NHS
Pennine Care
NHS Foundation Trust

2019/20

Annual report and accounts

Pennine Care NHS Foundation Trust

Annual Report and Accounts 2019/2020

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

Contents

Welcome from the Chair and Chief Executive

The Covid-19 pandemic has changed the way of life for all of us. It has been one of the most disruptive, impactful, life-changing events in our lifetime, with the NHS facing its biggest ever challenge since it was founded in 1948.

The crisis has had an immense impact on our organisation, transforming the way that we work and deliver care. It has been a difficult balancing act prioritising our Covid-19 response, while keeping all our other essential work going.

Our resourceful workforce has drawn on deep reserves of ingenuity, compassion and determination to carry on providing high quality services. Many colleagues have made huge sacrifices to care for others and we could not be prouder of them.

This virus has forced more distance, but also more connection, as we have found new ways to engage and communicate with people. We've fast-tracked digital technologies for clinical and corporate teams; working at an accelerated rate that could never have happened in other circumstances.

This vicious and brutal virus has also brought trauma and tragedy into our lives. We have lost a much-loved colleague to Covid-19: Grant Maganga, a mental health nurse who worked with us for ten years. We have lost patients on our wards and in the community, and our staff have lost family members and friends.

Every death has been deeply distressing, but we have also seen plenty of change for good. This awful crisis, despite its very sad and horrible implications in terms of sickness and loss, has galvanised us. It's drawn us together to see more clearly what we are collectively capable of achieving and brought into focus what can be done.

We introduced remote patient consultations, as well as new services, such as our 24/7 helpline for patients and carers. We established virtual training and development workshops and enabled home working for over one thousand staff.

We know that we will be living in the shadow of this pandemic for some considerable time, and we've therefore reimagined a different future and will 'lock in' the positive changes that have been made.

We've undertaken an 'appreciative enquiry' with staff and patients about people's experience during the lockdown to inform what changes we want to retain going forwards. We are also working closely with our partners, as it's essential that there is a consistent approach to recovery. Our recovery plan will reflect all of this. As we know, necessity is the mother of invention.

There is a widespread consensus that the psychological impact of the pandemic will create a surge in mental ill health that we need to prepare for. We're looking at how we can provide clinical services whilst 'living with Covid' and still keep people safe. This includes looking at ward occupancy levels and how our community services are delivered, and at the same time looking at how we could manage a 5%, 10% and 15% increase in activity. We must also ensure we look after the resilience and wellbeing of our staff.

With the pandemic turning our world upside down, it's easy to forget the significant developments and achievements of 2019/20. They seem a lifetime away, but it's important to recognise and highlight them, as our organisation completely transformed over the year.

We launched our new vision and values after extensive engagement with a wide range of different groups. Our vision is 'a happier and more hopeful life for everyone in our communities', underpinned by four values: kindness, fairness, ingenuity and determination.

We also launched our five-year plan, following 18 months of engagement and development with patients, carers and staff, as well as commissioners, partners and other agencies.

Our five-year plan has four big ambitions and will focus on improving and enhancing our mental health and learning disability services. As part of this strategy, we said goodbye to our community (physical health) services in Bury, Oldham, Rochdale and Trafford as they transferred to new NHS provider organisations over the year.

We have been very proud to run these services over the last seven years and there have been significant achievements, but we believe other provider organisations are better positioned to enable community health services to achieve more for the benefit of local people.

Phase one of our work with Niche Consulting, who were commissioned by the Greater Manchester Partnership to help with our mental health and learning disability programme, concluded. It looked at the current position in terms of funding, pressure on our inpatient services, readmission rates and out-of-area placements.

A review of our mental health and learning disability programme subsequently followed and the programme will now focus on four priority areas; acute care pathway, new community mental health team model, Trust-wide access model, and single gender accommodation.

The mental health and learning disability programme will be aligned to a new clinical and professional leadership structure. The new leadership structure will mean more visible medical, nursing, allied health professional, social work, and quality leadership and more devolved decision making; supported by an organisational development programme.

Following the transfer of community physical health services, we also started a corporate services redesign programme. We need to work within what is affordable and be as efficient and effective as possible; delivering great value in everything we do.

Our business case for single gender accommodation was approved, as well as a business case for a new 12-bedded male psychiatric intensive care unit at Tameside Hospital. Our current male psychiatric intensive care unit in Stockport will then be re-developed into a 10-bedded female unit.

Other service developments over the year included new safe havens in Oldham and Rochdale. These provide support to adults who are experiencing a mental health crisis out-of-hours and will reduce the need to admit to a ward.

Our children and young people's rapid response teams are now in place across our region. The four new teams cover the whole of Greater Manchester and provide risk assessment and management for young people who are experiencing a mental health crisis.

We established young people's safe zones across Greater Manchester, commissioning national charity, the Children's Society, to run them. Young people aged 13 to 18 years will be able to go to one of the safe zones when they are experiencing a mental health crisis.

We also secured an additional £1.3m over two years for crisis resolution home treatment teams, following a successful bid to Greater Manchester. This money will be used across all five boroughs to improve pharmacy input.

A lot of work took place on our learning disability strategy, including learning disability crisis pathway development and community learning disability team action plans.

Culture is as important as strategy, and therefore alongside work on a new strategic approach, we progressed our Just Culture work. We were one of the first NHS trusts in the country to adopt a Just Culture approach, which is based on an open, supportive and learning culture around incidents.

A new Dragons' Den scheme centred on quality improvement is also proving hugely popular; showcasing great innovation ideas from teams across our organisation.

We were pleased the annual staff survey results ranked us as the best performing trust nationally in our category for the question about 'feeling involved in changes that affect your work area, team and department'.

The survey highlighted however that we need to improve in areas, such as personal development and the number of staff experiencing physical violence from service users.

We are also very aware of the disproportionate impact of the Covid-19 pandemic on black, Asian and ethnic minority (BAME) groups, and have been doing a lot of work to try and ensure our colleagues are safe and supported.

The debate about inequality followed protests across the globe against widespread inherent racism and we publicly stated our support for the Black Lives Matter movement. We will

continue to do everything we can to stand up to racism and help tackle every form of prejudice.

We have done a lot of work on equality issues within our organisation, but we still have a long way to go. We know we can't change things overnight, and we need to tackle some structural and systemic issues, as well focus on our culture. We want our staff networks to play a bigger role in shining a light on issues and holding us to account, as we know that actions speak louder than words. Equality, diversity and inclusion will remain at the top of our agenda.

We were also pleased and proud that Bill McCarthy, executive regional director for the NHS North West personally invited our Chair to co-chair a formal BAME Advisory Group. This group will look at the management of Covid-19 by the NHS in the North West and other matters in relation to both BAME staff and communities. It will feed into the Regional Incident Management Team, which our Chair will also sit on.

In terms of changes to our Board of Directors, Dr Henry Ticehurst, our Medical Director announced his retirement after ten years in the post and many more as a consultant. Dr Nihal Fernando, our Deputy Medical Director and Director of Medical Education, was appointed to this post following a competitive interview process.

Suzanne Robinson, our Executive Director of Finance, also leaves us in the summer of 2020 for a new job at Greater Manchester Mental Health NHS Foundation Trust. Nicky Tamanis will then take up the post as our new Executive Director of Finance.

A huge thank you to Henry and Suzanne for their tremendous contribution. We were also delighted that Daniel Benjamin and Dr Julia Sutton-McGough were both reappointed for another three years as Non-Executive Directors.

We also had countless awards, accolades and achievements over the year.

Karen Johnson, community mental health nurse in Bury, received The Queen's Award for Voluntary Service for her charity, GEM Appeal. Tariela Laindon, nursing associate in Stockport won a Royal College of Nursing award for 'outstanding contribution to equality, diversity and inclusion in health and social care'. Carol Rushton, who also works in Stockport, won 'Best dementia nurse specialist' at the national dementia awards.

We swept the board at the Royal College of Psychiatrists North West awards, winning six out of the nine categories. Linda Chadburn, clinical effectiveness and quality improvement lead, was crowned 'clinical audit professional of the year' in the national NHS audit awards.

Our estates team won 'team of the year' at the national Design in Mental Health Awards. Our finance team won 'highly commended' for 'finance team of the year' at the national Healthcare Financial Management Associate Awards.

Our child and adolescent mental health services in Rochdale and Bury were both ranked in the top six nationally for productivity (out of 107 CAMHS services). The National Institute for Health Research's research activity league table showed that we had an 85% increase in the number of studies - the biggest increase out of all the mental health trusts in England.

Looking to the future, it's difficult to see how the NHS will not emerge stronger from this pandemic, however challenging and stressful the next year will be.

We have never been more impressed or felt prouder of our staff, who have worked under extraordinary pressure. Their commitment, compassion, determination, ingenuity, resilience and kindness has moved, humbled and inspired us.

Thank you also to our partners, governors, volunteers, members and community groups. Our dedicated governors and members continue to play an important role in shaping our work and are always focused on what matters. Our volunteers give so much of their time, skills and expertise freely to help others.

Our local communities and businesses have demonstrated overwhelming generosity during the pandemic, supplying handmade scrubs, toiletries, food, technology and much more. Their donations, gifts, messages and support meant so much at such a difficult and we are so grateful.

This is a profound and perhaps existential challenge that we're all facing together, and it's been heartening to see so much support and solidarity, not just across our Trust, but across the whole of the NHS and beyond.

Thank you to you all. Take care and stay safe.

Best wishes,

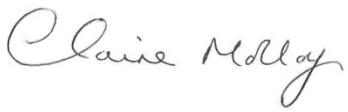
Evelyn Asante-Mensah OBE
Chair
22 June 2020

Claire Molloy
Chief Executive
22 June 2020

Performance report

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

The Board, having made appropriate enquiries, has a reasonable expectation that the Trust will still have access to adequate resources to continue its operational existence in the foreseeable future, being a period of at least twelve months from the date of the approval of the financial statements. On this basis, the Trust has adopted the going concern basis for preparing the financial statements. Full information can be found within the annual accounts, starting on page 135 of this report.



Claire Molloy
Chief Executive
22 June 2020

About Pennine Care

Pennine Care NHS Foundation Trust (Pennine Care) is proud to provide mental health and learning disability services to people across Greater Manchester. We serve a population of 1.3 million and our vision is a happier and more hopeful life for everyone in our communities. Nearly 4000 dedicated and skilled staff deliver care from around 100 different locations in five boroughs:

- **Bury, Oldham and Rochdale:** mental health and learning disability services for children and adults.
- **Tameside and Glossop:** children and adult mental health services, learning disability services, and health improvement.
- **Stockport:** mental health and learning disability services for children and adults.

Our mental health teams provide care and treatment for people with mild to moderate conditions such as depression, anxiety or dementia, or more serious mental health illness such as schizophrenia and bipolar disorder. We run Healthy Minds (psychological therapies), drug and alcohol services, psychiatric intensive care, rehabilitation services and many more. Our learning disability services are for people with a moderate to profound level of learning disability, such as those with Down's syndrome.

Pennine Care was first formed in 2002 as a mental health trust. We became the 100th foundation trust in 2008 and, in 2011, welcomed community health services from the boroughs of Bury; Heywood, Middleton and Rochdale; and Oldham. This was followed by a range of services in Trafford in 2013.

Following a decision by the Board of Directors in 2018 to redefine our service portfolio, focusing on the delivery of an enhanced offer around mental health and learning disabilities, work commenced in 2019/20 to transfer community services to alternative providers. As of 31 March 2020, all community services have successfully transferred to alternative providers, except for community dental services, the transfer of which was expected to conclude in 2020/21.

As a result of the transfer of community services, the Trust took the opportunity to review its organisational structure during 2019/10. This resulted in the development and approval of a new integrated leadership structure that will support enhanced clinical and professional leadership along with improved locality engagement and partnership working. The new structure will be implemented during 2020/21.

Our Trust Strategy

Our five-year plan (2020-2025) sets out an exciting vision of how we could look in five years' time. Through re-shaping our organisation, focussing on what we do best and building roots in communities, we can maximise people's potential.

We've spent 18 months gathering views and information to shape our five-year plan, talking with service users and carers; staff; our Council of Governors, commissioners and regulators; and aligned our ambitions with the overall vision for Greater Manchester.

Our vision is for a happier and more hopeful life for everyone in our communities. Our mission is therefore to help to maximise people's potential to live healthier and more rewarding lives, while creating a great place to work.

We have refreshed our values, so they reflect who we are and how we do things:

- **Kindness:** we believe that care and compassion underpin everything
- **Fairness:** we treat everyone fairly
- **Ingenuity:** we are resourceful and innovative
- **Determination:** we are courageous and ambitious for what we can achieve together

By 2025, we want to achieve these big ambitions:

- *Outstanding care*
- *People with lived experience shaping every decision*
- *Every service user having the opportunity to lead a fulfilling life*
- *All staff feel engaged and are involved in improvement*

To help us deliver our big ambitions we will focus on four key areas:

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

Performance overview

This section of the report will look in detail at the performance of the Trust during 2019/20, including service developments, achievements, updates and financial performance. It also looks ahead at future trends and challenges that may affect the Trust in the next financial year.

Review of last year's achievements

Last year's Annual Report set out Pennine Care's delivery priorities across five domains:

The tables below detail the progress made against the delivery objectives we set in 2019/20.

Quality - To drive and sustain quality improvement and innovation	
Delivery Priorities	**Position Statement**
Implement our 2019/20 quality strategy priorities	Good progress has been made with our ambitious Quality Strategy in its first year, including the launch of our Just Culture approach, establishing a Lived Experience Pool to facilitate greater involvement of service users and carers in our thinking; further developing our approach to sharing and learning; and the smarter use of data to improve patient safety.
Embed the 'Just Culture' principles; learning from incidents across our organisation	We have worked successfully to embed a Just Culture across our organisation and work continues across four priority/focus areas: • Safety/incidents • Workforce/HR • Experience/complaints • Legal
Work towards a CQC 'good' rating	The Trust continues to progress with actions detailed on the improvement plan. Our detailed plan includes several remedial actions and priority areas for immediate improvement. Further information regarding progress with the improvement plan can be found within the Annual Governance Statement from page 98
Develop a focus on quality improvement and involvement in research and innovation	We have significantly progressed our programme for embedding quality improvement within the organisation.

Quality - To drive and sustain quality improvement and innovation	
	Working with the Advancing Quality Alliance (AQuA), we have begun to train all staff in Quality Improvement (QI) methodologies. From our training, staff members have undertaken their own QI projects and other improvement activities within their area of work. We have also linked QI projects from our Trust-wide collaboratives to our Lived Experience Pool, to promote service user and carer involvement in improvement projects. We continue to develop the pool and encourage their alignment to QI activities. To date there are 103 QI activities initiated. The Board has also received QI training and has developed its own QI project, focused on improving Board member engagement with service users and carers. During 2019/20, we initiated two Trust-wide improvement collaboratives, based on our priorities. These are our falls collaborative for older people's inpatient services, and a collaborative to embed the Trust's kindness value into everyday practice, titled 'civility saves lives'. Our Dragon's Den has now had three cycles. This initiative focuses on drawing innovative improvement ideas from front-line staff and funding these. The first major business case from this process, a secure vehicle, was approved in February 2020.
Ensure that improving the patient experience is central to all our work	Pennine Care aims to include service users/carers in decision making on a much wider scale. To that end, our Lived Experience Pool (LEP) has grown considerably this year and we have trained 12 people with lived experience of services in QI methodologies, who have then been able to actively take part in a range of improvement projects during 2019/20.

People – Ensure that the workforce is able to deliver safe and effective services	
Delivery Priorities	**Position Statement**
Implement the 2019/20 priorities of our people strategy	Good progress has been made this year across priority outcomes of leadership development, training and development, workforce planning, new role development, equality diversity and inclusion, recruitment and retention initiatives.
Implement a plan to embed the refreshed vision and values across our organisation	In 2019/20, we launched our new Trust strategy, and our new Trust vision and values. Work is ongoing work to continually promote and embed our vision and values across the organisation.

People – Ensure that the workforce is able to deliver safe and effective services	
Retain our focus on culture development and organisational development	Our organisational development improvement plan has been refreshed, setting out the actions required to help shape the organisational culture and embed the new vision, values and culture.
Develop an effective and sustainable workforce	Our workforce challenges remain a significant risk for the Trust. During 2019/20, we have focused on recruitment and retention as well as more sustainable workforce plans. The national supply of nurses and medics remains an issue. We are beginning to work proactively with universities to develop a new approach to training and development, leading to recruitment.

Partnerships – Form effective partnership within each of our localities to transform services	
Delivery Priorities	**Position Statement**
Develop a partnerships strategy	During 2019/20, we commenced work on developing our partnerships strategy and this will continue during 2020/21 in line with our new Trust Strategy.
Work with our mental health commissioners and stakeholders to support transformation through locality plans and an improved clinical offer for our local populations	We have worked with the Greater Manchester Health and Social Care Partnership, our commissioners and Niche Consulting during 2019/20 on the development of a financial plan for sustainable services. We concluded phase one of this work, which looked at the current position in terms of funding, pressure on our inpatients services, readmission rates and out-of-area placements. Further work with our partners to develop and agree a sustainable service model was paused late in March 2020 due to the need to respond to the Covid-19 pandemic, and the national operational planning framework was suspended. We will revisit this with our commissioners and the Greater Manchester Health and Social Care Partnership at an appropriate time following the emergency response.
Work in partnership to support a smooth and effective transfer of our community services	All community services, with the exception dental services, have transferred to alternative providers. The transfer of dental services to an alternative provider was delayed due to Covid-19 emergency response.

