>0</td>
</tr>
<tr>
<td>Number that have existed for between two and three years</td>
<td>0</td>
</tr>
<tr>
<td>Number that have existed for between three and four years</td>
<td>3</td>
</tr>
<tr>
<td>Number that have existed for more than four years</td>
<td>0</td>
</tr>
</tbody>
</table>

It is confirmed that for each individual, at some point a risk-based assessment of whether assurance over tax and National Insurance arrangements is required has been performed, and where relevant, appropriate assurances have been sought.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than six months

<table>
<thead>
<tr>
<th>Number of new engagements, or those reaching six months duration, between 1 April 2013 and 31 March 2014</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations</td>
<td>0</td>
</tr>
<tr>
<td>Number for whom assurance has been requested</td>
<td>2</td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
</tr>
<tr>
<td>Number for whom assurance has been received</td>
<td>2</td>
</tr>
<tr>
<td>Number for whom assurance has not been received</td>
<td>0</td>
</tr>
<tr>
<td>Number that have been terminated as a result of assurance not being received</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2013 and 31 March 2014

| No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year | 0 |
| No. of individuals that have been deemed “board members and/or senior officials with significant financial responsibility” during the financial year. This figure should include both off-payroll and on-payroll engagements. | 3* |

* Determined as being the Chief Executive, Executive Director of Finance/Deputy Chief Executive and the Acting Director of Finance

Michael McCourt
Chief Executive
28 May 2014
Independent auditors’ report to the Council of Governors of Pennine Care NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion the financial statements, defined below:

• give a true and fair view of the state of the NHS Foundation Trust’s affairs as at 31 March 2014 and of its income and expenditure and cash flows for the year then ended; and
• have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

This opinion is to be read in the context of what we say in the remainder of this report.

What an audit of financial statements involves

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)"). An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

• whether the accounting policies are appropriate to the NHS Foundation Trust’s circumstances and have been consistently applied and adequately disclosed;
• the reasonableness of significant accounting estimates made by the directors; and
• the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinions on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

• the information given in the Strategic Report and the Directors’ Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
• the part of the Directors’ Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Other matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

• in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
• we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
• we have qualified, on any aspect, our opinion on the Quality Report.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Directors’ Responsibilities Statement set out on page 63 the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006: the Audit Code for NHS Foundation Trusts issued by Monitor and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Pennine Care NHS Foundation Trust in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Rebecca Gissing

(Senior Statutory Auditor) for and on behalf of PricewaterhouseCoopers LLP Chartered Accountants and Statutory Auditors Manchester

29 May 2014

(a) The maintenance and integrity of the Pennine Care NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.
Foreword to the accounts

Pennine Care NHS Foundation Trust is registered at 225 Old Street, Ashton-under-Lyne, Lancashire, OL6 7SR. These accounts for the period ended 31 March 2014 have been prepared by Pennine Care NHS Foundation Trust in accordance with Schedule 7, paragraph 24 and 25 of the National Health Service Act 2006. They are in the form which Monitor the Independent Regulator of NHS Foundation Trusts with the approval of HM Treasury directed.

Michael McCourt
Chief Executive
28 May 2014
## Statement of Comprehensive Income for year ended 31 March 2014

### Income

<table>
<thead>
<tr>
<th>NOTE</th>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from patient care activities</td>
<td>3.1</td>
<td>271,377</td>
</tr>
<tr>
<td>Other operating income</td>
<td>3.2</td>
<td>12,238</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>4.1</td>
<td>(279,859)</td>
</tr>
<tr>
<td>Operating surplus/(deficit)</td>
<td></td>
<td>3,756</td>
</tr>
<tr>
<td>Finance income</td>
<td>6.1</td>
<td>58</td>
</tr>
<tr>
<td>Finance costs</td>
<td>6.2</td>
<td>(1,274)</td>
</tr>
<tr>
<td>Surplus/(deficit) for the financial year</td>
<td></td>
<td>2,540</td>
</tr>
<tr>
<td>Public dividend capital dividends payable</td>
<td></td>
<td>(1,782)</td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td></td>
<td>758</td>
</tr>
</tbody>
</table>

### Other comprehensive income

- **Items that will not be reclassified to income and expenditure**
  - Impairments and reversals | (678) | 0 |
  - Gain on transfer by absorption from demising bodies | 2B | 9,635 | 0 |
  - Net gain/(loss) on revaluation of property, plant and equipment | 9 | 3,194 | (1,734) |
  - Net gain/(loss) on revaluation of intangibles | 0 | 0 | 0 |
  - Release of Reserves to Statement of Comprehensive Net Expenditure | 0 | 0 | 0 |
- **Items that may be reclassified to income and expenditure when conditions are met**
  - Net gain/(loss) on available for sale financial assets | 0 | 0 | 0 |

### Total Other Comprehensive Income

<table>
<thead>
<tr>
<th></th>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Other Comprehensive Income</td>
<td>12,151</td>
<td>(1,734)</td>
</tr>
</tbody>
</table>

### Total Comprehensive Income for the year

<table>
<thead>
<tr>
<th></th>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Comprehensive Income for the year</td>
<td>12,909</td>
<td>(6,592)</td>
</tr>
</tbody>
</table>

## Statement of Financial Position as at 31 March 2014

### Non-current assets

<table>
<thead>
<tr>
<th>NOTE</th>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intangible assets</td>
<td>8</td>
<td>472</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>9</td>
<td>96,985</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td></td>
<td>97,457</td>
</tr>
</tbody>
</table>

### Current assets

<table>
<thead>
<tr>
<th></th>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inventories</td>
<td>14</td>
<td>12,067</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>15</td>
<td>20,945</td>
</tr>
<tr>
<td>Total current assets</td>
<td></td>
<td>33,099</td>
</tr>
<tr>
<td>Non-current assets held for sale</td>
<td>11</td>
<td>320</td>
</tr>
<tr>
<td>Total current assets</td>
<td></td>
<td>33,419</td>
</tr>
<tr>
<td>Total assets</td>
<td></td>
<td>130,876</td>
</tr>
</tbody>
</table>

### Non-current liabilities

<table>
<thead>
<tr>
<th></th>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td>16</td>
<td>(15,970)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>18</td>
<td>(1,459)</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions</td>
<td>19</td>
<td>(3,062)</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>(2,953)</td>
<td>(3,147)</td>
</tr>
<tr>
<td>Total non-current liabilities</td>
<td></td>
<td>(23,444)</td>
</tr>
<tr>
<td>Total assets less current liabilities</td>
<td></td>
<td>107,432</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total non-current liabilities</td>
<td></td>
<td>(21,360)</td>
</tr>
<tr>
<td>Total Assets Employed:</td>
<td></td>
<td>86,072</td>
</tr>
</tbody>
</table>
The accounts on pages 153 – 216 were approved by the Board of Directors on 28 May 2014 and signed on its behalf by

Michael McCourt  
Chief Executive  
28 May 2014
Statement of Changes in Taxpayer’s Equity
for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>NOTE</th>
<th>Public Dividend capital £000</th>
<th>Retained earnings £000</th>
<th>Revaluation reserve £000</th>
<th>Total taxpayer’s equity £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>72,765</td>
<td>(1,104)</td>
<td>356</td>
<td>72,017</td>
</tr>
<tr>
<td>Retained surplus for the year</td>
<td>SOCI 0</td>
<td>758</td>
<td>0</td>
<td>758</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant, equipment</td>
<td>9</td>
<td>0</td>
<td>3,194</td>
<td>3,194</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangible assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>7 / 9</td>
<td>0</td>
<td>(678)</td>
<td>(678)</td>
</tr>
<tr>
<td>Gain/(loss) on transfer by absorption from demising bodies</td>
<td>28</td>
<td>0</td>
<td>9,635</td>
<td>9,635</td>
</tr>
<tr>
<td>Transfers between reserves relating to transfers by absorption</td>
<td>28</td>
<td>0</td>
<td>(2,404)</td>
<td>(2,404)</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PDC adjustment following cash settlement of balances transferred from demising bodies</td>
<td>28</td>
<td>146</td>
<td>0</td>
<td>146</td>
</tr>
<tr>
<td>New PDC Received</td>
<td>SCF 1,000</td>
<td>0</td>
<td>0</td>
<td>1,000</td>
</tr>
<tr>
<td>PDC Repaid In Year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PDC Written Off</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>73,911</td>
<td>6,885</td>
<td>5,276</td>
<td>86,072</td>
</tr>
</tbody>
</table>