Partnerships – Form effective partnership within each of our localities to transform services	
Develop a clear position and positive contribution within each of our local care organisations and the Greater Manchester system as part of our organisational redesign work	Our Executive Directors are aligned to localities to ensure we are engaged with the strategic direction of each locality. Our business planning process for 2020/21 considered the need for a locality focus in our plans and service developments. Our new integrated leadership model, which has been designed during 2019/20 and will be delivered in 2020/21, will ensure a locality focussed solution to support improved visibility of the mental health and learning disability agenda.

Money – Ensure financial sustainability, addressing immediate pressures and future plans	
Delivery Priorities	**Position Statement**
Deliver our 2019/20 financial plan	The Trust achieved its financial plan and control total in 2019/20. Further information regarding financial performance can be found on page 23
Implement an approach to value improvement in tandem with quality improvement **To strengthen the approach to benefits realisation and return on investment**	An improvement framework was launched during 2019/20 to support both the release of efficiency savings and investment decisions (capital and revenue). A new business case process provides clearer governance arrangements for all investment decisions and a stronger emphasis on benefits realisation / return on investment. Our Dragons Den initiative was launched in 2019, which attracted significant interest from staff with a wide variety of innovative improvement applications received and considered. Several schemes have been approved that support quality improvement, and further work to develop these schemes will continue into 2020/21: The 'Dragon's Den' process continues to be reviewed and refined to maximise opportunities for improvement across all areas.
Submit a five-year sustainability plan, in line with NHS Improvement requirements, including an income strategy	Our final five-year plan was submitted on 1 November 2019 in line with the national timetable. The plan delivers the proposed FIT (Financial Improvement Trajectory) targets until 2023/24.
Transform our approach to managing risk and reward with our mental health and learning disability commissioners	Pennine Care has taken the lead provider role in developing a 'Lead Provider Collaborative' for 'Tier 4' (inpatient) child and adolescent mental health services across Greater Manchester. We have worked collaboratively with the other local providers and NHS England to develop a business case for the new arrangements and

Money – Ensure financial sustainability, addressing immediate pressures and future plans	
	service delivery model. This work is currently paused due to the Covid-19 pandemic. Pennine Care is also a partner provider in the 'Lead Provider Collaborative' for 'Tier 4' adult inpatient services and Military Veterans services across the North West. We continue to work with our commissioners regarding sustainable financial models, and the aspirations to move to new contracting models over the coming years, designed to benefit locality and system working.

Infrastructure – Ensure we have the right estates and IM&T to delivery our quality aspirations	
Delivery Priorities	**Position Statement**
Redesign our organisational infrastructure, including management, governance and corporate services, for our future organisation	A new integrated leadership model for the Trust has been designed during 2019/20 and will be implemented throughout 2020/21. The new model ensures a balance of operational performance, quality and governance, and professional leadership voices to drive forward our Trust strategy. The new model will also ensure appropriate representation and leadership at both regional, locality and professional leadership networks and forums. To develop this model, we have undertaken extensive engagement with the following groups: • Service User and Carer Forum • Executive Directors • Corporate Services Integrated Leadership Group • Trust Management Board • Quality Committee • Mental Health and Learning Disability Programme Review Following the transfer of our community services to alternative providers we have begun to review our corporate services function to ensure it can effectively support our Trust strategy. A detailed benchmarking assessment was undertaken by NHS Improvement and Niche Consulting, who supported us to identify areas for further exploration including opportunities to redesign within early adopter departments and collaborative team working. The corporate service redesign programme would continue into 2020/21.

Infrastructure – Ensure we have the right estates and IM&T to delivery our quality aspirations	
Through our partnerships, develop innovative solutions e.g. to access funding opportunities and make the most of what is available within the system	During 2019/20 we have been working with partners to develop investment opportunities, such as mobile devices to support the implementation of the inpatient and outpatient electronic patient record; and investment in analytics to support quality improvement. The Trust has also invested in the Greater Manchester Integrated Digital Care Record, which has gone live in Rochdale and will be rolled out to other localities during 2020/21.
Roll out of Electronic Patient Record (EPR) to all services	Phase 1 and 2 of the electronic patient record and mobile device project is now complete (with the new systems rolled out to our community-based services). The Trust has carried out a listening exercise with staff to take stock of any lessons that need to be learned and to assess organisational readiness for the more complex phase 3 roll-out covering in-patients and outpatients. The insights gained have been incorporated into an action plan which is owned by the Chief Executive and Executive Directors to ensure the development and safe deployment of the full electronic patient record from 2020/21.
Develop a pragmatic estates strategy and implement 2019/20 priorities, including single gender accommodation and psychiatric intensive care unit developments	In line with the new Trust five-year strategy, a refreshed capital investment strategy has been developed over the course of 2019/20. This, along with the Trust-wide strategic direction, will allow the creation of a long-term investment plan into the environment which is aligned to the Trust vision. The Full Business Case outlining plans for the development of a Psychiatric Intensive Care Unit (PICU) on our Tameside hospital site was approved by NHS Improvement in February 2020. Construction has been paused due to the Covid-19 emergency response. A Full Business Case for the delivery of single gender accommodation across the Trust was approved by the Board of Directors in December 2019. Works were due to commence on our ward areas in March 2020, however due to the Covid-19 emergency response this has been paused. The business case will be reviewed in 2020/21 as part of recovery planning.

Service Development and Transformation Development achievements 2019/20

Business Area	Developments
Inpatients	• We have undertaken a significant amount of engagement with our users, carers and other stakeholders to agree the Trust's position for single gender accommodation. In 2020/21, we will begin a programme of work to move to single gender ward provision across adult and inpatient wards. • We have agreed a business case to redesign our psychiatric intensive care services to include a female unit. • We established a Trust-wide adult bed management service to support more efficient use of our inpatient beds.
Community	• We have worked with staff across the Trust, and wider stakeholders to develop a standardised pathway for community mental health teams. The new pathway provides a new therapeutic offer focused on recovery. • A new 'gatekeeping model' has been established and rolled out within our adult services. • Our Early Intervention in Psychosis (EIP) services have worked closely with NHS Improvement to support improvement of their national targets.
Learning Disability	• We have worked with users, carers and a wide range of partners to develop a learning disability strategy, which aims to provide best-practice, high quality learning disability services and to ensure that in everything we do we are working to tackle health inequalities experienced by those with a learning disability.
Alternatives to admission	• We have worked jointly with our commissioners to open our Safe Haven services across the Trust. • We have continued to develop our Core 24 compliant mental health A&E Liaison services. We will continue to develop all our services to meet full compliance during 2020/21, including all-age provision.
Primary Care	• We have launched the new Open Door Service in Tameside, working collaboratively with charitable and voluntary sector providers and healthcare commissioners. • We have co-designed a new primary care offer in Stockport, working closely with third sector providers.
Child and Adolescent Mental Health Services (CAMHS)	• We have led the programme across Greater Manchester for developing Rapid Response Teams and an acute liaison service. • We have launched safe zones for children and young people across Greater Manchester.

Business Area	Developments
	• We have been named the lead provider for the 'Tier 4' (inpatient) children and young people's 'Provider Collaborative', a joint venture between mental health providers across Greater Manchester.
Rehabilitation and High-Support needs	• We have begun to develop our provider collaborative for 'Tier 4' (inpatient) services with our provider partners across Greater Manchester. • We have been successfully named as a partner provider in the provider collaborative for Military Veterans services across the North West.
Transfer of Community Services	• We successfully transferred community services across Heywood, Middleton and Rochdale; Bury; Oldham and Trafford to two new providers. This was a significant undertaking, involving the TUPE transfer of thousands of staff and a complex due diligence process.

Future challenges and opportunities

The key risks and issues which could affect the delivery of the Trust's objectives and/or affect future sustainability are managed by the Board Assurance Framework (BAF). These are summarised below, and further detail is available within the Annual Governance Statement from page 98:

Trust Strategic Goal	Summary of high-level risk
Services	If patients do not receive safe, effective and high-quality care, this would result in patient/carer harm, non-regulatory compliance and an adverse effect on Trust reputation. This includes the following factors: • Failure to provide single gender accommodation; • Insufficient resource to undertake Quality Improvement (QI) and embed the approach across the organisation; • Insufficient resource to capture patient experience and co-production; • Compliance with mandatory training standards; • Failure to meet safe staffing/required resource levels; • Risk of insufficient clinical leadership in the organisation; • Capacity and ability to learn from incidents; • Failure to manage physical health needs of patients. If the Trust cannot demonstrate sustainability following changes to its service portfolio, there is a risk that it will remain in enforcement undertakings and could

Trust Strategic Goal	Summary of high-level risk
	be subject to regulatory intervention, which could compromise the longer-term viability of the organisation. Relevant to this includes: • Failure to secure income from mental health contracts that meet our demand; • Stranded costs following the transfer of community services to alternative providers; • Failure to embed the Improvement Programme to support delivery of the financial plan; • If the Trust does not deliver the 2020/21 plan and agreed control total, there is a risk of regulatory intervention; • Inability to reduce corporate overheads proportionate to size of organisation; • Failure to progress mental health programme budgeting with our commissioning partners. If the Trust is unable to effectively implement the Health Informatics and Estates enabling plans, it will be unable to deliver services in line with the quality and financial strategies. Relevant factors include: • Lack of capital funding with Trust's internal affordability plan; • Requirement to respond to and meet enhanced national standards and specifications; • Pressure on Health Informatics to deliver a complex range of service priorities.
People	If the Trust does not recruit and retain an appropriate skilled workforce, it will not be able to deliver and develop services in line with the plan for 2020/21. This links to: • Recruitment and retention challenges; • National supply shortages around professional groups; • Competition from other organisations in terms of their offer; • Turnover and sickness levels; • Workforce profiling issues (e.g. aging workforce).
Culture	If the Trust cannot deliver successful organisational development and design, it will not create an environment/culture that facilitates good engagement, retention and safe provision of services. Challenges impacting on our culture include: • Engagement with our staff groups on our delivery priorities; • Engagement across our local communities; • Robust plans to strengthen equality, diversity and inclusion.
Partnerships	If the Trust does not position itself successfully within local care organisations, then our expertise and the value it can bring to partnerships in the interests of mental health and learning disabilities will not be adequately represented. This could arise if we fail to develop a high enough profile for these specialisms, and fail to understand our local communities and their needs.

A range of controls, with clear risk owners, are in place to manage and mitigate these risks. These are reviewed regularly by Executive Director owners and quarterly by the Board of Directors.

In terms of opportunities for the coming year, these are summarised below:

Trust Strategic Goal	Key opportunities
Services	The Trust has an exciting plan for service transformation and improvement, both for operational and support services. The programme of work is underpinned by quality improvement methodology and will focus on improving the user experience, enabled by digital and estates enhancements. This programme is being refreshed for the remainder of 2020/21 as part of the Trust's recovery planning following Covid-19. Learning from the pandemic has been captured through and appreciative enquiry and is being integrated into the plan, ensuring that we capitalise on some of the identified improvements in how we work. The Trust will continue to explore programme budgeting opportunities with our commissioners to support the sustainability plan.
People	Whilst workforce issues continue to be a challenge, the response to the Covid-19 pandemic has created the opportunity to think differently and more creatively about how we deploy our workforce. We are also looking to enhance diversity and lived experience within our workforce, which provides an opportunity to drive continuous improvement of services. We are also working closely with our localities and Greater Manchester colleagues to explore opportunities together, to ensure a workforce solution for our local population need.
Culture	The roll-out of our new strategy and values affords us the opportunity to be different as an organisation. This will be enabled by the new integrated leadership structure which will enhance clinical and professional leadership within the organisation.
Partnerships	Learning from Covid-19 has concluded that our partnership working has improved immensely, with a range of our stakeholders. We will build on this opportunity to ensure that this progress is cemented when we return to 'business as usual'. Additionally, we continue to look for opportunities to work in partnership with our service users. These elements will be included in the development of our Partnership Strategy in the coming year.

Financial performance and information

The key headlines of financial performance for the financial year ending 31st March 2020:

- The Trust is reporting a surplus of £0.7m. This surplus includes: the impact of impairments (i.e. changes in the valuation of the Trust's fixed assets); transfer by absorption (transfer of assets to another NHS provider associated with a transfer of services); and a capital asset donation (Grace's Place). Adjusting for the value of these items means that the normalised reported position is a surplus of £1.5m.
- In achieving this position, efficiencies of £11.25m (4.6% of operating expenditure) were delivered over the year. This was achieved through:
    - Mental Health Improvement Programme of £1.2m
    - Corporate Services Model Hospital of £2.1m
    - Workforce redesign programme of £0.8m
    - £1.4m recovery of additional income through contract negotiation
    - £4.6m delivered through reviews of vacancies, staffing and skill mix
    - £1.1m was generated from a review of estates costs, savings from procurements and contribution from new investment
    - Other
- During the year the Trust has completed £5.5m of capital investments.
- The Trust's finance and use of resources rating was a 3. Further details of this can be found in the Single Oversight Framework section (page 52)

The following table summarises the actual financial performance for the period ending 31st March 2020.

	£'000
Income	250,859
Expenditure	(239,799)
Earnings before interest, tax, depreciation and amortisation	**11,060**
Non-operating costs (including depreciation, dividend and impairment)	(10,326)
Net surplus / (deficit)	**734**
Normalising adjustments:	
Impairment losses (reversals) net	(139)
Capital asset donations	(175)
Transfer by absorption	1,111
Normalised surplus per accounts	**1,531**

Transfer of Community Services

The Trust transferred community services to other providers during 2019/20 and this will continue into 2020/21 with some dental services and properties still to transfer. The key changes are:

- Operating income from patient care activities and other operating income has reduced by £35.2m in 2019/20 compared to 2018/19, of which
    - A reduction of £60.7m is due to the transfer of community services
    - An increase of £25.5m is due to inflation increases, investment and service changes in the remaining services
- The reduction in income was accompanied by a reduction in operating expenses relating to community services including the TUPE transfer of relevant staff
- The transfer by absorption loss of £1.1m is a technical adjustment that is required to reflect in the Trust's accounts the transfer of fixed assets to the new providers. More detail is included in Note 44 to the Accounts.

Income

The Trust can confirm, in accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), that its income from the provision of goods and services for the purposes of the health service in England was greater than its income from the provision of goods and services for any other purposes. The work required to generate the non-health care income has had no adverse impact on the provision of goods and services for the purposes of the health service in England.

Capital

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

	£'000
Information technology	2,692
Estates - backlog maintenance	886
Estates - routine maintenance	1,089
Estates - equipment	233
Estates - fire safety	113
Estates - new build - PICU	311
Estates - new build - Grace's Place donated asset	175
Total	**5,499**

During 2019/20 the Trust was fortunate enough to receive a capital allocation of £1.265m from the Department of Health and Social Care to support Information Technology investment.

Cash

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

The cash balance has increased by £2.9m during the year with a closing cash balance of £11.6m. The average daily cash balance during 2019/20 was £16.1m.

Better Payment Practice Code

The Trust continues to monitor its performance against the Better Payment Practice Code, which requires payment of all trade creditor invoices within 30 days of receipt and a valid invoice (unless other terms have been specifically agreed with the supplier). The target set is 95% for both value and volume of invoices. The results for the year were 94.9% by volume and 92.5% by value, which is an improvement on 2018/19 (90.6% volume, 91.9% by value).

	2019/20 number	2019/20 £'000	2018/19 number	2018/19 £'000
Non-NHS				
Total invoices paid in the year	51,784	98,792	61,052	100,067
Total invoices paid within the target	49,485	94,506	55,396	92,970
Percentage of invoices paid within the target	**95.6%**	**95.7%**	**90.7%**	**92.9%**
NHS				
Total invoices paid in the year	1,701	26,951	1,871	30,653
Total invoices paid within the target	1,286	21,786	1,612	27,181
Percentage of invoices paid within the target	**75.6%**	**80.8%**	**86.2%**	**88.7%**
Total				
Total invoices paid in the year	53,485	125,743	62,923	130,720
Total invoices paid within the target	50,771	116,292	57,008	120,151
Percentage of invoices paid within the target	**94.9%**	**92.5%**	**90.6%**	**91.9%**

Finance and Use of Resources

The assessment of the Trust's financial performance by NHS Improvement is based on the Single Oversight Framework (SOF). Within this there are five key financial performance measures known as the Use of Resources ratings. The financial risk is rated from 1 to 4,

where 4 equals the highest risk, and where 1 is considered the lowest risk with no regulatory concerns. The overall score is determined by a simple average, with the result rounded up.

The measures are designed to thoroughly assess the Trust's financial robustness and efficiency:

- Capital Service Capacity - the degree to which the organisation's generated income covers its financing obligation.
- Liquidity - days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.
- Income and Expenditure (I&E) margin - the degree to which the organisation is operating at a surplus/deficit.
- I&E margin: distance from financial plan - variance between a foundation trusts planned I&E margin in its annual forward plan and its actual I&E margin within the year.
- Agency spend - measures agency spend for the Trust against the NHSI target value (£6.5m) in 2019/20.

The table below details the financial performance by the Trust against the plan submitted to for 2019/20. The overall Use of Resources score for the Trust for the financial year 2019/20 is a score of 3.

Use of resource metric	Plan	Actual
Capital service capacity	3	1
Liquidity	2	2
I&E margin rating	2	2
I&E margin: distance from financial plan		1
Agency spend	3	4
Overall score	**2**	**3**

The deterioration in the agency metric reflects the increased spend on agency of £11.0m in 2019/20 compared to £10.9m in 2018/19. The metric compares actual spend against an agency ceiling. This ceiling was reduced following the transfer of community services. This increased spend is as a result of operational areas being supported by agency staff to alleviate pressures linked to vacancy levels, increased patient acuity and Covid-19.


adidas
adidas

Accountability report

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

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

Claire Molloy
Chief Executive
22 June 2020

Directors' Report

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

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

As an NHS Foundation Trust, the principal purpose of the organisation, in accordance with the principals enshrined in the NHS Constitution, is the provision of goods and services for the purposes of the health service in England. The Trust's principal activities are detailed in the performance report from page 10.

The Board of Directors

The Trust is led by a unitary Board of Directors comprising eight independent Non-Executive Directors (including the Chair) and seven Executive Directors (including the Chief Executive). Board members each contribute to the collective skill set and wide-ranging experience of the Board, gained from a variety of professions and industry. More detailed information on the individuals who make up the Board of Directors can be found from page 30.

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

As at 31 March 2020, membership of the Board of Directors was as follows:

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

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

There was a change to the Deputy Chief Executive arrangements during 2019/20. With effective from 1 June 2019, Suzanne Robinson and Dr Henry Ticehurst were appointed jointly as Deputy Chief Executive.

There will be several changes to the composition of the Board during 2020/21, which will be detailed within next year's Annual Report.

All our Non-Executive Directors are independent as they have not been employed by the Trust and do not have any financial or other business interests in the organisation. None have close family ties with Pennine Care NHS Foundation Trust's advisers, directors or senior employees; and none of the current Non-Executive Directors have served terms of office greater than six years.

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

Attendance (actual/eligible) at Board of Directors meetings (held in public) and statutory committees 1 April 2019 to 31 March 2020.

Board member	Board of Directors	Audit Committee	Appointment and Remuneration Committee	Term of appointment
Non-Executive Directors				
Evelyn-Asante Mensah	9/10		2/2	1 November 2017 – 31 October 2020
Joan Beresford	10/10		2/2	1 November 2017 – 31 October 2020 (second term of office)
Sandra Jowett	10/10	5/5	2/2	1 December 2017 – 30 November 2020 (second term of office)
Daniel Benjamin	10/10	5/5	2/2	4 September 2017 – 3 September 2020
Michael Livingstone	10/10		2/2	21 September 2018 – 20 September 2021 (second term of office)
Julia Sutton-McGough	10/10		1/2	1 September 2017 – 31 August 2020
John Scampion	10/10	5/5	2/2	19 February 2018 – 18 February 2021
Catherine Laverty	8/10	4/5	2/2	28 November 2018 – 27 November 2021
Executive Directors				
Claire Molloy	8/10			
Henry Ticehurst	10/10			
Keith Walker	7/10			
Judith Crosby	8/10			
Clare Parker	9/10			
Nicola Littler	8/10			
Suzanne Robinson	8/10			

Meetings of the Board of Directors

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

Formal Committees of the Board

As at 31 March 2020, the Board committee structure comprises of six formal committees of the Board of Directors, as follows:

- Audit Committee (statutory committee)
- Appointment and Remuneration Committee (statutory committee)
- Quality Committee
- Performance and Finance Committee
- People and Workforce Committee
- Charitable Funds Committee

Following each meeting, the Chair of the committee submits a report to the Board of Directors. The work of the committees is described below, and the Annual Governance Statement from page 98 provides an overview of how these arrangements support robust governance and have responded to the Covid-19 pandemic.

Audit Committee

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

- Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that support the achievement of the Trust's objectives. The Annual Governance Statement provides further information regarding the effectiveness of the system of internal control.
- Ensuring the establishment of an effective internal audit function in line with mandatory Public Sector Internal Audit Standards, which provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. The Trust's internal audit provider is Mersey Internal Audit Agency (MIAA). The Audit Committee agreed an internal audit plan aimed at providing assurances on the

effectiveness of governance, risk and controls across key systems that support the delivery of the Trust's objectives and functions of the organisation. Audit Committee seeks assurance regarding the delivery of the internal audit plan and the results of audit reviews. Where necessary, the Audit Committee refers the outputs of internal audit reviews to other Board committees for additional scrutiny.

- Reviewing the work, findings and opinions of the external auditor, and assuring itself of the independence of the external auditor and monitoring any non-audit work that the external auditors are asked to perform. Grant Thornton was appointed by the Council of Governors as the Trust's external auditor for a three-year term in 2015, following a procurement exercise. The contract was extended for a further two years in 2018, up to 31 May 2020. The Audit Committee continually assesses the effectiveness of external audit through regular reports regarding delivery against agreed audit plans. During 2019/20, the Audit Committee supported the Council of Governors to undertake a procurement exercise for the appointment of the external auditor commencing 1 June 2020. Detail regarding this process and the outcome can be found within the Council of Governors section of the annual report.
- Testing assurance processes and reviewing the findings of other significant internal and external assurance functions and their implications for the governance of the Trust.

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

Audit Committee membership as at 31 March 2020:

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

Appointment and Remuneration Committee

Chaired by the Trust Chair, and with a membership comprising all Non-Executive Directors, this Committee is responsible for reviewing the size, structure and composition of the Board and making recommendations regarding any changes. It also decides and reviews the terms and conditions of office of the Trust's Executive Directors in accordance with the requirements of the NHS Act 2006, the Trust constitution and all relevant Trust policies.

During 2019/20, the Chief Executive led the process for the substantive appointment of a Deputy Chief Executive. This role had been held on an acting basis by Dr Henry Ticehurst since 8 November 2018. Whilst it was the responsibility of the Chief Executive to put

effective deputising arrangements in place, the Appointment and Remuneration Committee welcomed involvement in the process. Interviews were held on 21 May 2019, with the interview panel consisting of Claire Molloy, Chief Executive, and Michael Livingstone, Non-Executive Director. The Committee met on 29 May 2019 to approve a recommendation from the interview panel to appoint Dr Henry Ticehurst and Suzanne Robinson to undertake joint Deputy Chief Executive responsibilities with effect from 1 June 2019.

Quality Committee

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

Quality Committee membership as at 31 March 2020:

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

Performance and Finance Committee

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

Performance and Finance Committee membership as at 31 March 2020:

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

People and Workforce Committee

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

People and Workforce Committee membership as at 31 March 2020:

- Professor Sandra Jowett (chair)
- Michael Livingstone
- Dr Julia Sutton-McGough
- Nicola Littler
- Keith Walker
- Judith Crosby

Charitable Funds Committee

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

Assessing the Board's Performance

In line with the Foundation Trust Code of Governance, the Executive Directors undergo annual individual performance evaluations led by the Chief Executive and including the Trust Chair. Non-Executive Directors are appraised annually by the Chair of the Trust following a process agreed with the Council of Governors, who have the power to reappoint or remove them from post, as laid down in the Trust's constitution. Details regarding the appraisal of the Chair can be found in the Council of Governors section of this report.

To support the development of a new organisational strategy, including a refreshed vision and values, the Board has spent a significant amount of time since 2018 exploring its role and contribution to the organisation; including its governance arrangements and development needs.

Along with a range of individual and group Executive Director / Non-Executive Director activities, the Board held two externally facilitated development days during 2019/20 to create a shared understanding of key areas for review and development, with particular focus given to the functioning and structure of the Board. Subsequently, a range of proposals were developed with the aim of achieving a better balance between maintaining the existing focus on fiduciary governance whilst building time and space to enhance the Board's skills and capability to work within strategic and generative modes of governance. The proposals also set out a framework for Board development encompassing opportunities for the Board to learn and develop together; immersive developmental events; and knowledge-based learning.

The above proposals were scheduled for implementation from April 2020 however, as a result of Covid-19, implementation was paused. The Board's governance arrangements would be reviewed during 2020/21 as part of Covid-19 recovery.

Working with the Council of Governors

The Board of Directors and Council of Governors work closely together. The Board of Directors is responsible for running the Trust's services and developing strategies and plans for the future. It is also accountable for the organisation's compliance with national standards, performance targets and financial requirements. The Council of Governors has a statutory responsibility to hold the Non-Executive Directors of the Board individually and collectively to account for the performance of the Board of Directors. Details of how this is undertaken are reported in the Council of Governors section of this report (page 81).

The Chair of the Trust chairs the meetings of both the Board of Directors and the Council of Governors. A report on all items discussed and approved by the Council of Governors are reported to the next meeting of the Board of Directors. All Non-Executive Directors attend the Chair, NED and Governor Committee, during which governors have the opportunity to understand the views of governors and members and seek assurance the Board is addressing all matters relating to the delivery of objectives, quality and safety, workforce, finance, and operational delivery. Moreover, Non-Executive Directors are invited to attend full Council of Governors meetings and governor-led local constituency meetings. The Chief Executive (or her representative) attends each meeting of the Council of Governors to deliver an organisational update and to invite the views of members. During 2019/20, arrangements have been in place for governor representatives to observe monthly meetings of the Board of Directors.

Board Directors' profiles

EVELYN ASANTE-MENSAH OBE commenced in post as Chair of the Trust in November 2017, having held senior positions in a variety of health and voluntary organisations over the last 25 years.

Among her notable roles, Evelyn was chair of Central Manchester Primary Care Trust and then NHS Manchester over a 12-year period, also holding a board-level role at Manchester Mental Health and Social Care Trust.

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

JOAN BERESFORD was appointed as a Non-Executive Director in November 2014.

Joan took early retirement from Stockport Metropolitan Borough Council where, for the last eighteen months of her service, she was Head of Integrated Commissioning based in Adult Social Care working closely with health commissioners and providers.

She has 41 years' service in local government having worked for Manchester City Council for 22 years prior to joining Stockport. She has undertaken a range of roles during this time; including administration, management, project management and eight years as a qualified social worker.

Joan was appointed Deputy Chair from 1 January 2017.

PROFESSOR SANDRA JOWETT was appointed as a Non-Executive Director in December 2014.

Sandra has worked with the NHS for much of her career, through her research and strategic leadership roles in a range of public and private sector organisations. She has worked in four universities and was, until December 2015, Deputy Vice-Chancellor at the University of Cumbria.

Prior to this she was a director of the UK arm of a global research company, responsible for its public policy research. For 15 years she led research teams at the National Foundation for Educational Research, undertaking largely government-commissioned work to inform service development and national policy in health and education.

Sandra was appointed Senior Independent Director from 1 January 2017; and chairs the People and Workforce Committee.

MICHAEL LIVINGSTONE was appointed as a Non-Executive Director in September 2015.

Up until the end of 2014 Mike was the Strategic Director of Children's Services at Manchester City Council. He has nearly 30 years' experience in local government having qualified as a social worker in 1985 and been a senior manager for over 15 years. Mike also spent five years with the national inspectorates as a lead inspector with the Social Services Inspectorate in the Department of Health and with Ofsted, working closely with other inspectorates including the CQC.

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

DANIEL BENJAMIN was appointed as a Non-Executive Director in September 2017.

Daniel has over 30 years of commercial experience, including working for IBM (in the IT industry) for 25 years in a variety of commercial and advisory roles.

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

Daniel has a significant amount of health, voluntary sector and community service experience and currently serves on the board of a Cancer charity. Daniel chairs the Performance and Finance Committee.

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

Since 2010, Julia has run her own consultancy business. This has included support for NHSE/I Quality improvement programmes (Productive General Practice) and Clinical Pharmacist in Practice. Current work includes training and organisational development support for Primary Care Networks including population health management, workforce planning, leadership, care model re-design and estates strategy development.

Before starting her own business, Julia was an executive board member at Sue Ryder Charity. During the early part of her career Julia spent time in the pharmaceutical industry, with eight years at SmithKline Beecham, AstraZeneca and Schering Health Care. Her roles included study management, clinical quality assurance and product management.

Julia chairs the Quality Committee.

JOHN SCAMPION was appointed as a Non-Executive Director in February 2018.

Qualifying as a chartered accountant in 1981, he joined the NHS in 1983, holding board level posts in Manchester, Rochdale, Oldham, Tameside, Central Manchester Hospitals and The Christie.

Since retiring from full time executive roles, he was chair, until 2013, of The Lifeline Project, a social enterprise company providing drug rehabilitation services. He was also chair of Manchester Mental Health and Social Care Trust until it merged with Greater Manchester West in 2015.

John chairs the Audit Committee, which oversees the system of governance for the organisation.

CATHERINE LAVERTY was appointed as Non-Executive Director in November 2018.

Cath has a strong background in mental health nursing; beginning her career on hospital wards before moving into a community-based role. She later provided mental health support to homeless people across the city of Manchester.

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

CLAIRE MOLLOY commenced as Chief Executive in September 2017.

Claire has over 20 years' experience in the NHS; and was Chief Executive at Cumbria Partnership NHS Foundation Trust for four years before joining Pennine Care. Prior to this she was Managing Director at Heart of England NHS Foundation Trust; and has worked within primary, community, and acute settings.

Claire has extensive experience of building strong relationships with partners in order to improve patient care and is passionate about staff engagement to build a strong and motivated workforce.

DR HENRY TICEHURST was appointed as the Medical Director from 1 June 2010; having previously served as Lead Consultant in Bury, and as a Consultant Psychiatrist in several our localities.

From 1 June 2019, Henry was appointed as Deputy Chief Executive (joint).

CLARE PARKER was appointed as Executive Director of Nursing, Healthcare Professionals and Quality Governance in May 2018.

Clare is a learning disability nurse by background. She spent most of her early career working within learning disability and mental health services, specifically with people who have challenging behaviour, complex and forensic needs.

She gained her master's degree in management from Manchester University and then moved into management, quality and nursing roles. Clare has worked for provider organisations, commissioning organisations and a local authority.

Clare's previous role was Executive Director of Quality and Nursing for Cumbria Partnership NHS Trust which is a mental health, learning disability and community trust.

She has achieved the Nye Bevan Award for Executive Healthcare Leadership, from the NHS Leadership Academy.

KEITH WALKER was appointed as Director of Operations in August 2014. The role was conferred Executive Director status from 1 December 2014.

Keith is responsible for overseeing the entire operations of the Trust's services. His priorities are to ensure that services are safe and effective, that patients receive high quality care and that staff are supported in the workplace.

Keith is a qualified mental health nurse and has worked in the NHS for over 20 years. Before joining Pennine Care in 2006, he worked in a number of clinical and management positions within adult and children's mental health services.

JUDITH CROSBY has been Executive Director of Service Development and Delivery since September 2015, having previously held the roles of Director of Finance and Deputy Director of Finance.

In her current role, Judith leads on the design and implementation of the Trust's Strategy. This involves ensuring that plans are in place to deliver safe and sustainable services in line with commissioning requirements across the health and social care system.

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

NICOLA LITTLER was appointed as Executive Director of Workforce from December 2018.

Nicky has 16 years' experience working within mental health NHS services in a senior human resources role. She started her career at Tameside Council, before joining our Trust for the first time in 2002.

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

SUZANNE ROBINSON was appointed as Executive Director of Finance from January 2019. From 1 June 2019, Suzanne was appointed as Deputy Chief Executive (joint).

Suzanne has over 17 years' experience working at a senior level at a number of large acute and specialist providers as well as commissioning organisations in the North West of England. She has a passion for finance skills development and improving the visibility and understanding of finance across the NHS, leading many of her teams to succeed in national finance awards.

In 2018 she became senior responsible officer for the Future Focused Finance Valuemakers programme which represents over 600 finance staff across the country. Suzanne also serves as chair of the healthcare financial management association (HFMA) Mental Health Finance Faculty, which supports and represents the interests of finance professionals in organisations delivering mental health and learning disability services providing an opportunity to promote the mental health agenda working on solution for common issues.

Statement of compliance with the NHS Foundation Trust Code of Governance

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

Pennine Care NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

As at 31 March 2020, the Trust was compliant with all the code's provisions.

The following table sets out the Trust's compliance with the disclosure requirements set out in the NHS Foundation Trust Code of Governance and the NHS Foundation Trust Annual Reporting Manual. Please refer to the director's report from page 30, council of governors and membership section from page 81, and the Annual Governance Statement from page 98 for full disclosures.