Statement of Changes in Taxpayer’s Equity for the year ended 31 March 2013

<table>
<thead>
<tr>
<th>NOTE</th>
<th>Public Dividend capital £000</th>
<th>Retained earnings £000</th>
<th>Revaluation reserve £000</th>
<th>Total taxpayer’s equity £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2012</td>
<td>72,692</td>
<td>3,754</td>
<td>2,090</td>
<td>78,536</td>
</tr>
<tr>
<td>Retained deficit for the year</td>
<td>SOCI 0</td>
<td>(4,858)</td>
<td>0</td>
<td>(4,858)</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant, equipment</td>
<td>9</td>
<td>0</td>
<td>(1,734)</td>
<td>(1,734)</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangible assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gain/(loss) on transfer by absorption from demising bodies</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Release of reserves to SOCI</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New PDC received</td>
<td>SCF 73</td>
<td>0</td>
<td>0</td>
<td>73</td>
</tr>
<tr>
<td>PDC repaid in year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PDC written off</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balance at 31 March 2013</td>
<td>72,765</td>
<td>(1,104)</td>
<td>356</td>
<td>72,017</td>
</tr>
</tbody>
</table>
Statement of Cash Flows for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>NOTE</th>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash flows from operating activities</td>
<td>SOCI</td>
<td>3,756</td>
</tr>
<tr>
<td>Operating Surplus/(Deficit)</td>
<td>4.1</td>
<td>3,260</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>7</td>
<td>3,859</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Release of PF/deferred credit</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Increase)/decrease in inventories</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>(Increase)/decrease in trade and other receivables</td>
<td>14</td>
<td>(7,908)</td>
</tr>
<tr>
<td>(Increase)/decrease in other current assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increase in trade and other payables</td>
<td>16</td>
<td>936</td>
</tr>
<tr>
<td>(Decrease)/Increase in other current liabilities</td>
<td>17</td>
<td>(194)</td>
</tr>
<tr>
<td>(Decrease)/Increase in provisions</td>
<td>19</td>
<td>(1,139)</td>
</tr>
<tr>
<td>Other movements in operating cash flow</td>
<td>(4)</td>
<td>1</td>
</tr>
<tr>
<td>Net Cash Inflow from Operating Activities</td>
<td>2,566</td>
<td>12,727</td>
</tr>
<tr>
<td>Cash flows from investing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Received</td>
<td>6.1</td>
<td>58</td>
</tr>
<tr>
<td>(Payments) for Property, Plant and Equipment</td>
<td>9 / 16</td>
<td>(5,969)</td>
</tr>
<tr>
<td>Proceeds of disposal of assets held for sale (PPE)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>(Payments) for intangible assets</td>
<td>(129)</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds of disposal of assets held for sale (Intangible)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net Cash (Outflow) from Investing Activities</td>
<td>(6,036)</td>
<td>(5,925)</td>
</tr>
<tr>
<td>Cash flows from financing activities</td>
<td>SOCIITE</td>
<td>1,000</td>
</tr>
<tr>
<td>Public Dividend Capital received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Dividend Capital adjustment for cash settlement of legacy balances</td>
<td>146</td>
<td>0</td>
</tr>
<tr>
<td>Public Dividend Capital paid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PDC dividends paid</td>
<td>(1,452)</td>
<td>(2,035)</td>
</tr>
<tr>
<td>Loans received from DH – Independent Trust Financing Facility (ITFF)</td>
<td>18</td>
<td>(1,250)</td>
</tr>
<tr>
<td>Loans repaid to DH – ITFF</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest paid</td>
<td>6.2</td>
<td>(181)</td>
</tr>
<tr>
<td>Interest element of Private Finance Initiative obligations</td>
<td>6.2</td>
<td>(1,067)</td>
</tr>
<tr>
<td>Capital element of Private Finance Initiative obligations</td>
<td>18</td>
<td>(205)</td>
</tr>
<tr>
<td>Net Cash inflow/Outflow from Financing Activities</td>
<td>(3,009)</td>
<td>(4,658)</td>
</tr>
<tr>
<td>Net (decrease)/increase in cash and cash equivalents</td>
<td>(6,479)</td>
<td>2,144</td>
</tr>
<tr>
<td>Cash and Cash Equivalents at Beginning of the year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies</td>
<td>27,424</td>
<td>25,280</td>
</tr>
<tr>
<td>Cash and Cash Equivalents at year end</td>
<td>20,945</td>
<td>27,424</td>
</tr>
</tbody>
</table>

1. Accounting policies

Monitor has directed that the annual report and accounts of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual, which shall be agreed with HM Treasury. Consequently, these financial statements have been prepared in accordance with the 2013 – 2014 Foundation Trust Annual Reporting Manual. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Foundation Trust Annual Reporting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts. The accounts have been prepared on a going concern basis.

1.1 Accounting standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

- IFRS 10 – Consolidated Financial Statements (effective financial year 2014/15)
- IFRS 11 – Joint Arrangements (effective financial year 2014/15)
- IFRS 12 – Disclosure of Interests in Other Entities (effective financial year 2014/15)

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.3 Critical accounting judgments

In the application of the Trust’s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4 Key sources of estimation uncertainty

The Trust has made assumptions and estimates in the following areas in preparing the accounts:

- In making “Other” provision (see note 19) for costs associated with correcting discrepancies in payroll data, the Trust has assumed that differences will have arisen over not more than a three year period on average, and has made assumptions that the average pay of staff affected will be equivalent to the top of band 3 Agenda for Change or equal to the Trust's median pay in 2011/12 (which was £26,700), depending on the nature of the difference identified.

IAS 32 – Financial Instruments (effective financial year 2014/15)

The Trust has considered the above new standards, interpretations and amendments to be published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust’s financial statements, apart from some additional disclosures. The Trust has not made early adoption of any other accounting standards, amendments or interpretations in year.
In making assumptions regarding restructuring costs (see note 19) the Trust has utilised actual estimates provided by payroll where applicable; where this is not possible the Trust has taken a prudent approach to estimating the likely costs of delivering the planned service re-design. It is not considered that the degree of variability that could arise as a result of these assumptions would prove to be material, there is not therefore any significant risk of material adjustments being required to the carrying value of assets and liabilities within the next financial year as a result of these estimates.

1.5 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment related payments are recognised in the period in which the service is received from employees.

Pension costs

NHS Pension Scheme

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

Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Property, Plant and Equipment

Recognition

Property, plant and equipment (PPE) is capitalised where:

- It is held for use in delivering service or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- It is expected to be used for more than one financial year; and
- The cost of the item can be measured reliably and meet the capitalisation threshold in that:
  - Individually they have a cost of at least £5,000; or
  - Form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent or they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

- Form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Measurement – valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the Trust’s services or for administrative purposes are measured subsequently at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed by external independent valuers with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date.

Fair values are determined as follows:

- Land and non specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS23 for fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use. Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset’s carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits, in all cases this is assessed as being straight-line over the life of the asset. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Revaluation gain and losses

In accordance with the FT ARM impairments that are due to a loss of economic benefits or service potential in the asset are charged to the operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.
An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘Held for Sale’ once all of the following criteria are met:

• The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• The sale must be highly probable, i.e.:
  • Management are committed to a plan to sell the asset;
  • An active programme has begun to find a buyer and complete the sale;
  • The asset is being actively marketed at a reasonable price;
  • The sale is expected to be completed within 12 months of the date of classification as ‘Held for Sale’;
• The actions needed to complete the plan indicate it is unlikely the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the ‘fair value less costs to sell’ falls below the carrying amount.

Assets are de-recognised when all material sale contract conditions have been met.

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

Donated assets

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

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

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury’s FReM, are accounted for as ‘on-Statement of Financial Position’ by the Trust. In accordance with IAS 17, the underlying assets are recognised as Property, Plant and Equipment at their fair value together with an equivalent financial liability. Subsequently the assets are accounted for as property, plant and equipment, and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income. Lifecycle maintenance costs attributable to the Trust are capitalised when they arise.

1.9 Intangible assets

Recognition

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

Software

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

Measurement

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

Subsequently intangible assets are measured at fair value, with amortised historic cost being taken as fair value.

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

Amortisation

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

1.10 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value, measured on a first-in, first-out (FIFO) basis.

1.12 Financial assets and financial liabilities

Recognition

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

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

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as ‘Fair Value through Income and Expenditure’, Loans and receivables or ‘Available-for-sale financial assets’. Financial liabilities are classified as ‘Fair Value through Income and Expenditure’ or as ‘Other financial liabilities’.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust’s loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and ‘other receivables’.
Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

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

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

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

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

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

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

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

1.13 Leases

Finance leases
The Trust does not have any finance leases.

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

Lease of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.14 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time of the money is significant, the estimated risk-adjusted cash flows are discounted using the HM Treasury’s discount rates in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury’s pension discount rate of 1.80% (2012 – 2013 2.35%) in real terms.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 19.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any ‘excesses’ payable in respect of particular claims are charged to operating expenses when the liability arises.

Legal costs
The Trust will recognise the costs arising from legal cases that are not covered by risk polling schemes with NHSLA. A provision for estimated costs where there is a probable outflow of economic benefit arising as a result of past events.

Restructuring and redundancy costs
Where the Trust has committed to a course of action that will give rise to future restructuring or redundancy costs, the estimated value of such costs shall be recognised as a provision.

1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

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

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

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

1.16 Public Dividend Capital

Non-clinical risk pooling
The NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated assets;

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding any cash balances held in GBS accounts that relate to a short-term working capital facility;

(iii) for 2013 – 2014 financial year only, net assets and liabilities transferred from NHS bodies that ceased to exist on 1 April 2013; and

(iv) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer) the dividend for the year is calculated on the actual average relevant net assets as set out in the ‘pre-audit’ version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

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1.17 Value Added Tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation Tax
The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A[3] to [8] ICTA 1988). Accordingly, the Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum.

1.19 Foreign exchange
The functional and presentation currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Any resulting exchange gains or losses are taken to the Statement of Comprehensive Income.

1.20 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts. Irrecoverable VAT is charged to the relevant functional expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Losses and special payments
Losses and special payments are charges to the relevant functional expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Transfers from other NHS bodies
For functions that have been transferred to the trust from another NHS body, the assets and liabilities transferred are recognised in the accounts at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred from PCTs that ceased to exist on 1 April 2013 is recognised within the income and expenditure reserve, in accordance with the principles of absorption accounting set out in HM Treasury Financial Reporting Manual 2013 – 2014, modified according to the departure agreed by the Department of Health for transfers on 1 April 2013. In 2013 – 2014 this applies to net assets transferred to Pennine Care from Trafford PCT, Bury PCT and Heywood, Middleton and Rochdale PCT on 1 April 2013. For property, plant and equipment assets and intangible assets, the net book value shall be recognised in the trust’s accounts. Where the transferring body recognised a revaluation reserve attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

1.23 Consolidation of charitable funds
HM Treasury previously granted dispensation to the application of IAS 27 (revised) by NHS foundation trusts solely in relation to the consolidation of NHS charitable funds. From 2013 – 2014 the Treasury dispensation is no longer available therefore the Trust is required to consolidate any material NHS charitable funds. This represents a change in accounting policy and requires treatment in accordance with IAS 8, with prior year comparatives and opening balance sheet restated where applicable. In 2013 – 2014 the Trust does not have any material charitable funds, and did not have any in 2012 – 2013, therefore no restatements are required.

1.24 Associates
Associate entities are those over which the trust has the power to exercise a significant influence, but not control. Associate entities are recognised in the trust’s financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the trust’s share of the entity’s profit or loss, or other gains and losses following acquisition. It is also reduced when any distribution (e.g. share dividends) are received by the trust from the associate.

2. Operating Segments
All activity at Pennine Care NHS Foundation Trust is healthcare related and a large majority of the Trust’s income is received from within UK Government departments. The main proportion of the operating expenses are payroll related and are for the staff directly involved in the provision of health care and the indirect and overhead costs associated with that provision. The Trust operates in a limited geographic area, primarily Greater Manchester with some services delivered across North West England. Therefore it is deemed that the business activities which earn the revenues for the Trust and in turn incur the expenses are one provision, which it is deemed appropriate to identify as a single segment, namely ‘healthcare’.

The Trust identifies the Trust Board (which includes all Executive and Non-Executive Directors) as the Chief Operating Decision Maker (CODM) as defined by IFRS 8. Monthly operating results are reported to Trust Board. The financial position of the Trust in month and for the year to date are reported, along with projections for future performance and position, as a position for the whole Trust rather than as component parts making up a whole. The Trust Board does not have separate directors for particular service areas or divisions. The Trust’s external reporting to Monitor (the regulator) is on a whole Trust basis, which also implies the Trust is a single segment.

All decisions affecting the Trust’s future direction and viability are made based on the overall total presented to the Board; the Trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.
3. Revenue

3.1 Operating income from patient care activities

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Health Authorities</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>NHS Trusts</td>
<td>1,047</td>
<td>191</td>
</tr>
<tr>
<td>Primary Care Trusts</td>
<td>0</td>
<td>222,401</td>
</tr>
<tr>
<td>Clinical Commissioning Groups and NHS England</td>
<td>240,959</td>
<td>0</td>
</tr>
<tr>
<td>Foundation Trusts</td>
<td>135</td>
<td>61</td>
</tr>
<tr>
<td>Local authorities</td>
<td>25,847</td>
<td>8,044</td>
</tr>
<tr>
<td>Department of Health</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>NHS other</td>
<td>24</td>
<td>233</td>
</tr>
<tr>
<td>Non-NHS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private patients</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Overseas patients (non-reciprocal)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Injury costs recovery</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>3,365</td>
<td>1,033</td>
</tr>
<tr>
<td></td>
<td><strong>271,377</strong></td>
<td><strong>231,986</strong></td>
</tr>
</tbody>
</table>

All Primary Care Trusts and Strategic Health Authorities ceased to exist on 31 March 2013. Newly created commissioning bodies included NHS England and local Clinical Commissioning Groups came into being on 1 April 2013.

3.2 Other operating income

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue relating to staff recharges</td>
<td>2,337</td>
<td>515</td>
</tr>
<tr>
<td>Education and training</td>
<td>5,337</td>
<td>3,603</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>2,598</td>
<td>1,536</td>
</tr>
<tr>
<td>Research and development</td>
<td>516</td>
<td>445</td>
</tr>
<tr>
<td>Reversal of impairments recognised as income</td>
<td>1,045</td>
<td>0</td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other revenue</td>
<td>405</td>
<td>5,876</td>
</tr>
<tr>
<td></td>
<td><strong>12,238</strong></td>
<td><strong>11,975</strong></td>
</tr>
<tr>
<td>Total operating revenue</td>
<td><strong>283,615</strong></td>
<td><strong>243,961</strong></td>
</tr>
</tbody>
</table>

Additional management information has resulted in income classified as ‘other revenue’ in 2012 – 2013 to be reclassified in 2013 – 2014 to other categories within other operating income.

3.3 Private patient income

The Trust does not receive any income related to private patient activity.

3.4 Operating lease income

The Trust does not receive any income in respect of operating leases.

3.5 Revenue from Commissioner Requested Services

Pennine Care NHS Foundation Trust’s Provider License specifies that certain services will be treated as Commissioner Requested Services (CRS), previously known as mandatory services. These services are generally those patient care services included within block contract arrangements with NHS commissioners, and some local authority commissioned services.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost and volume contract income</td>
<td>8,666</td>
<td>7,778</td>
</tr>
<tr>
<td>Block contract income</td>
<td>118,975</td>
<td>115,114</td>
</tr>
<tr>
<td>Community Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Block contract income</td>
<td>126,652</td>
<td>98,263</td>
</tr>
<tr>
<td>Total Commissioner Requested Services revenue</td>
<td><strong>254,293</strong></td>
<td><strong>221,155</strong></td>
</tr>
<tr>
<td>Other revenue from patient care</td>
<td>17,084</td>
<td>10,831</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>12,238</td>
<td>11,975</td>
</tr>
<tr>
<td>Total non-commissioner requested services revenue</td>
<td><strong>29,322</strong></td>
<td><strong>22,806</strong></td>
</tr>
<tr>
<td>Total operating revenue</td>
<td><strong>283,615</strong></td>
<td><strong>243,961</strong></td>
</tr>
</tbody>
</table>
### 4.1 Operating expenses

<table>
<thead>
<tr>
<th>Services from other NHS Trusts</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,411</td>
<td>4,860</td>
<td></td>
</tr>
<tr>
<td>Services from PCTs</td>
<td>0</td>
<td>9,750</td>
</tr>
<tr>
<td>Services from CCGs and NHS England</td>
<td>253</td>
<td>0</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Services from Foundation Trusts</td>
<td>2,795</td>
<td>2,401</td>
</tr>
<tr>
<td>Purchase of healthcare from non NHS bodies</td>
<td>1</td>
<td>50</td>
</tr>
<tr>
<td>Employee expenses – directors’ emoluments</td>
<td>1,216</td>
<td>663</td>
</tr>
<tr>
<td>Employee expenses – staff costs</td>
<td>213,000</td>
<td>181,475</td>
</tr>
<tr>
<td>Trust Chair and Non Executive Directors</td>
<td>126</td>
<td>128</td>
</tr>
<tr>
<td>Supplies and services – clinical (excluding drugs)</td>
<td>7,486</td>
<td>6,066</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>1,954</td>
<td>2,860</td>
</tr>
<tr>
<td>Drugs costs</td>
<td>2,289</td>
<td>2,409</td>
</tr>
<tr>
<td>Establishment</td>
<td>3,914</td>
<td>4,055</td>
</tr>
<tr>
<td>Research and development (including staff costs)</td>
<td>386</td>
<td>454</td>
</tr>
<tr>
<td>Transport including business travel</td>
<td>4,116</td>
<td>3,454</td>
</tr>
<tr>
<td>Premises</td>
<td>10,479</td>
<td>8,937</td>
</tr>
<tr>
<td>Increase/(decrease) in provision for the impairments of receivables</td>
<td>11</td>
<td>43</td>
</tr>
<tr>
<td>Increase in other provisions</td>
<td>514</td>
<td>0</td>
</tr>
<tr>
<td>Rentals under operating leases</td>
<td>13,832</td>
<td>3,699</td>
</tr>
<tr>
<td>Inventories write down</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Depreciation</td>
<td>3,188</td>
<td>2,574</td>
</tr>
<tr>
<td>Amortisation</td>
<td>72</td>
<td>49</td>
</tr>
<tr>
<td>Impairments and reversals of property, plant and equipment</td>
<td>4,904</td>
<td>5,123</td>
</tr>
<tr>
<td>Impairments and reversals of intangible assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loss on disposal of property, plant and equipment</td>
<td>(4)</td>
<td>0</td>
</tr>
<tr>
<td>Audit fees – statutory audit (Note 26)</td>
<td>64</td>
<td>65</td>
</tr>
<tr>
<td>Audit fees – regulatory reporting</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Audit fees – internal audit</td>
<td>114</td>
<td>161</td>
</tr>
<tr>
<td>Other auditor’s remuneration</td>
<td>119</td>
<td>66</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>475</td>
<td>307</td>
</tr>
<tr>
<td>Legal fees</td>
<td>81</td>
<td>491</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>327</td>
<td>483</td>
</tr>
<tr>
<td>Education and training</td>
<td>1,263</td>
<td>916</td>
</tr>
<tr>
<td>Redundancy</td>
<td>1,057</td>
<td>3,571</td>
</tr>
<tr>
<td>Other</td>
<td>1,415</td>
<td>958</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>279,859</strong></td>
<td><strong>246,058</strong></td>
</tr>
</tbody>
</table>

Comparative figures classifications for 2012 – 2013 have been re-presented to maintain consistency with 2013 – 2014 presentation.