Code provision / requirement of FT ARM	Reference	Comply or Explain
(A.1.1) The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Accountability report: • Directors' report • Council of Governors section	**Comply**

Code provision / requirement of FT ARM	Reference	Comply or Explain
(A.1.2) The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Accountability report • Directors' report • Board profiles • Meetings of the Board of Directors	**Comply**
(A.5.3) The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Accountability report • Council of Governors section	**Comply**
(Requirement of FT ARM) The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors	Accountability report • Council of Governors section	**Comply**
(B.1.1) The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Accountability report • Directors' report	**Comply**
(B.1.4) The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Accountability report • Directors' report • Board profiles	**Comply**
(Requirement of FT ARM) The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Accountability report • Directors' report • Council of Governors section	**Comply**

Code provision / requirement of FT ARM	Reference	Comply or Explain
(B.2.10) A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Accountability report • Directors' report • Council of Governors section	**Comply**
(Requirement of FT ARM) The disclosure in the annual report on the work of the nominations committee should include an explanation if either an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Accountability report • Council of Governors section	**Comply**
(B.3.1) A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	Accountability report • Directors' report • Council of Governors section	**Comply**
(B.5.6) Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Accountability report • Council of Governors section • Membership section	**Comply**

Code provision / requirement of FT ARM	Reference	Comply or Explain
(Requirement of FT ARM) If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Not applicable	**Comply**
(B.6.1) The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Accountability report • Directors' report	**Comply**
(B.6.2) Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Accountability report • Directors' report	**Comply**
(C.1.1) The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement.	Accountability report • Directors' report • Annual Governance Statement	**Comply**

Code provision / requirement of FT ARM	Reference	Comply or Explain
(C.2.1) The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Accountability report • Directors' report • Annual Governance Statement	**Comply**
(C.2.2) A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Accountability report • Directors' report (Audit Committee)	**Comply**
(C.3.5) If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable	**Comply**

Code provision / requirement of FT ARM	Reference	Comply or Explain
(C.3.9) A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Accountability report • Directors' report (Audit Committee) • Council of Governors section	**Comply**
(D.1.3) Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable	**Comply**
(E.1.4) Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Accountability report • Membership section	**Comply**

Code provision / requirement of FT ARM	Reference	Comply or Explain
(E.1.5) The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Accountability report • Directors' report	**Comply**
(E.1.6) The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Accountability report • Directors' report • Council of Governors section • Membership section	**Comply**
(Requirement of FT ARM) The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	Accountability report • Membership section	**Comply**

Code provision / requirement of FT ARM	Reference	Comply or Explain
(Requirement of FT ARM) The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	Accountability report • Directors' report • Council of Governors section	**Comply**

Summary of the requirements of Schedule 7 to the Regulations

Disclosure requirement	Reference
Any important events since the end of the financial year affecting the NHS foundation trust.	Refer to the performance report from page 10
An indication of likely future developments at the NHS foundation trust.	Refer to the performance report, future priorities and challenges from page 21
An indication of any significant activities in the field of research and development.	This will be referenced in the Trust's Quality Account, due to be published in December 2020.
Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.	Refer to the staff report from page 64
Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period.	Refer to the staff report from page 64

Disclosure requirement	Reference
Policies applied during the financial year for the training, career development and promotion of disabled employees.	Refer to the staff report from page 64
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees.	Refer to the staff report from page 64
Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests.	Refer to the staff report from page 64

NHS Oversight Framework

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

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

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

Segmentation

Our segmentation position as at 31 March 2020 is 3. Further information regarding the Trust's segment position and enforcement action taken by NHS Improvement can be found in the Annual Governance Statement on page 98.

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

Finance and use of resources

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

Area	Metric	2019/20 scores				2018/19 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	1	2	4	4	3	4	4	4
	Liquidity	2	3	3	3	3	3	3	3
Financial efficiency	I&E margin	2	3	4	4	2	3	3	3
Financial controls	Distance from financial plan	1	1	2	1	1	1	1	1
	Agency spend	4	4	4	4	3	3	2	1
Overall scoring		3	3	3	3	2	3	3	3

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

Statement of Accounting Officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Pennine NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Pennine Care NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Pennine Care NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Claire Molloy
Chief Executive
22 June 2020

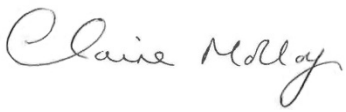
Statement as to disclosure to the auditors

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

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

For and on behalf of the Board:

Evelyn Asante-Mensah OBE
Chair
22 June 2020



Claire Molloy
Chief Executive
22 June 2020

Remuneration report

Annual statement 2019/20

There have been no major decisions or changes to senior managers' remuneration during 2019/20.

For the period April 2019 to March 2020 the employees involved have received a 0% pay award.

Senior managers' remuneration policy

The Appointment and Remuneration Committee is responsible for setting and agreeing senior managers' remuneration, along with their terms and conditions. Read more about the committee on page 82.

Details of senior managers' remuneration are provided on page 59.

Policy table:

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

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

With regards to senior managers paid more than £150,000 periodic reviews are undertaken in order to satisfy that the remuneration is reasonable.

For remuneration in relation to Non-Executive Directors see page 59. The fees of non-executive directors are set by the Chairman and Council of Governors.

Service contract obligations

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

Policy on payment of loss of office

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

There were no payments for loss of office.

Statement of consideration of employment conditions elsewhere in the foundation trust

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

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

Benchmarking activities are undertaken where deemed appropriate.

Annual report on remuneration

Please refer to the Directors' Report on page 30 for details of the membership and purpose of the Appointment and Remuneration Committee.

Section A: Total remuneration 2019/20 and 2018/19 (subject to audit)

		2019/20 Salary	2019/20 Expense payments (taxable)	2019/20 Performance pay and bonuses	2019/20 Long term performance pay and bonuses	2019/20 All pension-related benefits	2019/20 Total	2018/19 Salary*	2018/19 Expense payments (taxable)*	2018/19 Performance pay and bonuses	2018/19 Long term performance pay and bonuses	2018/19 All pension-related benefits	2018/19 Total
Name	**Title**	**£000s (Bands of £5k)**	**£s (nearest £100)**	**£000s (Bands of £5k)**	**£000s (Bands of £5k)**	**£000s (Bands of £2.5k)**	**£000s (Bands of £5k)**	**£000s (Bands of £5k)**	**£s (nearest £100)**	**£000s (Bands of £5k)**	**£000s (Bands of £5k)**	**£000s (Bands of £2.5k)**	**£000s (Bands of £5k)**
Executive Directors													
Ms C Molloy	Chief Executive	135 - 140	3,500	-	-	-	140 - 145	155 - 160	3,500	-	-	32.5 - 35	195 - 200
Ms S Robinson	Executive Director of Finance / Deputy Chief Executive (from 28 January 2019)	140 - 145	3,500	-	-	70 - 72.5	215 - 220	20 - 25	600	-	-	-	20 - 25
Dr H Ticehurst	Executive Medical Director / Deputy Chief Executive	180 - 185	-	-	-	102.5 - 105	285 - 290	170 - 175	-	-	-	97.5 - 100	270 - 275
Ms C Parker	Executive Director of Nursing, Healthcare Professionals and Quality Governance (from 21 May 18)	130 - 135	3,500	-	-	-	135 - 140	115 - 120	1,800	-	-	-	115 - 120
Ms J Crosby	Executive Director of Service Development and Delivery	125 - 130	3,500	-	-	-	130 - 135	125 - 130	3,500	-	-	-	130 - 135
Ms N Littler	Executive Director of Workforce (from 3 December 18)	90 - 95	3,500	-	-	110 - 112.5	205 - 210	30 - 35	1,100	-	-	-	35 - 40
Mr K Walker	Executive Director of Operations	125 - 130	3,500	-	-	70 - 72.5	200 - 205	125 - 130	3,500	-	-	-	130 - 135
Ms E Tilston	Acting Executive Director of Finance (from 7 November 18 to 27 January 19)	-	-	-	-	-	-	20 - 25	-	-	-	-	20 - 25
Mr M Roe	Deputy Chief Executive / Executive Director of Finance (until 7 November 18)	-	-	-	-	-	-	80 - 85	-	-	-	-	80 - 85
Ms J Stewart	Executive Director of Nursing and Healthcare Professionals (until 1 June 18)	-	-	-	-	-	-	20 - 25	600	-	-	-	20 - 25
Chair													
Ms E Asante-Mensah	Chair	45 - 50	-	-	-	-	45 - 50	45 - 50	-	-	-	-	45 - 50
Non-Executive Director													
Mr J Scampion	Non Executive Director	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Mr D Benjamin	Non Executive Director	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Dr J Sutton-McGough	Non Executive Director	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Mr M Livingstone	Non Executive Director	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Ms J Beresford	Non Executive Director / Deputy Chair	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Prof S Jowett	Non Executive Director / Senior Independent Director	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Ms C Laverty	Non Executive Director (from 28 November 18)	15 - 20	-	-	-	-	15 - 20	5 - 10	-	-	-	-	5 - 10
Lord K Bradley	Non Executive Director (until 31 August 18)	-	-	-	-	-	-	5 - 10	-	-	-	-	5 - 10

The figures in the 2018/19 Salary column have been restated to separately disclose senior manager car allowance payments within the Expense payments (taxable) column. These had previously been presented as Salary & fees in the 2018/19 Annual Report.

Section B: Total pension entitlement 2019/20 (subject to audit)

Name and Title	Real increase in pension at pension age (bands of £2.5k) £000	Real increase in pension lump sum at pension age (bands of £2.5k) £000	Total accrued pension at pension age at 31 March 2020 (bands of £5k) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5k) £000	Cash Equivalent Transfer value at 1 April 2019 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Employer's contribution to stakeholder pension £000
Claire Molloy Chief Executive	0	0	0	0	1,182	0	0	0
Suzanne Robinson Executive Director of Finance / Deputy Chief Executive	2.5 - 5.0	0 - 2.5	30 - 35	65 - 70	449	46	519	0
Henry Ticehurst Executive Medical Director / Deputy Chief Executive	5.0 - 7.5	15.0 - 17.5	70 - 75	210 - 215	1,401	134	1,596	0
Clare Parker Executive Director of Nursing, Healthcare Professionals and Quality Governance	0	0	55 - 60	0	713	0	677	0
Judith Crosby Executive Director of Service Development and Delivery	0 - 2.5	0 - 2.5	50 - 55	155 - 160	1,181	19	1,247	0
Nicola Litter Executive Director of Workforce	5.0 - 7.5	10.0 - 12.5	30 - 35	70 - 75	421	88	532	0
Keith Walker Executive Director of Operations	2.5 - 5.0	2.5 - 5.0	35 - 40	70 - 75	487	53	570	0

Section C: Pay multiples 2019/20 (subject to audit)

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. This includes estimated annual remuneration for temporary and agency staff and is based on full time equivalent annualised salary.

The mid-point banded remuneration of the highest paid director in Pennine Care in the financial year 2019/20 was £182,500 (2018/19: £175,000). This was 6.12 times (2018/19: 6.24) the median remuneration of the workforce, which was £29,840 (2018/19: £28,050).

In 2019-20, no employees (2018-19, no employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £12k to £184k (2018-19 £8k-£175k).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Section D: Expenses of directors and governors

Expenses claimed 2019-20	Number in post	Number claiming expenses	Total expenses claimed £ (rounded to nearest £100)
Governors	33	13	2,100
Executive and Non-Executive Directors	15	13	17,800

Expenses claimed 2018-19	Number in post	Number claiming expenses	Total expenses claimed £ (rounded to nearest £100)
Governors	33	12	1,900
Executive and Non-Executive Directors	19	12	9,500

Section E: Notes to the remuneration report calculation

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

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

The calculation required is:

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

Where:

PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year;

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

LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year;

LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;

EC is the employee's contribution paid during the year.

Notes on Cash Equivalent Transfer Value for section B

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

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

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

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

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise form this judgement. During the year, the Government announced that public sector pension schemes will be required to provide indexation on the Guaranteed Minimum Pension element of the pension. NHS Pensions has updated the methodology used to calculate CETV values as at 31 March 2020. The impact of the change in methodology is included within the reported real increase in CETV for the year.

Claire Molloy
Chief Executive
22 June 2020

Staff report

We have a diverse workforce and employ 3646 substantive staff. This is the head count, or number of people, who work for Pennine Care including medical consultants, nurses, therapists and specialist practitioners. Our staff work in a variety of settings including the community, hospitals and clinics.

In addition, we employ approximately 897 staff on our bank, who work for us flexibly when we require additional staffing support. We simply would not be able to deliver high quality care to our patients without their continuing hard work, commitment and dedication.

Workforce demographics

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

Category	Female	Male	Total
Employee	2,893	731	3,624
Senior Manager	3	2	5
Board of Directors	10	5	15
Total	2,906	738	3,646

Notes

The figures in the table above are a snapshot as at 31 March 2020 and are headcount, so a staff member with more than one assignment would only be counted once. The figures referenced exclude bank staff. The Board of Directors category includes the Chief Executive, Executive and Non-Executive Directors, and the Senior Manager category includes anyone reporting directly to a Director.

Analysis of staff costs (subject to audit)

Staff costs	Permanent £000	Other £000	2019/20 Total £000	2018/19 Total £000
Salaries and wages	120,309	25,642	**145,951**	173,099
Social security costs	10,775	2,238	**13,013**	15,316
Apprenticeship levy	712	17	**729**	856
Employer's contributions to NHS pension scheme	22,251	3,148	**25,399**	21,144
Pension cost - other	44	-	**44**	38
Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	11,022	**11,022**	10,898
Total gross staff costs	**154,091**	**42,067**	**196,158**	**221,351**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**154,091**	**42,067**	**196,158**	**221,351**
Of which				
Costs capitalised as part of assets	1,429	-	**1,429**	2,101

The above table has been subject to audit.

Average number of employees (WTE basis)	Permanent Number	Other Number	2019/20 Total Number	2018/19 Total Number
Medical and dental	88	124	**212**	158
Ambulance staff	-	-	**-**	-
Administration and estates	854	181	**1,035**	1,308
Healthcare assistants and other support staff	905	292	**1,197**	1,301
Nursing, midwifery and health visiting staff	1,147	195	**1,342**	1,719
Nursing, midwifery and health visiting learners	11	9	**20**	10
Scientific, therapeutic and technical staff	506	133	**639**	893
Healthcare science staff	-	-	**-**	1
Social care staff	-	-	**-**	-
Other	1	7	**8**	8
Total average numbers	**3,512**	**941**	**4,453**	**5,398**
Of which:				
Number of employees (WTE) engaged on capital projects	31	-	**31**	53

The above table has been subject to audit.

Staff Health and Wellbeing

We continue to place importance on promoting positive health and wellbeing for our staff, and a number of interventions and actions have been undertaken. The Trust's overall cumulative sickness absence rate for 2019/20 was 5.9%, which is a slight increase to the 2018/19 rate (5.47%).

Occupational Health Service and Staff Wellbeing Services

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

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

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

Sickness absence data

	2019/20	2018/19	2017/18
Total days lost	48,870	57,053	55,349
Total staff years	4,967	4,850	4,752
Average working days lost (per WTE)	9.8	11.8	11.6

Managing Attendance Policy

Our Managing Attendance (sickness absence) Policy was developed in partnership with staff side colleagues. This introduces consistent standards across the organisation for all staff, supporting the effective management of sickness and ensuring staff are appropriately supported both during their absence and in returning to work.

We review our health supportive initiatives and services to ensure that these provide the right level and area of support for staff to provide a supportive return to work; this can include making reasonable adjustments for staff that return from long term sick leave, or where an employee may have developed a disability to remain in work. In addition to this the Human Resources Team provide coaching and development opportunities for our managers to improve their skills in the area of absence management and support.

Staff policies and actions applied during the financial year

Information on health and safety performance and occupational health

The staff survey measures a number of questions relating to the safety of staff including the culture of safety and safety of the environment. We have seen an increase in positive responses to all questions in relation to safety culture in the Trust. There has though been an increase in negative responses in relation to the physical safety environment.

We continue to place importance on promoting positive health and wellbeing for our staff, and a number of interventions and actions have been undertaken.

The Staff Wellbeing Service continues to show positive results in enabling staff to return to work and remain in work

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

Information on policies and procedures with respect to countering fraud and corruption

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

Equality, diversity and inclusion (EDI)

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

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

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

There has been a significant focus during 2019 to establish clear governance arrangements to take forward and monitor progress of Equality, Diversity and Inclusion activities across the Trust.

To support the development and delivery of our equality, diversity and inclusion agenda, ensure actions are clearly set to deliver our objectives and provide oversight of actions, we have established an Equality, Diversity and Inclusion (EDI) Group, reporting into the Equality Diversity and Inclusion Steering Group. The steering group reports in turn to the People and Workforce Committee. This structure ensures that risks are identified, action plans monitored, data analysed, and issues addressed at all levels of organisation.

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

We publish an annual equality report, the last version of which is available for the public to view online at:

https://www.penninecare.nhs.uk/application/files/4915/6165/0489/Equality_and_diversity_annual_publication_2018-2019.pdf

The Workforce Disability Equality Standard (WDES) standard is designed to help NHS organisations review their progress against ten WDES metrics and agree and progress actions to close any gaps in the workplace experience between disabled and non-disabled staff.

The 2019 WDES report and action plan can be accessed via the following link:

https://www.penninecare.nhs.uk/application/files/4915/6770/0422/WDES_analysis_report_2018-2019_v2.pdf

The Trust has an Education, Learning and Development Policy that provides guidance about access to training for disabled employees.

The results for the Disability Equality Standard 2019/20 show an improvement in the percentage of staff who believe that the Trust provides equal opportunities for career progression or employment from those staff identifying as disabled.

An Accessible Information Standard (AIS) policy (supporting communication needs of the service users) was developed in September 2017 and refreshed in 2018 and is available for all staff on our intranet. Where information is requested in large print or Braille or alternative formats, appropriate reasonable adjustment are made for the individual concerned.

We continue to progress our actions to ensure compliance with the standards. AIS is part of the EDI Group action plan. The group will also work with the electronic patient record roll out to ensure the information needs of individuals are recorded.

To assess how the standard is being applied, a baseline audit of services was undertaken and an action plan to support our findings was produced. This information resulted in the

Trust providing bespoke training. Compliance with the standard is part of the on-going Information Culture Project Group and will reference the requirements of the AIS Charter, which was signed by local NHS trusts committed to working together to ensure a consistent approach.

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

We monitor and analyse our workforce equality data by protected characteristics. We know that we can be more representative of the demographics of the communities we serve, and this continues to be an area for improvement. As part of the Workforce Race Equality Scheme we monitor recruitment information and access to training by all protected characteristics (including disability) and ensure that fair and consistent application of practice is in place.

The Trust WRES report (2018/19) is available on our website and can be accessed via the following link:

https://www.penninecare.nhs.uk/application/files/7515/7305/1699/WRES_analysis_report_2019.pdf

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

Pennine Care was accredited with the Disability Confident Employer Status for a second year in 2018. The Disability Confident Employer Scheme replaced the Disability Two Ticks scheme and is designed to help organisations show that they are disability friendly employers. This goes on to support the recruitment and retention of disabled people and people with health conditions for their skills and talent. The Equality, Diversity and Inclusion Team work to continue to raise awareness of the scheme and to meet level 3. We have a range of policies in place to ensure that staff with disabilities, or who become disabled while in our employment, are fully supported to ensure they have fair access to employment, career development opportunities and training.

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

Our Managing Attendance (sickness absence) policy ensures that adjustments are considered as part of enabling individuals to return to work, and in sensitively working with individuals in a supportive way where disabilities may impact on health.

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

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

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

Staff groups

The Trust and its UNISON branch have been working together to set up self-organised groups for staff and volunteers who identify themselves as a member.

The Staff Networks have been running for almost a year and continue to grow in number.

LGBTQ+ (Lesbian, gay, bisexual and transgender): sponsored by the Executive Director of Nursing, Healthcare Professionals and Quality Governance, the LGBTQ+ staff network has been running for the past three years and has made significant progress in a number of areas. Bespoke sessions around LGBTQ+ have been rolled out to our Board of Directors and services, with further sessions planned. To further champion the LGBTQ+ agenda, the Trust awarded the NHS rainbow badge to all staff that have completed LGBTQ+ training.

BAME (Black, Asian and minority ethnic)**:** sponsored by the Chair of the Trust, the BAME staff network was refreshed towards the end of 2019, resulting in new Terms of Reference being produced. The group meets every two months and will be actively engaged in helping promote and advise the EDI work programme, taking a particular lead on Black History Month.

Disability: sponsored by the Executive Director of Workforce, the first meeting of the Disability Network took place towards the end of 2019. Terms of reference have been written and the group endeavours to meet every two months. The group will be actively engaged in helping promote / advise the EDI work programme, including increasing the reporting for staff with a disability in order to support and improve experience in work.

Freedom to Speak Up (FTSU) Guardian

Freedom to speak up is one element of a wider strategic approach to positive cultural transformation and improvement. We want to create a culture of listening, where all staff feel safe and able to speak up about anything that gets in the way of delivering high quality care or affects their experience in the workplace.

Our fulltime Freedom to Speak Up Guardian is independent and impartial. All staff, governors, volunteers, students can speak to her in confidence. The FTSU Guardian

works alongside the senior leadership team to ensure concerns are addressed promptly and effectively.

Board commitment

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

The Executive Director of Nursing, Healthcare Professionals and Quality Governance and executive lead for FTSU led a FTSU Board development session in February 2020.

Some of the concerns staff have spoken up about include patient safety, staff safety, failure to follow correct process, understaffing, wrongdoing, sexual harassment, biased recruitment, nepotism and bullying.

Time period	Numbers of staff speaking up to the FTSU Guardian
April 2019 – March 2020	81

Policy

Staff who had spoken up in the past contributed to the development of the Freedom to Speak Up Policy, which encourages staff to speak up to their line manager if they can, but it recognises that this is not always possible. Where staff do not feel able to speak up to their line manager or they have already tried to speak up to their line manager and they have not had a satisfactory response, they are asked to go to the Freedom to Speak Up Guardian.

Communicating the message

The FTSU Communication Plan helps to ensure that the FTSU message is communicated widely to all staff groups.

Triangulating information

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

Speak Up Ambassadors

Two Speak Up Ambassadors have been appointed during 2019/20. Ambassadors dedicated protected time, one day a week, to promote a culture of openness, honesty, transparency and learning, where staff are supported to speak up.

Staff from groups with additional barriers to speaking up, such as LGBTQ+ and BAME, are encouraged and supported to apply.

Regional FTSU Guardian network

The Freedom to Speak up Guardian is a member of the North West Guardian network and supports the training of new guardians across the region.

Engaging with employees

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

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

Our performance review system provides a focus on employees' contribution to the success of their team and the Trust objectives, capturing this assessment in a formal process for managers to provide direct feedback about individual performance, supporting individual's development and opportunities to contribute going forward. Following conversations with staff, a pilot scheme redesigning the appraisal process has been undertaken with a new revised system of appraisal which will make it easier for staff and managers to keep an ongoing record of performance and development across the year, in light of policy updates, both locally and nationally.

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

There are a number of communication channels to ensure staff remain up to date. The Trust intranet site has been refreshed and there are weekly e-bulletins, a dedicated staff Facebook group and ad-hoc global email updates. During periods of consultation, there are specialist intranet pages populated to inform staff of developments and share documentation. Our Chief Executive publishes a regular online blog focusing on key topics for our workforce and our quality agenda priorities.

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

There is also a Partnership Committee and a Medical Local Negotiating Committee which are used to consult and update union representatives on a range of topics. It also provides an opportunity for our senior leadership to discuss issues, initiatives or factors affecting our workforce with Partnership Officers and Staff Side colleagues.

Involving employees in the Trust's performance

The use of Tableau, our front-end information system, has continued to be embedded. This provides information in an accessible and consistent way; managers can access real time information about the performance of their team and how they contribute to the Trust performance.

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

Staff Survey results

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give a score for the Trust across 11 themes. All themes use a 0-10 score where a higher rating is more positive than a lower rating

The response rate to the 2019 survey among Trust staff was 32% (2018: 37%). All permanent employees are invited to complete the survey.

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

	2019/20		2018/19		2017/18	
	Trust	**Comparison group (av)**	**Trust**	**Comparison group (av)**	**Trust**	**Comparison group (av)**
Equality, diversity and inclusion	9.1	9.1	9.2	9.2	9.3	9.2
Health and wellbeing	6.1	6.1	6.2	6.1	6.2	6.1
Immediate managers	7.3	7.2	7.2	7.2	7.2	7.1

Morale	6.3	6.3	6.3	6.2	No comparison available	
Quality of appraisals	5.3	5.7	5.2	5.5	5.1	5.4
Quality of care	7.3	7.4	7.4	7.4	7.3	7.4
Safe environment: Bullying and harassment	8.2	8.2	8.3	8.2	8.3	8.3
Safe environment Violence	9.5	9.5	9.6	9.5	9.6	9.5
Safety culture	6.8	6.8	6.7	6.8	6.7	6.7
Staff engagement	7.1	7.1	7.1	7.0	7.0	7.0
Team working	6.9	6.9	6.9	6.9	7.0	6.9

There have been no statistically significant changes across the theme results apart from the decreased result for the safety culture – violence. This has been driven by a 3.7% increase in staff responding that they have personally experienced physical violence at work from patients/service users, their relatives or other members of the public.

Local surveys

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

Actions during 2019/20

The priorities for the Trust during the year to improve areas noted in the staff survey are shown below.

Priority area	Action	Staff survey results
Staff bullying and harassment	A working group has been established to investigate the reasons and themes behind the levels of perceived bullying and harassment. We are working with NHS Improvement to support this work.	No improvements have been noted through the staff survey results yet.

Feedback about changes made in response to errors, near misses and incidents	The Trust launched its *Just Culture* programme for the Trust and has established working groups to embed new ways of working. We will build feedback about incidents and mechanisms for managing bullying and harassment into our work on *Just Culture.*	There has been a 3% increase in staff saying that they felt they would be treated fairly following an incident and a 1% improvement in feeling that they receive feedback following an incident.
Access to staff training and development	Increased funding was provided by the Trust to support access to learning and development.	There has been an increase in staff having learning needs identified but a decrease in staff feeling that they have been able to access non mandatory training.
Recognition	We have rolled out the new Thank You Card Scheme across the Trust and redesigned our leadership development programmes.	Six of the seven questions relating to perceptions of line mangers have shown a positive improvement. There has also been an increase in the recognition staff get for good work.
Influence	Quality Improvement (QI) training has been rolled out across the Trust and a clear work plan in place to embed quality improvement.	Staff saying they are involved in changes introduced that affect their work area/team and department has increased, we have the highest rating of our comparators. There has also been an increase in staff saying that they were able to make suggestions to improve the work of their team/ area or service.
Quality of one to one discussions and reviews	We have redesigned the paperwork associated with annual reviews/ appraisals and have been piloting these in a wide range of teams in mental health services.	All questions related to the quality of appraisals have shown an improvement, although the numbers of appraisals undertaken as decreased.

Monitoring improvements

We have continued to use a pulse survey three times a year with a representative third of staff each survey. The pulse surveys provide a quick turnaround of results and provide a useful monitoring mechanism to see whether changes made are impacting on the feelings of staff.

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

Future plans to support improving results

Based on the results of the 2019/20 staff survey, the following areas will be prioritised:

Priority area	Action
Staff bullying and harassment	Embedding the learning from the Just Culture work around bullying and harassment.
Quality of appraisals	We will finalise the evaluation of the pilot of the new processes and paperwork and embed with a training plan.
Staff safety culture - violence	Work to investigate the increase in physical violence being experienced by staff, identifying hot spot areas and plans to address and support.

Trade union facility time

From 1 Apr 2017 public sector organisations have been required to report on trade union facility time. Facility time is paid time off for union representatives to carry out trade union activities. The Trust has two Partnership Officers, comprising of a full-time chair plus one partnership officer working part-time; and part-time administrative support. The function is funded to undertake 70 hours of trade union work per week – as at 31 Mar 2020 the actual number of hours worked each week was 38.5 (total workforce headcount 3,646).

We can provide information directly relating to Partnership Officers and admin support. Pennine Care is currently working to ensure that a full disclosure, stating information relating to the percentage of time spent on facility time and percentage of pay bill spent on facility time and paid trade union activities in line with the Trade Union Regulations 2017 (Facility Time Publication Requirements) is published on the Pennine Care website, this will include roles over and above formal Partnership Officer roles.

Additional payment information

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

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

All off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months.

	Number
Number of existing engagements as of 31 March 2020	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: New Off-payroll engagements

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months.

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	1
Of which...	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	1
No. of engagements that saw a change to IR35 status following the consistency review	0

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

Off-payroll payment engagements of board/Governing Body members, and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

Number of off-payroll engagements of board/governing Body members and/or senior officials with significant financial responsibility during the financial year. *	0
The total number of individuals both on and off payroll that have been deemed 'board members and/or senior officials with significant financial responsibility' during the	7

financial year, (includes engagements which are ON PAYROLL as well as those off payroll).	

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

Expenditure on Consultants

During 2019/20 expenditure on consultants was £468k.

Exit Packages (subject to audit)

Reporting of compensation schemes - exit packages 2019/20	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	4	**4**
£10,000 - £25,000	3	1	**4**
£25,001 - 50,000	-	4	**4**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**4**	**9**	**13**
Total cost (£)	£120,000	£174,000	**£294,000**

Reporting of compensation schemes - exit packages 2018/19	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	3	**3**
£10,000 - £25,000	-	3	**3**
£25,001 - 50,000	3	2	**5**
£50,001 - £100,000	2	-	**2**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**6**	**8**	**14**
Total resource cost (£)	£385,000	£129,000	**£514,000**

Exit packages: other (non-compulsory) departure payments	2019/20		2018/19	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	9	174	8	129
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-

Exit payments following Employment Tribunals or court orders	-		-		-		-
Non-contractual payments requiring HMT approval	-		-		-		-
Total	**9**		**174**		**8**		**129**
Of which:							
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-		-		-		-

The above exit package tables have been subject to audit.

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

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

Council of Governors and Foundation Trust Membership

Foundation Trust governance structures comprise three essential elements:

- Board of Directors
- Council of Governors
- Membership

Board of Directors

Please see Directors' Report on page 30.

Council of Governors

Pennine Care has a Council of Governors that comprises 33 members who represent our local communities, staff and stakeholder organisations.

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

- appoint and, if appropriate, remove the Chair;
- appoint and, if appropriate, remove the other Non-Executive Directors;
- decide the remuneration and allowances and other terms and conditions of office of the chair and the other Non-Executive Directors;
- approve (or not) any new appointment of a Chief Executive;
- appoint and, if appropriate, remove the NHS Foundation Trust's Auditor;
- receive the NHS Foundation Trust's annual accounts, any report of the Auditor on them, and the annual report at a general meeting of the Council of Governors;
- hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.
- represent the interests of the Trust's members, the public and staff in the governance of the Trust.
- Approve amendments to the Trust's constitution.

Elected governors are elected by members of their respective constituencies at regular intervals which must not exceed three years, after which time they are eligible to stand for re-election to serve further terms of office.

Trust constitution

In 2018, the Trust commissioned an independent external well-led review, from which several recommendations related to the Council of Governors, particularly its composition. In response to the recommendation and the strategic direction of travel for the

organisation, a range of proposed changes were required to the Trust's constitution. The Trust established a Constitutional Review Task and Finish Group comprising representatives from the Council of Governors.

A number of proposals to amend and update the Trust constitution were presented to the Board of Directors and Council of Governors for approval. The Board accepted the proposals at its meeting on 27 March 2019. An extra-ordinary Council of Governors meeting was held on 2 April 2019 to formally approve the changes, which ultimately reduced the overall size of the Council from 46 to 33 seats:

- Trafford constituency was dissolved from 1 July 2019
- Staff constituency classes were refreshed, and the overall number of staff governors reduced from eight to seven
- Removed the seats for CCG appointed governors, noting that the Trust regularly engaged with commissioners through a range of other meetings

Other constitutional changes included:

- Reducing the quorum for Council of Governor meetings; additional clauses relating to the exclusion of governors; removal of the provision for bank staff to be staff members (but they would be invited to be public members instead); changes to the standing orders in relation to the Trust Charity; and updated election rules.

Meetings of the Full Council of Governors

The formal meeting of the Council of Governors is chaired by the Trust Chair. Meetings are also attended by Non-Executive Directors and the Chief Executive (or her representative). One of the key functions of the meeting is to provide assurance about the Trust's performance to governors and for the governors to approve recommendations made by its committees. There have been five full meetings of the Council of Governors between 1 April 2019 and 31 March 2020 and all were open to the public.

Appointment and Remuneration Committee

Chaired by the Trust Chair, this Committee is responsible for making recommendations to the full Council of Governors regarding the appointment, re-appointment or removal of Non-Executive Directors, setting the remuneration and terms and conditions of, and evaluating the performance of, the Non-Executive Directors. The Committee has met five times during the period 1 April 2019 to 31 March 2020.

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

Review of Chair and Non-Executive Director remuneration

In July 2019, the Committee reviewed national benchmarking information by NHS Providers on the Chair and Non-Executive Director remuneration. The Committee agreed to recommend a pay freeze for the financial year 2018/19, and this was in turn approved by the Council of Governors on 14 August 2019.

In September 2019, NHS Improvement/England (NHSI/E) issued a 'structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts.'

The framework set out the pay structure as follows:

- Chair remuneration would be aligned to ranges based on trusts' size and complexity
- For Non-Executive Directors a uniform annual rate of £13,000 per annum (based on 3-4 days per month)
- Local discretion to award two supplementary payments of up to £2,000.

The Committee on 22 January 2020 and 10 March 2020 to review the framework and received detailed reports on the implications. The Committee further discussed:

NED remuneration

The Committee noted that Non-Executive Directors within Pennine Care were appointed on the basis of committing an average 4 - 6 days per month to the role (an *additional 2 days*). During 2019/20 the Chair and Non-Executive Directors, supported by the Trust Secretary, reviewed the requirements for their respective roles and how that translated into the time they spent in the Trust. Their involvement was split into two categories: those functions considered to be essential to the Non-Executive Director role; and a number of supplementary areas that further enhanced the Non-Executive Director role and enabled them to support the Trust in assuring the delivery of the strategic priorities.

Designated additional responsibilities

The framework allowed for the award of supplementary payments in recognition of additional duties. As a medium-sized organisation, the guidance limited the Trust to making two such awards, up to a maximum of £2,000 per annum.

In Pennine Care, three Non-Executive Directors currently received a supplementary allocation of £3,030 as Chair of Audit Committee, Deputy Chair, and Senior Independent Director respectively. As part of the review of the Non-Executive Director role, it was proposed that the chairing of sub-committee meetings was a core function and should not therefore attract any additional remuneration in future.

On 10 March 2020, the Committee agreed the following recommendations:

- The Chair's remuneration stayed the same and no uplift was applied

- The status quo remained in terms of the Non-Executive Directors' current time commitment (4 - 6 days) and that pay was set at £13,000 per annum but in recognition of the additional involvement beyond the core functions of the role, 'local discretion' was applied to award an additional payment of £2,000 per annum on the basis of approximately 1.5 - 2 days per month for all Non-Executive Directors.
- To award a supplementary payment of £2,000 per annum to the roles of Deputy Chair and Senior Independent Director, to take effect from the time these posts are next appointed to, and to review the supplementary payment made to the Chair of Audit Committee at such time as that post is reappointed/appointed to.

The recommendations are subject to approval at the full Council of Governors meeting on 12 May 2020.