### 4.2 Operating leases

#### Trust as a lessee

<table>
<thead>
<tr>
<th>Land</th>
<th>Property and Equipment</th>
<th>Other</th>
<th>Total</th>
<th>2013 – 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>6</td>
<td>13,782</td>
<td>44</td>
<td>13,832</td>
<td>3,699</td>
</tr>
</tbody>
</table>

#### Payments recognised as an expense

<table>
<thead>
<tr>
<th>Minimum lease payments</th>
<th>6</th>
<th>13,782</th>
<th>44</th>
<th>13,832</th>
<th>3,699</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingent rents</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sub-lease payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
<td>13,782</td>
<td>44</td>
<td>13,832</td>
<td>3,699</td>
</tr>
</tbody>
</table>

#### Payable:

| No later than one year | 0 | 4,040 | 14 | 4,054 | 3,530 |
| Between one and five years | 0 | 15,078 | 16 | 15,094 | 12,682 |
| After five years        | 0 | 19,121 | 0  | 19,121 | 16,537 |
| **Total**               | 0 | 38,239 | 30 | 38,269 | 32,749 |

Total future sublease payments expected to be received: 0 0

No individual leases are considered significant for further disclosure.
5. Employee benefits and staff numbers

5.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanently employed</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>170,329</td>
<td>155,804</td>
</tr>
<tr>
<td>Social security costs</td>
<td>11,463</td>
<td>11,463</td>
</tr>
<tr>
<td>Employer contributions to NHS Pensions scheme</td>
<td>20,855</td>
<td>20,855</td>
</tr>
<tr>
<td>Other pension costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>1,057</td>
<td>1,057</td>
</tr>
<tr>
<td>Agency/contract staff</td>
<td>11,830</td>
<td>0</td>
</tr>
</tbody>
</table>

Total employee benefits 215,534 189,179 26,355 185,879

Total employee benefits are analysed as:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>
| Monthly average staff numbers
<table>
<thead>
<tr>
<th>Number</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money purchase schemes</td>
<td>0</td>
</tr>
<tr>
<td>Defined benefit schemes</td>
<td>8</td>
</tr>
</tbody>
</table>

5.2 Directors’ remuneration

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Directors’ remuneration</td>
<td>1,088</td>
</tr>
<tr>
<td>Employer contributions to the pension scheme</td>
<td>128</td>
</tr>
<tr>
<td>Total</td>
<td>1,216</td>
</tr>
</tbody>
</table>

The highest paid director in 2013 – 2014 was Mr M. Roe, receiving salary in the bracket £160,000 – £165,000. The highest paid director in 2012 – 2013 was Mr J. Archer, receiving salary in the bracket £170,000 – £175,000. Full disclosure is given in the Remuneration Report.

5.3 Staff Numbers

<table>
<thead>
<tr>
<th>Total</th>
<th>Permanently employed</th>
<th>Other</th>
<th>Number</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and dental</td>
<td>190</td>
<td>137</td>
<td>53</td>
<td>182</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>1,202</td>
<td>1,202</td>
<td>0</td>
<td>943</td>
</tr>
<tr>
<td>Healthcare assistants and other support staff</td>
<td>887</td>
<td>887</td>
<td>0</td>
<td>903</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>1,850</td>
<td>1,850</td>
<td>0</td>
<td>1,608</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting learners</td>
<td>56</td>
<td>56</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>851</td>
<td>851</td>
<td>0</td>
<td>661</td>
</tr>
<tr>
<td>Social Care Staff</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bank and agency staff</td>
<td>434</td>
<td>434</td>
<td>407</td>
<td>407</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>65</td>
</tr>
</tbody>
</table>

Total | 5,476 | 4,989 | 487 | 4,769 |

Of the above – staff engaged on capital projects 0 | 0 | 0 | 0
5.4 Exit Packages agreed

<table>
<thead>
<tr>
<th>Exit package cost band (including any special payment element)</th>
<th>2013 – 2014</th>
<th>Total number of exit packages by cost band</th>
<th>2012 – 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*Number of compulsory redundancies</td>
<td>*Number of other departures agreed</td>
<td>Number</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>6</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>£10,001 – £25,000</td>
<td>4</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>£25,001 – £50,000</td>
<td>3</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>£50,001 – £100,000</td>
<td>3</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>£100,001 – £150,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£150,001 – £200,000</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>&gt;£200,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total number of exit packages by type (total cost)</td>
<td>16</td>
<td>70</td>
<td>86</td>
</tr>
<tr>
<td>Total resource cost (£000s)</td>
<td>426</td>
<td>2,249</td>
<td>2,675</td>
</tr>
</tbody>
</table>

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

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

5.5 Ill health retirements

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>£000s</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>184</td>
<td>305</td>
</tr>
</tbody>
</table>
5.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

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

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained.

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infertility. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

d) Future requirements

Pennine Care NHS Foundation Trust estimates its employer contributions for 2014-15 will be £23.5m. The published annual accounts of the NHS Pension Scheme in 2012 – 2013 disclosed a liability for the whole scheme of £284bn, which is underwritten by the Exchequer. Employer contribution rates in 2014-15 will remain at 14%, but are forecast to increase from 1 April 2015 on the basis of the most recent valuation of the scheme.
### 6.1 Finance Income

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rental revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFI finance lease revenue (planned)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PFI finance lease revenue (contingent)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other finance lease revenue</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Interest revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other loans and receivables</td>
<td>58</td>
<td>117</td>
</tr>
<tr>
<td>Impaired financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>58</td>
<td>117</td>
</tr>
<tr>
<td><strong>Total investment income</strong></td>
<td>58</td>
<td>117</td>
</tr>
</tbody>
</table>

### 6.2 Finance Costs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interest</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loans from the Independent Trust Financing Facility</td>
<td>206</td>
<td>212</td>
</tr>
<tr>
<td>Finance leases</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest on obligations under finance leases</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest on obligations under PFI contracts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– main finance cost</td>
<td>1,067</td>
<td>1,029</td>
</tr>
<tr>
<td>– contingent finance cost</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total interest expense</strong></td>
<td>1,273</td>
<td>1,241</td>
</tr>
<tr>
<td>Provisions – unwinding of discount</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,274</td>
<td>1,243</td>
</tr>
</tbody>
</table>

### 7.1 Impairment of PPE and intangibles (expenditure)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandonment of assets in course of construction</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Over specification of assets</td>
<td>571</td>
<td>0</td>
</tr>
<tr>
<td>Changes in market price</td>
<td>4,310</td>
<td>5,123</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,904</td>
<td>5,123</td>
</tr>
</tbody>
</table>

### 7.2 Reversals of impairment of assets (income)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandonment of assets in course of construction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Over specification of assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Changes in market price</td>
<td>1,045</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,045</td>
<td>0</td>
</tr>
</tbody>
</table>
8.1 Intangible non-current assets

<table>
<thead>
<tr>
<th>Software purchased</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013-2014</strong></td>
<td></td>
</tr>
<tr>
<td><strong>At 1 April 2013</strong></td>
<td></td>
</tr>
<tr>
<td>Purchased</td>
<td>475</td>
</tr>
<tr>
<td>Additions – purchased</td>
<td>129</td>
</tr>
<tr>
<td>Additions – internally generated</td>
<td>0</td>
</tr>
<tr>
<td>Additions – donated</td>
<td>0</td>
</tr>
<tr>
<td>Additions – government granted</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>275</td>
</tr>
<tr>
<td>Reclassified as held for sale</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation gains</td>
<td>0</td>
</tr>
<tr>
<td>Impairments charged to reserves</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments charged to reserves</td>
<td>0</td>
</tr>
<tr>
<td><strong>At 31 March 2014</strong></td>
<td>879</td>
</tr>
</tbody>
</table>

Amortisation

<table>
<thead>
<tr>
<th>Accumulated at 1 April 2013</th>
<th>335</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided during the year</td>
<td>72</td>
</tr>
<tr>
<td>Reclassified as held for sale</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation or indexation gains</td>
<td>0</td>
</tr>
<tr>
<td>Impairments charged to operating expenses</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments charged to operating expenses</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
</tr>
<tr>
<td><strong>Accumulated at 31 March 2014</strong></td>
<td>407</td>
</tr>
<tr>
<td><strong>Net Book Value at 31 March 2014</strong></td>
<td>472</td>
</tr>
</tbody>
</table>

Net book value at 31 March 2014 comprises:

<table>
<thead>
<tr>
<th>Purchased</th>
<th>472</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donated</td>
<td>0</td>
</tr>
<tr>
<td>Government granted</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>472</td>
</tr>
</tbody>
</table>
### 8.2 Intangible non-current assets

<table>
<thead>
<tr>
<th>Software purchased</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012-2013</strong></td>
<td>£000</td>
</tr>
</tbody>
</table>

#### Cost or valuation:

<table>
<thead>
<tr>
<th>Description</th>
<th>2012-2013 £000</th>
<th>2013-2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>At 1 April 2012</td>
<td>339</td>
<td>339</td>
</tr>
<tr>
<td>Additions – purchased</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions – internally generated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions – donated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions – government granted</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>136</td>
<td>136</td>
</tr>
<tr>
<td>Reclassified as held for sale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation gains</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>At 31 March 2013</strong></td>
<td>475</td>
<td>475</td>
</tr>
</tbody>
</table>

#### Amortisation:

<table>
<thead>
<tr>
<th>Description</th>
<th>2012-2013 £000</th>
<th>2013-2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accumulated at 1 April 2012</td>
<td>286</td>
<td>286</td>
</tr>
<tr>
<td>Provided during the year</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>Reclassified as held for sale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation or indexation gains</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments charged to operating expenses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
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#### Net book value at 31 March 2013

- **Purchased**: 140 £000
- **Donated**: 0 £000
- **Government granted**: 0 £000
- **Total at 31 March 2013**: 140 £000
## 9.1 Property, plant and equipment 2013 – 2014

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<th>Buildings excluding dwellings</th>
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<th>Transport equipment</th>
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<th>Furniture and fittings</th>
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<tr>
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### Revaluation Reserve Balance for Property, Plant and Equipment

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<th>Transport equipment</th>
<th>Information technology</th>
<th>Furniture and fittings</th>
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### Additions to Assets Under Construction in 2013 – 2014

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### 9.2 Property, plant and equipment 2012 – 2013

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<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Total £000</th>
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<td>(3,710)</td>
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<td>6,033</td>
<td>1,502</td>
<td>295</td>
<td>3,318</td>
<td>89,047</td>
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**Depreciation**

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**Net book value at 31 March 2013**

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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
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<td>68,575</td>
<td>6,033</td>
<td>422</td>
<td>44</td>
<td>1,606</td>
<td>85,981</td>
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**Asset financing:**

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<tr>
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Revaluation Reserve Balance for Property, Plant and Equipment

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<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Total £000</th>
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<td>(1,734)</td>
</tr>
<tr>
<td>At 31 March</td>
<td>270</td>
<td>86</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>356</td>
</tr>
</tbody>
</table>

9.3 Economic life of property, plant and equipment

<table>
<thead>
<tr>
<th>Property, Plant and Equipment</th>
<th>Min life years</th>
<th>Max life years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Buildings excluding dwellings</td>
<td>25</td>
<td>80</td>
</tr>
<tr>
<td>Plant and machinery</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Transport equipment</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Information technology</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

9.4 Economic life of intangible assets

<table>
<thead>
<tr>
<th>Property, Plant and Equipment</th>
<th>Min life years</th>
<th>Max life years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Software – purchased</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

9.5 Revaluation of PPE

In 2013 – 2014 the Trust obtained a full valuation of the land and buildings within the estate, including assets transferred by absorption from demised Primary Care Trusts. The assessment was undertaken by an independent expert at the Valuation Office Agency, and included site visits across the estate. The Valuation Office Agency has been carrying out asset valuations for Pennine Care NHS Foundation Trust continuously for 5 years. The effective date of revaluation was 31 March 2014.

The valuations have been undertaken having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation – Professional Standards 8th Edition. The basis of the valuation was “Market Value” based on “Existing Use Valuation” (EUV).
## 10.1 Property, plant and equipment held under finance lease 2013 – 2014

<table>
<thead>
<tr>
<th></th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost or valuation:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At 1 April 2013</td>
<td>0</td>
<td>12,651</td>
<td>12,651</td>
</tr>
<tr>
<td>Transfers by absorption 1 April 2013</td>
<td>585</td>
<td>0</td>
<td>585</td>
</tr>
<tr>
<td>Additions</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications as held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Upward revaluation</td>
<td>0</td>
<td>408</td>
<td>408</td>
</tr>
<tr>
<td>Impairments – write down of accumulated depreciation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments – recognised in expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>At 31 March 2014</strong></td>
<td>585</td>
<td>13,059</td>
<td>13,644</td>
</tr>
<tr>
<td><strong>Depreciation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated at 1 April 2013</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>0</td>
<td>351</td>
<td>351</td>
</tr>
<tr>
<td>Reclassifications as held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Upward revaluation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments – write down of accumulated depreciation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments – recognised in expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Accumulated at 31 March 2014</strong></td>
<td>0</td>
<td>351</td>
<td>351</td>
</tr>
<tr>
<td><strong>Net book value at 31 March 2014</strong></td>
<td>585</td>
<td>12,708</td>
<td>13,293</td>
</tr>
<tr>
<td><strong>Asset financing:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owned</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Held on finance lease</td>
<td>585</td>
<td>0</td>
<td>585</td>
</tr>
<tr>
<td>On-SOFP PFI contracts</td>
<td>0</td>
<td>12,708</td>
<td>12,708</td>
</tr>
<tr>
<td>PFI residual: interests</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>585</td>
<td>12,708</td>
<td>13,293</td>
</tr>
</tbody>
</table>

The above assets are included in the Trust’s total PPE disclosed in note 9. Land received via transfer by absorption is long-leasehold with no rent payable, there is no associated liability.

## 10.2 Property, plant and equipment held under finance lease (PFI) 2012 – 2013

<table>
<thead>
<tr>
<th></th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost or valuation:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At 1 April 2012</td>
<td>0</td>
<td>14,263</td>
<td>14,263</td>
</tr>
<tr>
<td>Additions</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications as held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Upward revaluation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments – write down of accumulated depreciation</td>
<td>0</td>
<td>(591)</td>
<td>(591)</td>
</tr>
<tr>
<td>Impairments – recognised in expenditure</td>
<td>0</td>
<td>(1,021)</td>
<td>(1,021)</td>
</tr>
<tr>
<td>Reversal of impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>At 31 March 2013</strong></td>
<td>0</td>
<td>12,651</td>
<td>12,651</td>
</tr>
<tr>
<td><strong>Depreciation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated at 1 April 2012</td>
<td>0</td>
<td>197</td>
<td>197</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>0</td>
<td>394</td>
<td>394</td>
</tr>
<tr>
<td>Reclassifications as held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Upward revaluation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments – write down of accumulated depreciation</td>
<td>0</td>
<td>(591)</td>
<td>(591)</td>
</tr>
<tr>
<td>Impairments – recognised in expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Accumulated at 31 March 2013</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net book value at 31 March 2013</strong></td>
<td>585</td>
<td>12,708</td>
<td>13,293</td>
</tr>
<tr>
<td><strong>Asset financing:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owned</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Held on finance lease</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>On-SOFP PFI contracts</td>
<td>0</td>
<td>12,651</td>
<td>12,651</td>
</tr>
<tr>
<td>PFI residual: interests</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2013</strong></td>
<td>0</td>
<td>12,651</td>
<td>12,651</td>
</tr>
</tbody>
</table>

The above assets are included in the Trust’s total PPE disclosed in note 9.
### 11.1 Non-current assets held for sale 2013 – 2014

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Buildings excluding dwellings</th>
<th>Other property, plant and equipment</th>
<th>Intangible assets</th>
<th>Other assets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance brought forward 1 April 2013</strong></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>500</td>
</tr>
<tr>
<td>Plus assets classified as held for sale in the year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less assets sold in the year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less impairment of assets held for sale</td>
<td>(180)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(180)</td>
</tr>
<tr>
<td>Plus reversal of impairment of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less assets no longer classified as held for sale, for reasons other than disposal by sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Balance carried forward 31 March 2014</strong></td>
<td>320</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>320</td>
</tr>
</tbody>
</table>

### 11.2 Non-current assets held for sale 2012 – 2013

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Buildings excluding dwellings</th>
<th>Other property, plant and equipment</th>
<th>Intangible assets</th>
<th>Other assets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance brought forward 1 April 2012</strong></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plus assets classified as held for sale in the year</td>
<td>500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>500</td>
</tr>
<tr>
<td>Less assets sold in the year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less impairment of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plus reversal of impairment of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less assets no longer classified as held for sale, for reasons other than disposal by sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Balance carried forward 31 March 2013</strong></td>
<td>500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>500</td>
</tr>
</tbody>
</table>
12. Capital Commitments

Contracted capital commitments at 31 March not otherwise included in these annual accounts:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2014 £000</th>
<th>31 March 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property, plant and equipment</td>
<td>330</td>
<td>2,522</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>330</td>
<td>2,522</td>
</tr>
</tbody>
</table>