Succession Planning

The Council of Governors Appointment and Remuneration Committee reviews the Non-Executive Director terms of office and discusses succession planning at each meeting. A number of Non-Executive Director appointments / re-appointments are scheduled for 2020: three Non-Executive Directors are eligible for re-appointment (Evelyn Asante-Mensah, Dr Julia Sutton-McGough, and Daniel Benjamin); and two Non-Executive Directors come to the end of their second three year term of office (Joan Beresford and Professor Sandra Jowett). The Committee will be making recommendations to the full Council of Governors in relation to Non-Executive Director re-appointments / appointments during 2020/21.

Chair appraisal

In September 2019, NHSE/I issued a new standardised framework for conducting the annual Chair appraisal. On 22 January 2020, the Committee noted the requirements of the new guidance and approved the updated process. As a minimum, the Chair's appraisal process would comprise an annual face-to-face appraisal discussion with the Senior Independent Director, informed by:

- Self-assessment
- Internal stakeholder feedback
- External stakeholder feedback

The stages of annual appraisal were provided along with the assessment, evaluation, appraisal output and timescales.

In terms of Governor feedback, the guidance suggested this should be provided by the Lead Governor on behalf of the full Council; however it was felt that all governors should have the opportunity to submit their views, therefore two focus groups were established, facilitated by the Senior Independent Director.

The Council approved the updated process for the appraisal at its meeting on 26 February 2020. The outputs of the appraisal were presented to the Committee on 5 May 2020, and formally presented to the full Council of Governors on 12 May 2020.

Composition of the Council of Governors, terms of office and attendance at statutory meetings: 1 April 2019 to 31 March 2020

The table below shows the attendance (actual/eligible) of individual governors at statutory meetings during 2019/20.

Name and Constituency	Term of Office	Attendance at Full Council of Governors	Attendance at Appointment and Remuneration Committee
Public Governors: Bury			
Ken Kendall	1 July 2016 to 30 June 2019	1/2	0/1
Derek Rowley	1 July 2018 to 30 June 2021	3/5	1/4
Clive Brown	1 July 2017 to 30 June 2020	4/5	4/4
Lucette Tucker	1 July 2018 to 30 June 2021	4/5	1/4
Marion Atkinson	1 July 2019 to 30 June 2022	2/3	2/3
Public Governors: Oldham			
John Starkey	1 July 2018 to 30 June 2021	5/5	3/4
Norma Bewley	1 July 2018 to 30 June 2021	5/5	3/4
Kath Oldham	1 July 2017 to 30 June 2020	3/5	2/4
Jim McDermott	1 July 2019 to 30 June 2022	4/5	2/4
Public Governors: Heywood, Middleton and Rochdale			
Karen Kelland	1 July 2016 to 30 June 2019	2/2	0/1
Howard Bowden	1 July 2018 to 30 June 2019	0/2	0/1
Sohail Ahmad	1 July 2018 to 30 June 2020	2/5	1/4
Eileen Stapleton	1 July 2019 to 30 June 2022	3/3	0/3
Des Farry	1 July 2019 to 30 June 2022	3/3	1/3
Kenneth Hall	1 July 2019 to 30 June 2021	2/3	1/3
Public Governors: Stockport			
Paul Carter	1 July 2019 to 30 June 2022	5/5	2/4
Brian Wild	1 Feb 2019 to 30 June 2022	5/5	1/4

Name and Constituency	Term of Office	Attendance at Full Council of Governors	Attendance at Appointment and Remuneration Committee
Mary Foden	1 July 2017 to 30 June 2020	5/5	3/4
June Somekh	1 July 2018 to 30 June 2021	3/5	2/4
Public Governors: Tameside and Glossop			
Wendy Hartley	1 July 2019 to 30 June 2022	3/5	3/4
Joyce Howarth MBE (Lead Governor)	1 July 2018 to 30 June 2021	5/5	3/4
John Reddy	1 July 2017 to 30 June 2020	4/5	2/4
Jean Hurlston	1 July 2019 to 30 June 2022	2/3	1/3
Public Governor: Rest of England			
Karen Morris	1 July 2019 to 12 Nov 2019	1/2	1/1
Staff Governor: Unregistered Nurses, Health and Social Care Professionals			
Ellie Mackle	1 Nov 2019 to 30 June 2022	1/2	0/2
Staff Governor: Registered Health and Social Care Professionals			
Kirsten Barker	1 Nov 2019 to 30 June 2022	2/2	0/2
Lina Papista	1 Nov 2019 to 30 June 2021	2/2	0/2
Staff Governor: Corporate and Support			
Richard Cliff	1 Nov 2019 to 30 June 2021	5/5	2/4
Staff Governor: Medical			
Dr Jaco Nel	1 Nov 2019 to 30 June 2022	1/2	0/2
Staff Governor: Registered Nurses			
Kim Marshall	1 Nov 2019 to 30 June 2022	1/2	0/2
John Stanley	1 Nov 2019 to 30 June 2021	2/2	2/2
Appointed Governors: Bury			
Cllr Annette McKay	27 July 2018 to 17 Feb 2020	0/5	0/4
Appointed Governors: Oldham			
Cllr Norman Briggs	Appointed 22 May 2019	0/3	0/3

Name and Constituency	Term of Office	Attendance at Full Council of Governors	Attendance at Appointment and Remuneration Committee
Appointed Governors: Rochdale			
Cllr Peter Joinson	Appointed 10 May 2013	1/5	0/4
Appointed Governors: Stockport			
Cllr Angie Clark	Appointed 27 July 2018	4/5	0/4
Appointed Governors: Tameside			
Cllr Jackie Lane	Appointed 1 July 2008	1/5	0/4

Attendance by Non-Executive Directors at full Council of Governors meetings 2019/20

All Non-Executive Directors attend the Chair, NED and Governor Committee meetings and so attend the full Council of Governors meeting on a rotational basis:

Non-Executive Director	Attendance (actual / eligible)
Evelyn Asante-Mensah	2/5
Joan Beresford	4/5
Sandra Jowett	3/5
Daniel Benjamin	1/5
Michael Livingstone	0/5
Julia Sutton-McGough	1/5
John Scampion	2/5
Catherine Laverty	4/5

Other committees of the Council of Governors

As of 31 March 2020, the Council of Governors structure comprised of three other committees:

- Chair, Non-Executive Director and Governor Committee
- Membership and Engagement Committee
- External Auditor Review Group

Chair, Non-Executive Director and Governor Committee

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

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

The Committee meets on a quarterly basis.

Membership and Engagement Committee

The purpose of the Committee is to support the fulfilment of the Council of Governor's statutory role in representing the interests of the members of the Trust as a whole and the interests of the public. The Committee meets on a quarterly basis and chaired by the Deputy Chair to ensure there is robust feedback to the Board of Directors about the effectiveness of member engagement and the representativeness of the Trust's membership.

The Committee identifies and agrees a regular programme of work which supports member engagement aligned to broader Trust engagement and involvement. Governors are given the opportunity to report on engagement activities they have been involved within the previous quarter, either within their constituencies or Trust-wide. During the year, this has included involvement in development of the Trust's new vision and values; Men's Healthwatch Forum, Nurturing Young Minds Official Opening, and Whittaker Day Hospital Networking Event.

In addition, local constituency meetings continue to take place regularly and report into the Membership and Engagement Committee. These meetings provide governors with a forum to hear from services about local developments and discuss member engagement opportunities. External partners are also invited to attend to contribute to discussions. During this year, these forums have enabled governors to hear about services and developments across a wide range of areas, including local care organisation plans; looked after children; the Triangle of Care; and carer / patient experience.

Governors are also given the opportunity to visit service areas so they can meet staff and learn more about the services we provide. Services visited during 2019/20 included Healthy Young Minds Services, Early Attachment Service, Community Mental Health Services and Safe Haven, to name a few.

In order to streamline governor processes, local constituency meetings and service engagement visits had been combined to take place on the same day and at the same venue.

Please see the Membership section for more information about how governors seek the views of Trust's members and public.

External Auditor Review Group

One of the statutory duties of the Council of Governors is to appoint the Trust's external auditor. In August 2019, the Council of Governors approved the re-establishment of the External Auditor Review Group because the contract for the incumbent provider was due to conclude at the end of May 2020. The Group was tasked with managing the process of appointing the external auditor and, in conjunction with the Audit Committee, making a recommendation to the Council of Governors.

The group was led by the Chair of the Audit Committee with membership drawn from three representatives of the Council of Governors (two public governors and one staff governor); supported by the Executive Director of Finance. The Head of Procurement and Assistant Trust Secretary provided additional support and advice to the group.

The group initially met in October 2019 to agree the tender specification, use of procurement frameworks, and procurement timetable/process. Bids were invited from potential suppliers during December 2019 / January 2020. Only one bid was received, from Grant Thornton – the incumbent provider.

The group reconvened on 29 January 2020 to agree moderated scoring of the bid documentation and conduct an interview with representatives from Grant Thornton. The group also reflected on the factors that were influencing the market for audit services in the UK (both in the private and public sector); and the experiences of other local / regional NHS trusts in this area.

The group concluded there were a range of benefits in recommending the re-appointment of Grant Thornton and on this basis the Group concluded that Grant Thornton should be recommended for the appointment.

At its meeting on 12 February 2020, the Council of Governors approved a recommendation from the External Auditor Review Group to re-appoint Grant Thornton as the Trust's external auditor.

Governor development

The Board of Directors has a duty to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately. The Trust facilitates an on-going Governor development programme, commencing with a welcome and induction for all new governors in July each year. From 2019/20, individual induction meetings with the Chair were introduced as part of the induction process. Existing governors are invited to participate in the induction process to refresh their own skills and knowledge, and to share their learning with new incumbents.

Governor development sessions are scheduled on a monthly basis; incorporating 'formal' sessions linked to the Council of Governors statutory duties and 'informal' sessions on Trust services. Additionally, governors are given the opportunity to attend a range of external events, such as the NHS Providers Governwell programme, the North West Governors' Forum, and the national NHS Providers Annual Governor Focus conference. The Trust also facilitates joint Board of Directors and Council of Governors development sessions.

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

- Quality Account
- Overview of NHS Finances and the 2019/20 Financial Plan
- Update on the Mental Health Strategy and Integrated Mental Health programme
- Mixed-sex accommodation update
- Learning from deaths
- Overview of External Audit (including Quality Accounts 2018/19)
- PICU business case
- Mental Health Transformation update and outcomes from the Niche sustainability programme

Governor involvement in preparing the forward plan

Directors must take account of governors' views when setting forward plans for the Trust; giving governors the opportunity to feed in the views of Trust members and the public and to question the Non-Executive Directors if these views do not appear to be reflected in agreed plans. Governors are regularly consulted on the Trust's strategy and operational

plans as the Chief Executive (or her representative) attends each full Council of Governors meetings to offer updates and invites views that can be communicated to the Board of Directors.

Regular development sessions have been facilitated throughout the year where governors had an opportunity to feed into the forward plan:

- Draft operational plan/financial plan 2019/20
- Final operational plan/financial plan 2019/20
- Strategic landscape and town by town local care organisation update
- Five-year plan development and submission

The draft five-year plan was circulated to the Council in December 2019 for comment and a further development session was held in January 2020. The Board approved the final five-year plan on 1 April 2020. Materials are available to the Council which summarises the key headlines to quickly explain the overall strategy in a few sentences/words.

Review of Governor effectiveness

Led by the Chair, the Council of Governors should periodically assess its collective performance. This year, the Trust commissioned NHS Providers (NHSP) to support a robust and objective assessment process.

The process was conducted by a survey aimed to gather the views of governors on the effectiveness of the Council of Governors; this included a review of the effectiveness of the new committee arrangements, which were co-produced with governors as part of the well-led review.

The feedback session with governors, facilitated by NHSP, took place on 26 February 2020. During the session, governors were asked to discuss the self-assessment results and feedback reflections.

To support the effectiveness review, the Trust also commissioned The Connectives, who had previously worked with the Board, to facilitate a session on the Trust's behaviours framework and the Council of Governors refreshed Code of Conduct.

Nominated Lead Governor

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

The existing Lead Governor is Joyce Howarth MBE, who was elected for the period 1 October 2019 to 30 September 2020.

Register of interests

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

Membership

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

Membership is free and provides individuals with the opportunity to:

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

As at the end of March 2020, the Trust has 19,260 members, approximately 15,611 of whom are public members living, in the main, in the local areas receiving services from Pennine Care. The remainder of our membership comprises our staff across all disciplines and services, and across all geographical areas served by the organisation.

Membership eligibility

Public

Members of the public, aged 16 and above and residing in one of the identified public constituencies are eligible to become members of Pennine Care NHS Foundation Trust. During 2019, Trafford community services transferred to a new provider therefore the Trafford constituency was dissolved as part of the constitution review. Public members in Trafford were given the opportunity to transfer to Rest of England constituency. At the end of March 2020, there were six public constituency areas, as listed below:

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

Staff

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

The staff constituency composition was reviewed during 2019, and now comprises five classes, as follows:

- Medical
- Registered health and social care professionals
- Registered nurses
- Unregistered nurses, health and social care professionals
- Corporate and support

How to get in touch

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

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

Telephone: 0161 716 3374

Members wishing to contact governors or directors of the Trust are asked to do so via the Membership Office in the first instance, as detailed above.

Membership and engagement

As at 31 March 2020, the breakdown of members by public constituency was as follows:

Constituency	Number of members
Bury	2,072
Heywood, Middleton and Rochdale	2,698
Oldham	2,376
Stockport	2,262

Constituency	Number of members
Tameside and Glossop	2,707
Rest of England:	3,496
Total	15,611

During 2019/20, the Trust recruited 69 new public members; 921 members were removed from the membership database, mainly as a result of a data cleansing exercise. The Trust continues to work on more meaningful engagement with members rather than aim for mass recruitment.

The Trust monitors its membership by ethnicity, age and gender. The total number of members of non-white British has grown by 1.8% and there has been an increase in 'Asian or Asian British – Pakistani' during this reporting period by 1.15%. In terms of the age category, the highest membership rate is from aged 50 - 59, and the largest increase this year was aged 60 – 74 at 0.46%. We have almost twice as many female members as we do male.

The Trust strives to engage meaningfully with its membership across the whole of the Trust footprint and participates in a range of events in order to link with existing and potential new members. The Trust continues with its series of public engagement events to reach into the communities, which are aimed at promoting the governor role, health and wellbeing messages, signposting to services, and linking to partner and third sector organisations.

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

In order to increase awareness of the governor role and the membership scheme within the Trust, the membership team have made additional efforts to target various communities and groups which have been previously under-represented including people of working age, younger people and ethnic minorities. As a result of this we were pleased that we had nominations from a wide range of diverse backgrounds in the 2019 elections to the Council of Governors.

Governors and the Non-Executive Directors linked to each borough continue to work closely with service leads within their local constituency areas to ensure there is a route by which they can communicate and engage with our membership to ensure it is reflective of local communities. The membership team uses information collected from local meetings to inform where they need to focus any engagement opportunities to develop awareness of the Trust and its services. Please see the Council of Governors sections for more information about the work of the Membership and Engagement Committee.

Governors have the opportunity to raise any issues/concerns on behalf of members and the wider public. In conjunction with the governors, the membership team produced a new form to capture members / public / governor views and queries. This is supported by a four-stage process that ensures responses are provided in a timely manner. The response is sent directly to the governor who raised the comment and is reported into the Chair, Non-Executive Director and Governor Committee for discussion, on a quarterly basis. The Committee is responsible for deciding whether the comment has been responded to appropriately and can be closed, or whether further assurance is required. If necessary and appropriate, items may be escalated or referred onto other forums.

The membership team, often supported by our governors, has arranged and attended various health-related events across the Trust footprint, including those run by local user and carer groups, Healthwatch organisations, third sector, charity and community groups to ensure governors have the opportunity to meet with, and seek views from, members and the public across different communities. The membership team joined with various third sector and partner organisations to organise network events for World Suicide Prevention Day and World Mental Health Day during 2019.

During this period the membership team has worked with the Executive Director of Workforce and the Equality and Diversity Officer to develop an equality, diversity and inclusion (EDI) survey, which was sent out to all members with email addresses. Feedback from the survey would help inform the development of the Trust's EDI strategy through understanding the views and experiences of people from different backgrounds, as well as identifying key areas for development and action. During 2020/21, further engagement work would take place to reach out to diverse community groups in each borough.

During 2019, community services transferred to alternative providers and the membership team supported staff members by attending staff engagement sessions, feeding the questions and answers from these events to the community transfer hub.

The membership team continues to work collaboratively with various departments to increase recruitment and engagement with members of the public and staff; for example, Patient Experience, Involvement, Volunteering, Organisational Development and Communications.

We continue to shift towards more digital forms of engagement, providing the benefits of technological advancements and social media, whilst at the same time attempting to reduce costs. The membership team also records videos by governors to provide information and feedback for a more interactive approach to engagement.

Annual Governance Statement 2019/20

a) Scope of responsibility

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

b) The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Pennine Care NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Pennine Care NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

c) The risk and control framework

The Trust uses an integrated approach to managing risk across the organisation, which is consistent with best practice and set out in the Trust's Risk Management Framework. The overarching risk management framework features within the portfolio of the Executive Director of Service Development and Delivery, however all Executive Directors are responsible for monitoring, managing and mitigating the risks aligned to their respective areas.

The Trust undertook a fundamental review of its risk management arrangements during 2019/20 to ensure robust arrangements were in place for the identification, assessment and prioritisation of risks across and at all levels of the organisation, with the impact on patient safety always considered. New reporting arrangements were introduced to align strategically significant risks to the relevant Board sub-committees and ultimately to the

Board Assurance Framework (BAF), where they inform the setting and prioritisation of their respective agendas.