13. Better Payment Practice Code

13.1 Measure of compliance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total invoices paid in the year</td>
<td>54,061</td>
<td>76,554</td>
<td>47,029</td>
<td>74,867</td>
</tr>
<tr>
<td>Total invoices paid within target</td>
<td>51,706</td>
<td>74,145</td>
<td>44,705</td>
<td>72,541</td>
</tr>
<tr>
<td>Percentage of invoices paid within target</td>
<td>95.64%</td>
<td>96.85%</td>
<td>95.06%</td>
<td>96.89%</td>
</tr>
</tbody>
</table>

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

13.2 The Late Payment of Commercial Debts (Interest) Act 1998

<table>
<thead>
<tr>
<th></th>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts included in finance costs from claims made under this legislation</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Compensation paid to cover debt recovery costs under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

14.1 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>31 March 2014 £000</th>
<th>31 March 2013 £000</th>
<th>31 March 2014 £000</th>
<th>31 March 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables</td>
<td>7,275</td>
<td>1,578</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prepayments and accrued income</td>
<td>1,618</td>
<td>824</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other receivables</td>
<td>3,199</td>
<td>1,684</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provision for the impairment of receivables</td>
<td>(25)</td>
<td>(46)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>0</td>
<td>119</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PDC Dividend receivable</td>
<td>0</td>
<td>321</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prepayments – PFI lifecycle</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12,067</td>
<td>4,480</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Total current and non current

<table>
<thead>
<tr>
<th></th>
<th>31 March 2014 £000</th>
<th>31 March 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include in NHS receivables are prepaid pension contributions</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

14.2 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>31 March 2014 £000</th>
<th>31 March 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>9,472</td>
<td>603</td>
</tr>
<tr>
<td>By three to six months</td>
<td>214</td>
<td>66</td>
</tr>
<tr>
<td>By more than six months</td>
<td>63</td>
<td>146</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9,749</td>
<td>815</td>
</tr>
</tbody>
</table>

The Trust does not hold any collateral for its receivables.
### 14.3 Provision for impairment of receivables

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>46</td>
<td>11</td>
</tr>
<tr>
<td>Amount written off during the year</td>
<td>(32)</td>
<td>(8)</td>
</tr>
<tr>
<td>Amount recovered during the year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increase in receivables impaired</td>
<td>11</td>
<td>43</td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>25</td>
<td>46</td>
</tr>
</tbody>
</table>

### 15. Cash and Cash Equivalents

<table>
<thead>
<tr>
<th></th>
<th>31 March 2014</th>
<th>31 March 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening balance</td>
<td>27,424</td>
<td>25,280</td>
</tr>
<tr>
<td>Net change in year</td>
<td>(6,479)</td>
<td>2,144</td>
</tr>
<tr>
<td>Closing balance</td>
<td>20,945</td>
<td>27,424</td>
</tr>
</tbody>
</table>

Made up of
- Cash with Government Banking Service: 20,500 £000, 27,400 £000
- Commercial banks and cash in hand: 445 £000, 24 £000
- Current investments: 0 £000, 0 £000

### 16. Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Non-current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March</td>
<td>31 March</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>2013</td>
</tr>
<tr>
<td>Interest payable</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>NHS payables – revenue</td>
<td>3,183</td>
<td>2,811</td>
</tr>
<tr>
<td>Non-NHS payables – revenue</td>
<td>204</td>
<td>690</td>
</tr>
<tr>
<td>Non-NHS payables – capital</td>
<td>192</td>
<td>356</td>
</tr>
<tr>
<td>Tax and social security costs</td>
<td>3,703</td>
<td>3,401</td>
</tr>
<tr>
<td>Accruals</td>
<td>8,526</td>
<td>7,546</td>
</tr>
<tr>
<td>VAT payable</td>
<td>47</td>
<td>0</td>
</tr>
<tr>
<td>PDC dividend payable</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>81</td>
<td>207</td>
</tr>
<tr>
<td>Total</td>
<td>15,970</td>
<td>15,011</td>
</tr>
</tbody>
</table>

### 17. Other liabilities

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Non-current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March</td>
<td>31 March</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>2013</td>
</tr>
<tr>
<td>PFI/LIFT deferred credit</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lease incentives</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other – deferred income</td>
<td>2,953</td>
<td>3,147</td>
</tr>
<tr>
<td>Total</td>
<td>2,953</td>
<td>3,147</td>
</tr>
</tbody>
</table>

### Total other liabilities (current and non-current)

|                      | 2,953   | 3,147     |
18.1 Borrowings

<table>
<thead>
<tr>
<th>Current</th>
<th>Non-current</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 March</td>
<td>31 March</td>
</tr>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>2014</td>
<td>2013</td>
</tr>
<tr>
<td>Bank overdraft – Government Banking Service</td>
<td>0</td>
</tr>
<tr>
<td>Bank overdraft – commercial banks</td>
<td>0</td>
</tr>
<tr>
<td>Loans from Independent Trust Financing Facility (ITFF)</td>
<td>1,250</td>
</tr>
<tr>
<td>Loans from other entities</td>
<td>0</td>
</tr>
<tr>
<td>PFI liabilities:</td>
<td></td>
</tr>
<tr>
<td>Main liability</td>
<td>209</td>
</tr>
<tr>
<td>Lifecycle replacement received in advance</td>
<td>0</td>
</tr>
<tr>
<td>Finance lease liabilities</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1,459</td>
</tr>
</tbody>
</table>

Total other liabilities (current and non-current) 22,714 24,169

Loans – repayment of principal falling due in:

<table>
<thead>
<tr>
<th>ITTF</th>
<th>PFI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>0 – 1 years</td>
<td>1,250</td>
<td>209</td>
</tr>
<tr>
<td>1 – 2 years</td>
<td>1,250</td>
<td>224</td>
</tr>
<tr>
<td>2 – 5 years</td>
<td>3,750</td>
<td>760</td>
</tr>
<tr>
<td>Over 5 years</td>
<td>0</td>
<td>15,271</td>
</tr>
<tr>
<td>Total</td>
<td>6,250</td>
<td>16,464</td>
</tr>
</tbody>
</table>

18.2 Prudential Borrowing Limit

The Prudential Borrowing Limit disclosures are no longer required, the Prudential Borrowing Code having been repealed by the Health and Social Care Act 2012.

<table>
<thead>
<tr>
<th></th>
<th>Pensions relating to other staff</th>
<th>Legal claims</th>
<th>Restructuring</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>Balance at 1 April 2013</strong></td>
<td>85</td>
<td>374</td>
<td>2,979</td>
<td>830</td>
<td>4,268</td>
</tr>
<tr>
<td>Added through absorption accounting</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>61</td>
<td>168</td>
<td>625</td>
<td>719</td>
<td>1,573</td>
</tr>
<tr>
<td>Utilised during the year</td>
<td>(21)</td>
<td>(195)</td>
<td>(1,353)</td>
<td>(39)</td>
<td>(1,605)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>0</td>
<td>(118)</td>
<td>(967)</td>
<td>(20)</td>
<td>(1,105)</td>
</tr>
<tr>
<td>Unwinding of discount</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Change in discount rate</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td>127</td>
<td>229</td>
<td>1,284</td>
<td>1,527</td>
<td>3,167</td>
</tr>
</tbody>
</table>

**Expected timing of cash flows:**

<table>
<thead>
<tr>
<th></th>
<th>No later than one year</th>
<th>Later than one year and not later than five years</th>
<th>Later than five years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>Balance at 1 April 2012</strong></td>
<td>98</td>
<td>186</td>
<td>534</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>0</td>
<td>323</td>
<td>2,979</td>
</tr>
<tr>
<td>Utilised during the year</td>
<td>(16)</td>
<td>(72)</td>
<td>(475)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>0</td>
<td>(63)</td>
<td>(59)</td>
</tr>
<tr>
<td>Unwinding of discount</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Change in discount rate</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2013</strong></td>
<td>85</td>
<td>374</td>
<td>2,979</td>
</tr>
</tbody>
</table>

£3,039k is included in the provisions of the NHS Litigation Authority at 31 March 2014 in respect of the clinical negligence liabilities of Pennine Care NHS Foundation Trust (31 March 2013: £2,987k).
Provisions made at 31 March 2014 include:

Pensions relating to other members of staff
These are commitments made to four former members of staff who receive Injury Benefits through NHS Litigation Authority. Payments are handled by NHSLA and recharged quarterly. The provision is made on the basis of a discounted cash flow using HM Treasury rate for 2013 – 2014 of 1.80%. It is expected that the cash flows will continue annually for at least five years.

Legal claims
The provision includes the excess payable on clinical negligence claims being handled by NHSLA where the cases have been notified to the Trust as outstanding at 31 March 2014. It is expected that these balances will be settled within one year. There is also provision for other legal cases that the Trust is currently dealing with that do not relate to clinical negligence. The provision includes the estimated legal costs and, where relevant, estimated settlement. All costs are expected to be settled within one year.

Restructuring
The provision includes the costs associated with implementing service re-design and restructuring that the Trust has committed to in 2013 – 2014 but have not yet been fully implemented. These costs include the estimated redundancy costs for those areas where relevant. It is expected that all costs will be incurred within one year.

Other
A data health check on Pennine Care NHS Foundation Trust’s payroll data identified a number of discrepancies that, when resolved, could give rise to additional costs; these costs have been estimated based on average pay rates and payroll data for the relevant period. Work is underway to review each case and to resolve any differences, it is expected that any further costs will be incurred during 2014-15.