An efficient and effective BAF is a fundamental component of good governance, providing a tool for Boards to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to organisational success. In March 2020, the Trust's internal auditor reported on their assessment of the Trust's BAF, specifically the approach to which the organisation maintains and uses the BAF to support the overall assessment of governance, risk management and internal control.

The review included assessment of the structure for managing, monitoring and reporting on the BAF; the Board's engagement in the review and use of the BAF; and the quality of the content of the BAF and whether this demonstrated clear connectivity with the Board agenda and external environment. The findings of the audit were that the Trust's BAF was assessed as fully compliant with the required objectives.

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

In March 2020, to support the Board's focus and oversight, the BAF was further updated to reflect the impact of the response to the Covid-19 within a separate section, aligned to each of the four strategic areas of focus, with these specific risks being reviewed monthly by the Board of Directors.

In April 2020, the Board of Directors approved the organisation's new five-year strategic plan, which will drive our future focus on the delivery of an enhanced offer around mental health and learning disabilities, in line with our redefined service portfolio and resultant transfer of community services to alternative providers. By the end of March 2020, all community services had been transferred with the exception of dental services, the transfer of which is expected to conclude during 2020/21. The impact of the transfer on our financial performance is outlined in the main body of the annual report at page 24.

The BAF sets out the key strategic risks in the context of the organisation's revised strategic goals, which are identified as four key areas of focus, as follows:

- Services
- People
- Culture
- Partnerships

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

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

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

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

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

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

Risks on the register are reviewed at team, service, divisional and Trust-wide forums. The Trust's governance architecture is structured with all Divisions holding a monthly Integrated Leadership Group (ILG), reporting to the Trust Management and Improvement Board, Trust-wide Executive Director chaired groups (eg: Quality Group) and up to the relevant Non-Executive Director chaired Board sub-committees (ie: Quality Committee; Performance and Finance Committee; People and Workforce Committee).

The key high level risks facing the Trust in the next year are contained within the Board Assurance Framework and include:

SERVICES: Risks to the provision of our services that could result in patient/carer harm, non-regulatory compliance and an adverse effect on the Trust's reputation such as failure to provide single gender accommodation; insufficient resource to undertake Quality Improvement and embed it across the organisation; insufficient resource to capture and

utilise patient experience, engagement and co-production; failure to manage the physical health needs of patients and the capacity and ability to learn from incidents. These risks could be mitigated by implementing the priorities set out in our Quality Strategy, delivering and embedding the CQC improvement plan and the introduction of focussed groups such as our Complex Healthcare Steering Group.

Additionally, if the Trust cannot demonstrate sustainability following changes to our service portfolio, there is a risk that we will remain in enforcement undertaking and could be subject to regulatory intervention, which could compromise our longer term viability. Mitigations would include the delivery of our 2020/21 financial plan and our sustainability plan in line with our five-year sustainability plan submission to NHS Improvement (NHSI); agreeing a collaborative approach to managing risk and reward with our mental health and learning disability commissioners; and strengthening our approach to benefits realisation and return on investment.

Furthermore, if the Trust is unable to effectively implement the Health Informatics and Estates enabling plans, it will be unable to deliver services in line with the quality and financial strategies. It is therefore crucial that we deliver the priorities set out in our Health Informatics Strategy and implement the capital programme for estates for 2020/21 in line with our financial planning requirements. We need to work with NHS partners across the organisation to improve the infrastructure and redesign our offer to support the new organisation.

PEOPLE: If we are unable to recruit and retain an appropriate skilled workforce, we will not be able to deliver and develop services in line with the plan for 2020/21. Factors impacting on this include national supply shortages around certain professional groups; competition from other organisations; sickness levels and workforce profiling issues such as an aging workforce. We have a number of recruitment actions and initiatives to help us combat these risks, which are overseen by our People and Workforce Committee.

CULTURE: If we are unable to effect successful organisational development and design, we will not create an environment that facilitates good engagement, retention and safe provision of services. Factors implementing on our culture include the risk of inadequate engagement with our staff groups on our delivery priorities; insufficient role design; a lack of engagement across our local communities and poor inclusion and equality. To mitigate these risks we have introduced a new vision and a set of organisational values with a supporting behaviours framework; we will implement the priorities in our People Strategy, with a focus on leadership development and will aim to create a diverse and inclusive organisation through focussed action on Equality, Diversity and Inclusion.

PARTNERSHIPS: If we are unable to position ourselves successfully within the Local Care Organisations, there is a risk that our expertise and the value it can bring to partnerships in the interests of mental health and learning disabilities will not be adequately represented. This could arise if we fail to develop a high enough profile for

these specialisms; a failure to develop links with other organisations and by failing to understand our local communities and their needs. We are therefore developing a robust partnership framework that will drive our approach to engagement with staff, service users and carers and the public and will set out our ambition around developing new partnerships. We will work with our stakeholders, those who commission our services and other community stakeholders to support system transformation through locality plans and an improved clinical offer to our local populations; and we will work in partnership to support a smooth and effective transition of our community services.

Furthermore, the BAF also reflects the key risks arising from the Covid-19 pandemic, which include:

SERVICES: The expected surge in demand as a result of impact of Covid-19 and social distancing measures on people's metal health presents a risk in being able to manage and meet needs and expectations within existing resources; the refreshed financial framework and payment system risks us being unable to implement the agreed outcomes from the work with Niche Consulting and our commissioners failing to follow through on their commissioning intentions and financial commitments from 2019/20.

PEOPLE: Staff are tired and have had to work in different and stressful ways for a sustained period of time and there is a risk that we find it hard to retain the level and skills of the workforce we need as people choose to leave; there is a risk that Covid-19 has a significant psychological impact on our staff that results in higher sickness absence and an inability to deliver core services.

PARTNERSHIPS: the immense amount of partnership work necessary to develop recovery plans at both a locality level and GM system level risks us being able to focus on the priorities for Pennine Care because of capacity constraints and focus elsewhere, for example, the CQC Improvement Plan.

CULTURE: the command and control arrangements that are likely to be in place for some considerable time to come increase the risk of us not being able to develop our own culture in the way we would want to, given it is the counter opposite to a command and control approach

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

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

The CQC is updated regularly at our engagement meetings with regard to the progress made within the improvement plan and of the 47 areas for improvement, of which 34 have been completed. Of the remaining 13 areas, one is suspended due to the fact that we are reliant on the acute trusts we work with to update the resuscitation policies (this work is currently on hold due to Covid-19). We endeavour to complete this as soon as the acute trusts are in a position to provide us with their refreshed policies. Achieving some of the actions relies upon investment from our CCGs/Local Authorities, for example: the staffing model for our health-based places of safety; and provision of advocacy services. The remaining actions are more significant pieces of work that are being progressed through longer-term plans; however Covid-19 has impacted on some of the work, such as single gender accommodation, the roll-out of the electronic patient record, and alternatives to admission programmes of work.

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

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

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

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

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

Throughout 2018/19 and 2019/20, the Trust has been actively discharging the undertakings and providing regular updates to NHSI on the steps taken to improve our position, including:

- A comprehensive review of all services and their sustainability, undertaken in collaboration with commissioners, which in turn informed a decision approved by the Board of Directors in December 2018 to refocus its service portfolio and concentrate on the provision of mental health and learning disability services.

- A review of our structure, capacity and capability, overseen by a Transformation Programme Board, to inform the development of a sustainability plan and long-term strategy, for approval by the Board of Directors and finalised in line with national timescales.
- The Trust was rated 'Requires Improvement' by the CQC in 2018 and has been participating in the 'Moving to Good' programme and paired with Tees, Esk and Wear Valley NHS Foundation Trust.

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

The organisation had five strategic objectives during 2019/20 – Quality, People, Partnerships, Money and Infrastructure, each underpinned by an overarching strategy, supported by a suite of delivery plans. On 1 April 2020, the Board of Directors approved a new five year strategy which includes four key strategic areas of focus – Services; People; Culture and Partnerships - to which the supporting delivery plans will be realigned.

During 2018/19, the Trust revised its governance arrangements, which were assessed by the internal auditors at the end of March 2019 and awarded a rating of 'Substantial Assurance'. These arrangements continued to be embedded and refined during 2019/20, then were adapted further to take account of the need for a prompt organisational response to the Covid-19 pandemic.

During March 2020 the Trust updated its Business Continuity Plans across all services to enable a rapid and appropriate response to managing the Covid-19 pandemic. A Gold Command, with robust supporting governance arrangements and reporting into a Response Oversight Team with both Executive and Non-Executive Board level representation, was implemented.

Following guidance from NHS England/Improvement issued at the end of March 2020, the Board of Directors approved an updated scheme of delegation and governance structure to release capacity and enable the required focus on responding to the emergency. These arrangements were approved up to the end of September 2020 but with monthly review by the Board of Directors to ensure they remained necessary and appropriate. The guidance suggested trusts should streamline their Board and committee meetings to focus agendas and meet virtually, not face-to-face, and while under normal circumstances the public can attend at least part of the Board meetings, Government social isolation requirements constitute 'special reasons' to avoid face to face gatherings as permitted by legislation. It was therefore agreed that Board meetings would take place via videoconferencing and public access would be restricted for the immediate future until it was appropriate and operationally possible to open the meetings up again, which was subsequently achieved by allowing the public to access the meetings remotely from June 2020. The Board agendas were refocused to cover Covid-19 and Trust response; patient safety including, in

private session, any relevant serious incidents; legal essentials; finance; and Committee Chairs' reports.

All Board sub-committee meetings were suspended with the exception of the Audit Committee, which continued as scheduled to seek assurance on the robustness of our systems and processes during this period and to deal with any statutory functions delegated to it from the Board of Directors. The scheduled in-month Board development sessions were converted into a Combined Assurance Committee that comprised all Board members, and combined the functions of the Quality; People and Workforce; Performance and Finance Committees and allow mid-month updates and assurances to be delivered during this period and consider the impact and response to Covid-19, and wider assurance through the lens of Quality; People and Workforce; and Performance and Finance. The rationale for these refined arrangements takes into account the seriousness of the challenge posed on the entire healthcare system by Covid-19. Streamlining the committee work freed up senior leaders, and not least senior clinicians, to focus on the overwhelming burden that the virus placed on Trust services, especially at its peak. The refined arrangements retain a proportionate level of assurance emanating from the structured and regular discussions between the Committee Chair and the Lead Executive. The Trust's auditors were kept fully briefed on these updated arrangements.

The Trust's Quality Group plays an important part in the monitoring of timely improvements against the recommendations in the CQC improvement plan, reporting/escalating to the Quality Committee on a monthly basis. The Trust Management and Improvement Board focus more on the well-led element of the improvement plan.

Running in parallel with the improvement plan are the strategic delivery plans under the Trust Quality Strategy. Our Quality Strategy has five domains of:

- Engagement and Experience
- Patient Safety
- Well-led
- Clinical Effectiveness
- Quality Improvement

Progress on the Quality Strategy and delivery plans is monitored via the Quality Group and Quality Committee.

Clinical risks are routinely assessed, recorded, reviewed and updated on the Trust's Risk Register. Current significant clinical risks include:

Recruitment and retention – key risks recorded and impact on organisational capacity. A workforce plan has been developed to address the challenges faced by clinical vacancies within services.

Health Informatics/Electronic Patient Record - the Trust's Health Informatics Strategy sets out how we will improve, but clinical risks remain in relation to access to electronic clinical records (in/out of hours) and the risks associated with potential failure of clinical systems.

Breaching regulatory compliance in relation to the 'must do' recommendations from the CQC inspection and specifically including the work required to meet single gender accommodation and safer staffing. Both workstreams have dedicated Executive leads and associated action plans.

Limited resource within the Trust for obtaining the views of patients remains a risk – Involvement and Engagement. Plans are in place to recruit to a new leadership role and develop the strategic plan for the organisation.

Specific to one of our local care groups, Stockport MBC have served notice of their intention to end their Section 75 agreement with the Trust, posing a significant number of risk issues relating the caseload split, financial pressures and staff being at risk. This has been delayed as a result of Covid-19, with discussions ongoing and the impact still to be worked through.

Data security incidents and breaches are recorded as part of the Trust's incident management processes, and are investigated either by the Head of Information Governance or the Information Security Officer. The Trust is part of the NHS CareCert programme which provides alerts to the Trust regarding potential or active cyber security threats; and is working towards the Cyber Essential Plus accreditation.

The Trust operates a Change Control Board, where new systems or processes, or amendments to existing systems or processes are approved. Data security and the assessment of risk form part of that control approval process; and has an established Data Protection Impact Assessment (DPIA) process. Areas of unmitigated risk are escalated onto the departmental or corporate risk register, as appropriate.

The Trust's People and Workforce Strategy was approved by the Board of Directors in 2018. The five-year strategy focuses on the national context and challenges, Greater Manchester position and local workforce challenges. Underpinning the strategy is the People and Workforce delivery plan, which supports the implementation of short, medium and long term workforce strategies that seek to address having the right people, with the right skills, at the right place and time. Outputs from the strategy and delivery plan are monitored and governed by the People and Workforce Committee, which is a formal Board sub committee; updates on progress are reported to Board on a monthly basis.

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

Effective Workforce Plan that is updated annually

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

The four domains are:

I. Effective and sustainable workforce

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

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

II. Capable and Skilled Staff

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

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

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

III. Effective Leadership

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

With the development of the new Trust Values, we are focussed on the development of equipping our leaders with the skills, behaviours and competencies to model our values.

Our commitment to delivering on the duties as set out in the Equality Act 2010, our leaders are challenged to demonstrate fairness and transparency in their decision making, planning and implementation of changes.

IV. Health, Wellbeing and Staff Engagement

(Expectation 2: retention)

Focussed work is underway to:

- Identify trends of bullying and harassment in the Trust and complete a diagnostic to understand the root causes;
- Develop proposals for interventions that are designed to reduce the levels of bullying and harassment identified in the staff surveys and the actual numbers;
- Develop a staff engagement strategy to include a reward and recognition framework;
- Complete a diagnostic of medical engagement using the medical engagement tool and develop appropriate interventions.

Engagement activity is supported by staff networks, particularly the Disability Staff Network, which provides a two way communication channel, as well as capturing staff experience in support of wellbeing.

Working groups have been established for each key work stream, each group membership includes key stakeholders from across both Clinical and Corporate services. This allows for a multi-disciplinary informed approach to decision making to develop a sustainable future workforce. Activity against the delivery plan is reported through the People and Workforce Steering Group on a monthly basis with regular reports to the People and Workforce Committee.

Measure and Improve

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

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

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

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

Develop local quality dashboards for safe sustainable staffing

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

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

To support our Quality Leads and Operational Managers to ensure that are inpatient units are staffed safely and flexibly to support the needs of the changing patients, a Tableau quality performance dashboard has been developed that presents staffing levels alongside activity information, sickness patterns, patient acuity and incidents information. This allows them to see at a glance, by day, whether staffing levels are having an impact on the quality of care on the wards by seeing the incidents details presented alongside it. This allows Quality Leads and Operational Managers to react quickly, make professional judgement to any emerging issues that might not have been obvious without the data triangulated and readily available.

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance

(https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/)

As an employer with staff entitled to membership of the NHS Pension Scheme control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

Following significant ownership changes across the Trust's estate in the last year, the foundation trust will be reviewing and updating its risk assessments and renewing its Sustainable Development Management Plan (SDMP) in 2020. This will take account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Due to the various tenure arrangements for the estate and land, the revision of the SDMP will involve wider stakeholders. This is to assist in ensuring its obligations and other requirements placed on the Trust to manage and reduce our environmental impact are met. The SDMP plan will reflect the needs and ambitions of the organisation and empower staff to contribute and embed sustainable healthcare within their roles and departments.

d. Capacity to handle risk

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

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

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

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

The Trust promotes and encourages staff at all levels to assess risk and escalate their concerns via the agreed processes, recognising the need to promote a culture of reporting risks.

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

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

Compliance is monitored both internally and externally. The suite of training courses ensures staff are able to identify, assess, report and escalate areas of concern/risk relating to service delivery, finance, information governance and clinical activities.

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

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

The Trust has a robust financial reporting process to ensure resources are used economically, efficiently and effectively. The financial position for each Divisional Business Unit (DBU) is completed by the Finance Business Partners (Management Accounts) and the Head of Financial Services, the position is then reviewed by the senior finance team and Executive Director of Finance before being finalised. Upon finalisation the position is shared with Executive Directors, the Performance and Finance Committee and the Board of Directors. This includes highlighting the key financial drivers in the year-to-date and forecast position. There are also regular reviews of balance sheet reconciliations to ensure they are accurate. The procedures the team follow and the financial position are reviewed by Internal and External Audit, who provide an opinion on the level of risk to the Trust.

Each year the final position of the Trust is reviewed by External Audit who provide a statement on their assessment of the financial position of the Trust.

The financial position is routinely discussed with budget managers and Managing Directors to ensure that they understand and believe the position to be a true and fair reflection of their performance. The Trust's key financial successes for 2019/20 include:

- Meeting the control total;
- Receiving £12m Provider Sustainability Funding (PSF)/Financial Recovery Funding (FRF);
- Meeting cash requirement with year-end cash balances of £11.5m, being £8.7m higher than the planned £2.8m;
- 12% improvement to trading position deficit of 12%;
- No revenue loan required in 2019/20;
- Capital expenditure of £5.5m, representing 84% of plan;
- Delivering 85% of recurrent efficiency.