Following a VAT inspection by HMRC and national communications from HMRC to NHS bodies on the recovery of VAT for Contracted Out Services, the Trust has identified that HMRC may seek to recovery VAT that was reclaimed in the last four years. A provision for this has been made and communication with HMRC continues.

20. Private Finance Initiative contracts

20.1 PFI schemes off-Statement of Financial Position
The Trust has no PFI schemes deemed to be off-Statement of Financial Position.

20.2 PFI schemes on-Statement of Financial Position
The Etherow Unit at Tameside Hospital
The scheme is for the provision of specialist mental health care for the elderly population of Tameside and Glossop. The scheme forms part of (22%) the overall Health in Tameside PFI scheme that will complete remodel of the hospital site in Tameside.

At 31 March 2014 the current net liability of the scheme is £16,464k, and current unitary payments are £2,252k per annum.

The contract commenced in September 2009 and is due to expire in August 2041.

There are no deferred assets or residual interests associated with the Trusts’ section of the PFI transaction.

<table>
<thead>
<tr>
<th>Total obligations for on-statement of financial position PFI contracts due:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>31 March 2014</strong></td>
</tr>
<tr>
<td>Not later than one year</td>
</tr>
<tr>
<td>Later than one year, not later than five years</td>
</tr>
<tr>
<td>Later than five years</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
</tr>
<tr>
<td>Less: interest element</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

20.3 Charges to expenditure
The total charged in the year to expenditure in respect of off-statement of financial position PFI contracts and the service element of on-statement of financial position PFI contracts was £950k (prior year £916k).

The Trust is committed to the following annual charges:

<table>
<thead>
<tr>
<th>PFI scheme expiry date:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>31 March 2014</strong></td>
</tr>
<tr>
<td>Not later than one year</td>
</tr>
<tr>
<td>Later than one year, not later than five years</td>
</tr>
<tr>
<td>Later than five years</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>
21. Financial Instruments

21.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust’s treasury management operations are carried out by the finance department, within parameters defined formally within the Trust’s Standing Financial Instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust’s internal auditors, KPMG.

Currency risk

The Trust is a domestic organisation with transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust’s income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

The Trust’s objective is to minimise credit risk, which it achieves by a programme of proactive credit control and internal controls. The risk of default on receivables that were within due date at year end and have not been impaired is considered to be low.

Liquidity risk

The Trust’s operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

21.2 Financial Assets

<table>
<thead>
<tr>
<th>At ‘fair value through profit and loss’</th>
<th>Loans and receivables</th>
<th>Available for sale</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Embedded derivatives</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receivables</td>
<td>0</td>
<td>11,191</td>
<td>0</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>20,945</td>
<td>0</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>0</td>
<td>32,136</td>
<td>0</td>
</tr>
<tr>
<td>Embedded derivatives</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receivables</td>
<td>0</td>
<td>3,479</td>
<td>0</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>27,424</td>
<td>0</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2013</strong></td>
<td>0</td>
<td>30,903</td>
<td>0</td>
</tr>
</tbody>
</table>
21.3 Financial Liabilities

<table>
<thead>
<tr>
<th>At ‘fair value through profit and loss’</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Embedded derivatives</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Payables</td>
<td>0</td>
<td>12,212</td>
</tr>
<tr>
<td>Other borrowings</td>
<td>0</td>
<td>6,250</td>
</tr>
<tr>
<td>PFI and finance lease obligations</td>
<td>0</td>
<td>16,464</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>0</td>
<td>3,129</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>0</td>
<td>38,055</td>
</tr>
</tbody>
</table>

| Embedded derivatives                  | 0     | 0     |
| Payables                               | 0     | 13,598| 13,598|
| Other borrowings                       | 0     | 7,500 | 7,500 |
| PFI and finance lease obligations      | 0     | 16,669| 16,669|
| Other financial liabilities            | 0     | 4,268 | 4,268 |
| **Total at 31 March 2013**             | 0     | 42,035| 42,035|

Maturity of financial liabilities

<table>
<thead>
<tr>
<th>Liabilities falling due in:</th>
<th>31 March 2014</th>
<th>31 March 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>0 – 1 years</td>
<td>16,800</td>
<td>19,321</td>
</tr>
<tr>
<td>1 – 2 years</td>
<td>1,474</td>
<td>1,468</td>
</tr>
<tr>
<td>2 – 5 years</td>
<td>4,510</td>
<td>4,492</td>
</tr>
<tr>
<td>Over 5 years</td>
<td>15,271</td>
<td>16,754</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>38,055</td>
<td>42,035</td>
</tr>
</tbody>
</table>

22. Related party transactions

22.1 Related party transactions with government bodies

Pennine Care NHS Foundation Trust is a public interest body authorised by Monitor, the Independent Regulator for Foundation Trusts.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Pennine Care NHS Foundation Trust. The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

<table>
<thead>
<tr>
<th>Income £000</th>
<th>Expendable £000</th>
<th>Receivable £000</th>
<th>Payable £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bury CCG</td>
<td>37,882</td>
<td>0</td>
<td>443</td>
</tr>
<tr>
<td>Central Manchester CCG</td>
<td>1,111</td>
<td>0</td>
<td>421</td>
</tr>
<tr>
<td>Heywood, Middleton and Rochdale CCG</td>
<td>46,702</td>
<td>0</td>
<td>1,067</td>
</tr>
<tr>
<td>North Manchester CCG</td>
<td>1,425</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Oldham CCG</td>
<td>46,448</td>
<td>24</td>
<td>1,021</td>
</tr>
<tr>
<td>Stockport CCG</td>
<td>23,712</td>
<td>0</td>
<td>333</td>
</tr>
<tr>
<td>Trafford CCG</td>
<td>23,886</td>
<td>0</td>
<td>270</td>
</tr>
<tr>
<td>Tameside and Glossop CCG</td>
<td>19,676</td>
<td>0</td>
<td>2,178</td>
</tr>
<tr>
<td>NHS England</td>
<td>35,958</td>
<td>52</td>
<td>2,382</td>
</tr>
<tr>
<td>Health Education England</td>
<td>5,471</td>
<td>45</td>
<td>6</td>
</tr>
<tr>
<td>Central Manchester University Hospital Foundation Trust</td>
<td>577</td>
<td>621</td>
<td>131</td>
</tr>
<tr>
<td>Pennine Acute NHS Hospital</td>
<td>1,157</td>
<td>4,228</td>
<td>271</td>
</tr>
<tr>
<td>Stockport NHS Foundation Trust</td>
<td>1,180</td>
<td>1,770</td>
<td>0</td>
</tr>
<tr>
<td>Tameside Hospital NHS Foundation Trust</td>
<td>0</td>
<td>1,537</td>
<td>0</td>
</tr>
</tbody>
</table>

245,485 8,233 8,573 1,463

Where receivable and payable balances exist without corresponding Income and Expenditure balances these are in relation to items considered as ‘recharges’ between the respective organisations. In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with Local Authorities in respect of joint working arrangements. These entities are listed on the next page.
2.2 Related party transactions with key management personnel

IAS 24 requires disclosure of key management personnel. For this purpose we have included the Executive and Non Executive Directors and the level of senior management immediately below (namely deputies and associate level directors).

<table>
<thead>
<tr>
<th>Income</th>
<th>Expendable</th>
<th>Receivable</th>
<th>Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Bury MBC</td>
<td>5,401</td>
<td>680</td>
<td>567</td>
</tr>
<tr>
<td>Oldham MBC</td>
<td>6,046</td>
<td>559</td>
<td>639</td>
</tr>
<tr>
<td>Rochdale MBC</td>
<td>5,508</td>
<td>302</td>
<td>474</td>
</tr>
<tr>
<td>Stockport MBC</td>
<td>3,756</td>
<td>513</td>
<td>500</td>
</tr>
<tr>
<td>Tameside MBC</td>
<td>3,950</td>
<td>384</td>
<td>45</td>
</tr>
<tr>
<td>Trafford MBC</td>
<td>2,975</td>
<td>257</td>
<td>617</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27,636</strong></td>
<td><strong>2,695</strong></td>
<td><strong>2,842</strong></td>
</tr>
</tbody>
</table>

23. Continuity of Service Risk Rating performance

The two key financial performance measures are determined by Monitor in the Risk Assessment Framework for foundation trusts, and are jointly known as the Continuity of Service Risk Ratings. The measures applicable were introduced in 2013–2014, replacing the former regime of Financial Risk Ratings and focus on the financial capability of foundation trusts to continue to deliver services. The financial risk is rated from 1 to 4, where 1 equals the highest risk, and where 4 is considered the lowest risk with no regulatory concerns. The overall score is determined by a simple average, with the result rounded up. The two ratings defined by the Risk Assessment Framework are:

- Capital Service Capacity measures the coverage of debt servicing requirements, which includes capital and interest payments on all loans and PFI arrangements, and the annual PDC Dividend payable to the Department of Health.
- Liquidity Ratio measures the liquidity days based on net current assets (excluding inventories) divided by operating expenditure, multiplied by 360.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Service Capacity</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Liquidity</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Overall Average</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

*Ratios were not reportable at 31 March 2013 and there were not included in foundation trusts’ Annual Plan Review for that year.

24. Third Party Assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

<table>
<thead>
<tr>
<th>31 March 2014</th>
<th>31 March 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Patient monies held by the Trust</td>
<td>232</td>
</tr>
</tbody>
</table>
25. Losses and spacial payments
The total number of losses cases in 2013-2014 and their total value was as follows:

<table>
<thead>
<tr>
<th>Total value of cases £000</th>
<th>Total number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses</td>
<td></td>
</tr>
<tr>
<td>Cash losses (including overpayment, physical loss, theft)</td>
<td>0</td>
</tr>
<tr>
<td>Fruitless payments and constructive losses</td>
<td>0</td>
</tr>
<tr>
<td>Bad debts and claims abandoned (excluding NHS cases)</td>
<td>3</td>
</tr>
<tr>
<td>Stores losses and damage to property or buildings</td>
<td>0</td>
</tr>
<tr>
<td>Special payments</td>
<td></td>
</tr>
<tr>
<td>Extra-contractual payments</td>
<td>0</td>
</tr>
<tr>
<td>Extra-statutory and extra-regulatory payments</td>
<td>0</td>
</tr>
<tr>
<td>Compensation payments</td>
<td>121</td>
</tr>
<tr>
<td>Special severance payments</td>
<td>0</td>
</tr>
<tr>
<td>Ex-gratia payments</td>
<td>1</td>
</tr>
<tr>
<td>Total losses and special payments</td>
<td>125</td>
</tr>
</tbody>
</table>

The total number of losses cases in 2012 – 2013 and their total value was as follows:

<table>
<thead>
<tr>
<th>Total value of cases £000</th>
<th>Total number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses</td>
<td></td>
</tr>
<tr>
<td>Cash losses (including overpayment, physical loss, theft)</td>
<td>0</td>
</tr>
<tr>
<td>Fruitless payments and constructive losses</td>
<td>0</td>
</tr>
<tr>
<td>Bad debts and claims abandoned (excluding NHS cases)</td>
<td>0</td>
</tr>
<tr>
<td>Stores losses and damage to property or buildings</td>
<td>0</td>
</tr>
<tr>
<td>Special payments</td>
<td></td>
</tr>
<tr>
<td>Extra-contractual payments</td>
<td>0</td>
</tr>
<tr>
<td>Extra-statutory and extra-regulatory payments</td>
<td>0</td>
</tr>
<tr>
<td>Compensation payments</td>
<td>67</td>
</tr>
<tr>
<td>Special severance payments</td>
<td>0</td>
</tr>
<tr>
<td>Ex-gratia payments</td>
<td>5</td>
</tr>
<tr>
<td>Total losses and special payments</td>
<td>72</td>
</tr>
</tbody>
</table>

Details of cases individually over £250,000
There were no cases individually over £250,000 in either year.

26. Auditor remuneration and Liability Limitation Agreement
In 2013 – 2014 the Trust statutory external auditors are PricewaterhouseCoopers LLP (PwC). (2012 – 2013 auditor was PwC LLP). The remuneration for the statutory audit was £64k plus VAT (2012 – 2013: £65k + VAT).

Other auditor remuneration is analysed:

<table>
<thead>
<tr>
<th>2013 – 2014 £000</th>
<th>2012 – 2013 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The auditing of accounts of any associate of the Trust</td>
<td>0</td>
</tr>
<tr>
<td>2. Audit-related assurance services</td>
<td>0</td>
</tr>
<tr>
<td>3. Taxation compliance services</td>
<td>0</td>
</tr>
<tr>
<td>4. Other taxation advisory services</td>
<td>0</td>
</tr>
<tr>
<td>5. Internal audit services (paid to the external auditor)</td>
<td>0</td>
</tr>
<tr>
<td>6. All assurance services not falling within items 1 to 5</td>
<td>119</td>
</tr>
<tr>
<td>7. Corporate finance transaction services not falling within items 1 to 6 above</td>
<td>0</td>
</tr>
<tr>
<td>8. All other non-audit services</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
</tr>
</tbody>
</table>

These services were approved by the Executive and noted by the Audit Committee having assessed that appropriate safeguards to protect auditor independence were in place.

The Trust’s contract with its auditors provides for a limitation of the auditor’s liability of £1,000,000 as set out in the engagement letter.
27. Events after the reporting period

The Trust has not identified any events that occurred after the reporting period that would require disclosure as non-adjusting events in accordance with IAS 10.

28. Transfer by absorption

On 1 April 2013 the Trust received assets and liabilities transferred from three other NHS bodies, the demising bodies Trafford PCT, Bury PCT and Heywood, Middleton and Rochdale (HMR) PCT. The assets transferred relate to the delivery of community health services, and the usage of assets is consistent before and after the transfer date. The transfer of the net assets is accounted for by modified absorption accounting, as set out in Note 1.22. The following table sets out the values transferred and applied in the Trust’s accounts:

<table>
<thead>
<tr>
<th></th>
<th>Bury PCT</th>
<th>HMR PCT</th>
<th>Trafford PCT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Land</td>
<td>600</td>
<td>880</td>
<td>1,685</td>
<td>3,165</td>
</tr>
<tr>
<td>Buildings</td>
<td>1,812</td>
<td>2,286</td>
<td>1,411</td>
<td>5,509</td>
</tr>
<tr>
<td>Plant and equipment</td>
<td>165</td>
<td>261</td>
<td>138</td>
<td>564</td>
</tr>
<tr>
<td>Information technology</td>
<td>68</td>
<td>0</td>
<td>0</td>
<td>68</td>
</tr>
<tr>
<td>Fixtures and fittings</td>
<td>349</td>
<td>170</td>
<td>0</td>
<td>519</td>
</tr>
<tr>
<td>Total net book value of PPE</td>
<td>2,994</td>
<td>3,597</td>
<td>3,234</td>
<td>9,825</td>
</tr>
<tr>
<td>Current liabilities</td>
<td>(76)</td>
<td>(64)</td>
<td>(50)</td>
<td>(190)</td>
</tr>
<tr>
<td>Net value of transfer</td>
<td>2,918</td>
<td>3,533</td>
<td>3,184</td>
<td>9,635</td>
</tr>
</tbody>
</table>

Transfers are initially recognised entirely in retained earnings, with subsequent adjustments to account for revaluation reserves transferred and the impact of the Department of Health settling transferred liabilities during the year 1 April 2013 to 31 August 2013 on behalf of the Trust. The following table summarises the reserves adjustments:

<table>
<thead>
<tr>
<th></th>
<th>Bury PCT</th>
<th>HMR PCT</th>
<th>Trafford PCT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Amount initially recognised in retained earnings</td>
<td>2,918</td>
<td>3,533</td>
<td>3,184</td>
<td>9,635</td>
</tr>
<tr>
<td>Transfers to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>(1,301)</td>
<td>(501)</td>
<td>(602)</td>
<td>(2,404)</td>
</tr>
<tr>
<td>PDC capital</td>
<td>(93)</td>
<td>(3)</td>
<td>(50)</td>
<td>(146)</td>
</tr>
<tr>
<td>Overall impact on retained earnings</td>
<td>1,524</td>
<td>3,029</td>
<td>2,532</td>
<td>7,085</td>
</tr>
</tbody>
</table>
GLOSSARY

A&E
AMH
BMI
CAMHS
CCG
CMHT
COG
CPA
CQC
CQUIN
CRT/CRHT
EIT
ESDT/ESD
HEF
HinC
HMR
HoNOS
HR
ICD
LAC
LD
LSCB/LSAB
LTC
LTVT
MASH
MAU
MEWS
MH MDS
MRSA
NEWS
NICE
NSF
OD
OL&D
OT
PALS
PARIS
PBS
PDMH
QOF
QRP
RAID
SAB
SCR
SMI
SMS
TAD
TPR

Accident and Emergency
Adult Mental Health
Body Mass Index
Child and Adolescent Mental Health Service
Clinical Commissioning Groups
Community Mental Health Team
Condition Orientated Group
Care Programme Approach
Care Quality Commission
Commissioning for Quality and Innovation
Crisis Resolution and Home Treatment
Early Intervention Team
Early Supported Discharge Team
Health Equalities Framework
Hospital in the Community
Heywood, Middleton and Rochdale
Health of the Nation Outcome Scales
Human Resources
International Classification of Diseases
Looked After Children
Learning Disability
Local Safeguarding Children’s/Adults Board
Long Term Conditions
Long Term Ventilation Team
Multi-Agency Safeguarding Hubs
Medical Assessment Unit
Modified Early Warning Score
Mental Health Minimum Data Set
Meticillin-Resistant Staphylococcus Aureusis
National Early Warning Score
National Institute for Health and Care Excellence
National Service Framework
Organisational Development
Organisational Learning and Development
Occupational Therapy
Patient Advice Liaison Service
Patient Record Information System
Positive Behavioural Support
Prescribing in mental health services
Quality Outcomes Framework
Quality Risk Profile
Rapid Assessment Interface Discharge
Safeguarding Adults Board
Serious Case Review
Serious Mental Illness
Short Message Service
Trust Approved Documentation
Temperature, pulse, respiration