The Trust also has the following internal mechanisms for staff to report any concerns:

- Standards of Business Conduct Policy
- Anti-Fraud Bribery and Corruption Policy
- Raising Concerns at Work (Whistleblowing) Policy
- Senior Independent Director, Freedom to Speak Up Guardian

f. Information governance

During 2019/20, and following the NHS Digital (NHSD) Guide to Notification of Data Security and Protection Incidents framework, the Trust reported nineteen information governance breaches via the Data Security and Protection Toolkit; Incident Reporting Tool. Of those nineteen, seven were reported to the Information Commissioner's Office:

Reference	Incident Details	ICO Action
13211	A meeting invitation was sent via email (correctly using 'Bcc') to some of Pennine Care Volunteer's email addresses. Email sent with an attachment in error with containing demographic details of the volunteers.	Incident closed by ICO: No further action 10/06/2019
13601	Trust unable to locate two Health Visiting records which were required for a strategy meeting.	Incident closed by ICO: No further action 25/06/2019
13790	Appointment letter sent to a patient's parents when patient (aged 16) had not given permission for them to be informed.	Incident closed by ICO: No further action 15/08/2019
13904	Letter sent to a patient's parents' house against wishes of the patient.	Incident closed by ICO: No further action 03/10/2019

14346	Two appointment letters were sent to an incorrect address.	Incident closed by ICO: No further action 30/08/2019
17267	Following the provision of an incorrect correspondence address in a referral, the Trust sent a letter to an incorrect address.	Incident closed by ICO: No further action 07/11/2019
17515	A copy of a report containing hand delivered to a patient's previous address in error.	Incident closed by ICO: No further action 13/11/2019

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

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

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

The Information Governance Assurance Group (IGAG) supports and drives the broader information governance agenda to provide the Board (via the Performance and Finance Committee) with the assurance that effective information governance best practice mechanisms are in place within the organisation. This includes monitoring compliance with the national Information Governance Assurance Framework i.e. the Data Security and Protection Toolkit.

The Caldicott Guardian and the SIRO jointly chair the IGAG, and ensure that issues arising from the group are escalated to appropriate committees or the Board. The Trust Data Protection Office (DPO) is a member of the IGAG.

The Trust has self-assessed against the Data Security and Protection Toolkit, which assesses annual performance against and compliance with Department of Health information governance policies and standards. Due to the current Covid-19 pandemic, NHSD has deferred the requirement for Trust's to submit the Toolkit assessment for 2019/20 to September 2020 (correct at the time of writing). For the 2018/19 Toolkit, the Trust achieved *Standards Met*.

The Trust continues to monitor its compliance against the requirements of the new data protection legislation (including General Data Protection Regulations) post its implementation in May 2018, is part of the NHS CareCert programme and is working towards the Cyber Essential Plus accreditation.

g. Annual Quality Report

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

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

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

In light of the sector's response to the Covid-19 pandemic, revised guidance was issued in relation to the Quality Report and Account and the original submission deadline was deferred. There is no requirement for NHS foundation trusts to prepare a quality report and include it in its annual report for 2019/20, nor is there a requirement to commission external assurance on the Quality Report.

The Trust is working to revised timeframes and will be seeking views via consultation on the draft Quality Account from the Council of Governors; Joint Health Overview and Scrutiny Committee, Healthwatch and the local Clinical Commissioning Groups, with a view to approving and publishing it in December 2020.

The Quality Account details progress against the Trust's quality improvement initiatives across our services in 2019/20 and sets out the Trust's key priorities for quality improvement in 2020/21. The four initiatives chosen by our stakeholder groups for the next 12 months are:

Care Planning (this will be the final year of a three-year initiative)

The CQC inspection conducted in summer 2016 found that the care planning process they found on our units and in our teams did not meet the standards expected for collaborative care planning. As a Trust we prioritised this development as we believe involving service users in their own care and allowing choice should be at the centre of what we do, and we have been working on this area as a quality improvement initiative.

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

We are now in the final year of this quality initiative and have included care planning in the Trust's Clinical Audit Programme. To support staff and help to share best practice ideas, we issued clinical teams with a best practice handbook, which the CQC subsequently recognised as outstanding practice. Further work has been undertaken to ensure the care planning process meets the needs of patients with learning disabilities. We continue to undertake regular audits of care plans across our wards, the results of which are reported to the Quality Committee and shared with the individual wards and local Integrated Leadership Group meetings. Lessons learned, good practice and improvements are shared, supported by our ongoing clinical audit programme.

Learning Library (the second of a five-year initiative)

The Trust's Quality Strategy (2018/2023) articulates our ambitions and ways in which we will achieve continuous improvement over a five year period. It includes five domains:

- Safety
- Experience
- Effectiveness
- Quality improvement
- Well-led

Our improvement journey will only succeed if we nurture, develop and support our staff ensuring they are highly skilled and working in an environment that fosters positive attitudes and a desire to improve. The sharing of learning is crucial to achieving this and the Trust has therefore developed a "learning library", whereby we reviewed how we share learning and best practice and introduced new methods, building our library into a portfolio of different tools and resources. This work has been led through a delivery group and progress against the project plan is reported into our Quality Group and Quality Committee.

Just Culture (the second of a five-year initiative)

NHS Improvement promotes the *Just Culture* Framework as "a powerful tool to promote cultural change". The framework supports staff to be open about mistakes and allows valuable lessons to be learnt. Their guide encourages managers to treat staff involved in a patient safety incident in a consistent and constructive way, claiming that fair treatment of staff supports learning by making staff feel confident to speak up when things go wrong rather than feeling blamed. The Trust is working hard to change the culture in the organisation and embedding the *Just Culture* Framework will help us on our change journey. We want our staff to feel that they can be open and feel supported. Sponsored by our Executive Director of Nursing, Healthcare Professionals and Quality Governance we have a project plan outlining the steps and milestones, including agreed "pause" points where we check if we are being just or not. Our Communications department works to ensure wide coverage across our footprint, reporting on progress and sharing feedback

from surveys, focus groups and other feedback loops. Our governance structures allow and encourage frontline to Board reporting. This initiative is a key component in the implementation of the Trust's Quality Strategy.

National Institute for Health and Care Excellence (NICE) study days (a new four-year initiative)

NICE study days are a new initiative to encourage joined-up organisation-wide use of NICE clinical products and the appropriate implementation of NICE guidance and other associated NICE products to ensure we deliver evidence-based care to our service users. This has been highlighted as important to our service users and carers at engagement events held by the Quality Governance team. The approach has been piloted during 2019/20 with a focus on dementia and Post-traumatic stress disorder (PTSD). Learning from these pilots has aided us to develop a robust framework to continue this programme of activity. We aim to hold four study days over the next financial year, with the topics selected being aligned to our organisational priorities.

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

In preparing the Quality Account, the directors will take steps to satisfy themselves that:

- The content meets the requirements as set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance.
- The content is consistent with internal and external sources of information.
- It presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported is reliable and accurate.
- There are proper internal controls over the collection and reporting of the
- measures of performance included and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate internal scrutiny and review.

h. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in

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

The Board of Directors granted delegated authority to the Audit Committee to review and approve the 2019/20 Annual Accounts and Annual Report, including the Annual Governance Statement and governance self-certifications. The Audit Committee received the Head of Internal Audit Opinion for 2019/20, which provides an overall opinion on the robustness of the Trust's internal control, governance and risk management arrangements. The overall opinion for the period 1st April 2019 to 31st March 2020 provides Substantial Assurance; that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

My review has also incorporated the outputs of the annual governance self-certification process, which forms part of the annual reporting submissions and enables Boards to review and obtain assurance that they are in compliance with the conditions of the provider licence and relevant legislation.

Conclusion

As outlined above, the Trust continues to work closely with NHS Improvement with a view to removing the enforcement undertakings following submission of the strategic sustainability plan and hence I can confirm that there are no significant control issues in the Trust in 2019/20.

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

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

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

Signed

Claire Molloy

Chief Executive
22 June 2020

Independent auditor's report to the Council of Governors of Pennine Care NHS Foundation Trust NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Pennine Care NHS Foundation Trust (the 'Trust') for the year ended 31 March 2020 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2019-20 and the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical

Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accounting Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which states that The Trust recognises that there are operational and funding factors that represent material uncertainties with regard to the adoption of the going concern basis. In its draft plan submitted to NHSI on 5 March 2020 the Trust achieved a breakeven control total, with a reported deficit position for 2020-21 of £10.8m matched by £10.8m of non-recurring Finance Recovery Fund. In planning to achieve the control total and break- even position, a review of the Trust's cash position shows no requirement for a revenue loan in 2020-21.

The Trust further explains that as a consequence of the Covid-19 pandemic, all NHS Providers will be moving to block contract payments 'on account' for an initial period of 1st April 2020 to 31st July 2020, with suspension of the usual PBR national tariff payment architecture, and the Operational Planning process has been suspended with immediate effect. A top up mechanism will be available and funded centrally to ensure all trusts make a break-even position.

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

In concluding that there is a material uncertainty, our audit work included but was not restricted to:

- we assessed the likelihood of NHS Improvement transferring services to other NHS bodies;
- we assessed the information available regarding future funding and planning assumptions for the Trust included in the Trust's cash flow forecasts over the period under assessment;
- we assessed whether the Trust had updated its cash flow forecasts to reflect the impact of Covid-19;
- we assessed the completeness and accuracy of the disclosures in the going concern note.

Overview of our audit approach

Financial statements audit

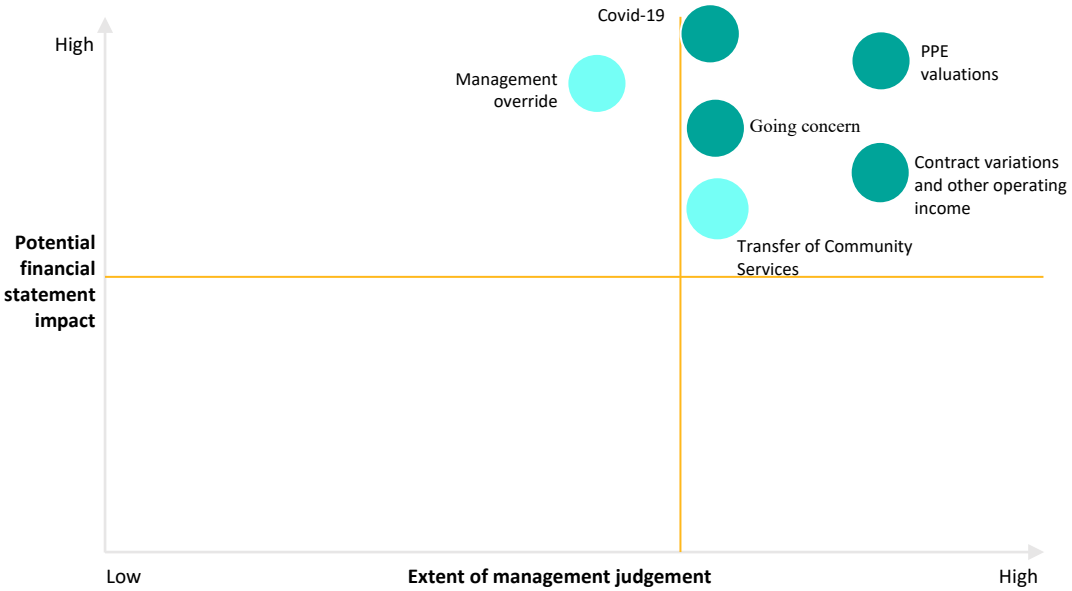
- Overall materiality: £4,233,000, which represents 1.75% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
  - Going concern material uncertainty
  - valuation of land and buildings
  - the occurrence and accuracy of patient care revenue and other operating revenue
  - Covid-19.

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

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

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter	How the matter was addressed in the audit
Risk 1: Valuation of Land and Buildings The Trust re-values its land and buildings on an annual basis to ensure that the carrying value is not materially different from the current value at the financial statements date. A full revaluation is undertaken at least once every five years with a desktop valuation performed in the intervening years. This valuation represents a significant estimate by management in the financial statements. The Trust has engaged the services of a valuer to perform a full revaluation of its estate and estimate the current value as at 31 March 2020. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions.	Our audit work included, but was not restricted to: • Evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work • Evaluating the competence, capabilities, and objectivity of the valuation expert • Discussing with the valuer the basis on which the valuation was carried out • Challenging the information and assumptions used by the valuer to assess completeness and consistency with our understanding • Testing revaluations made during the year to see if they had been input correctly into the Trust's asset register.

Key Audit Matter	How the matter was addressed in the audit
As a result of the Covid-19 pandemic, the Trust's valuers have declared a 'material uncertainty' in relation to their valuation as at 31 March 2020. This is in response to the global impact of Covid-19 generating an unprecedented set of circumstances on which Cushman & Wakefield have had to base their valuation. As a result, the valuers declared that a higher degree of caution should be attached to their valuation than would normally be the case. This material uncertainty is being declared by all RICS compliant valuers of NHS property nationally and is not specific to the Trust. We therefore identified valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement, and a key audit matter.	The Trust's accounting policy on valuation of property, including land and buildings, is shown in note 1.8 to the financial statements and related disclosures are included in note 17 and 19. **Key observations** As, disclosed in note 1.27 to the financial statements, the outbreak of Covid-19 has caused uncertainties in markets. As a result, the Trust's valuer has declared a 'material valuation uncertainty' in their valuation report which was carried out during February and March 2020 with a valuation date of 31 March 2020. The values in the valuation report have been used to inform the measurement of property assets at valuation in the financial statements. The Trust has disclosed the estimation uncertainty related to the year-end valuations of land and buildings in note 1.27 to the financial statements. The Trust's valuer prepared their valuations in accordance with the RICS Valuation – Global Standards using the information that was available to them at the valuation date in deriving their estimates. We obtained sufficient audit assurance to conclude that: • the basis of the valuation of land and buildings was appropriate, and • the assumptions and processes used by management in determining the estimate of valuation of property were reasonable • the valuation of land and buildings disclosed in the financial statements is reasonable.
Risk 2: Revenue Recognition NHS Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognition income from patient care activities and other operating revenue for

Key Audit Matter	How the matter was addressed in the audit
pressures. In this environment, we have considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue. We have rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We have determined these to be income from: • Block contract income element of patient care revenues • Education and training income • Provider Sustainability Funding and Financial Recovery Funding. We have not deemed it appropriate to rebut this presumed risk for all other material streams of patient care income and other operating revenue. We therefore identified revenue recognition as a significant risk, which was one of the most significant assessed risks of material misstatement.	appropriateness and compliance with the DHSC Group Accounting Manual 2019-20 • updating our understanding of the Trust's system for accounting for income from patient care activities and other operating revenue, and evaluated the design of the associated controls • using the DHSC mismatch report, we investigated unmatched revenue and receivable balances over the NAO £0.3m threshold, corroborating the unmatched balances used by the Trust to supporting evidence • agreeing on a sample basis income from contracts with commissioners to signed contracts • agreeing a sample of any contract variations to supporting evidence • agreeing a sample of the income from additional non-contract activity in the financial statements to any signed contract variations, invoices, and other supporting documentation, such as correspondence from the Trust's commissioners which confirms their agreement to pay for the additional activity and the value of the income • agreeing, on a sample basis, income and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence • agreeing income from PSF/FRF to NHSI notifications. The Trust's accounting policy on revenue recognition is shown in note 1.3 to the financial statements and related disclosures are included in note 3. **Key observations** We obtained sufficient audit evidence to conclude that:

Key Audit Matter	How the matter was addressed in the audit
	• the Trust's accounting policies for recognition of contract income and other operating revenue comply with the DHSC group accounting manual 2019-20 and have been applied appropriately • income from patient care activities and other operating income and the associated receivable balances are not materially misstated.
Risk 3 Covid-19 The global outbreak of the Covid-19 virus pandemic has led to unprecedented uncertainty for all organisations, requiring urgent business continuity arrangements to be implemented. We expect current circumstances will have an impact on the production and audit of the financial statements for the year ended 31 March 2020, including, and not limited to: • Remote working arrangements and redeployment of staff to critical front line duties may impact on the quality and timing of the production of the financial statements, and the evidence we can obtain through physical observation • Volatility of financial and property markets will increase the uncertainty of assumptions applied by management to asset valuation and receivable recovery estimates, and the reliability of evidence we can obtain to corroborate management estimates • Financial uncertainty will require management to reconsider financial forecasts supporting their going concern assessment and whether material uncertainties have arisen; and • Disclosures within the financial statements will require significant revision to reflect the unprecedented situation and its impact on the preparation of the financial statements	Our audit work included, but was not restricted to: • Documenting and understanding the implications that the Covid-19 pandemic has on the Trust's ability to prepare the financial statements and updates to financial forecasts • Liaison with other audit suppliers, regulators, and government departments to co-ordinate practical cross sector responses to issues as and when they arise We have evaluated: • the adequacy of the disclosures in the financial statements relating to the impact of the Covid-19 pandemic. • whether sufficient audit evidence can be obtained in the absence of physical verification of assets through remote technology • whether sufficient audit evidence can be obtained to corroborate significant management estimates such as asset valuations and recovery of receivable balances • management's assumptions that underpin the revised financial forecasts and the impact on management's going concern assessment and

Key Audit Matter	How the matter was addressed in the audit
as at 31 March 2020 in accordance with IAS1.	• we have reviewed the Trust's Local and Corporate Risk Register, for risks identified from COVID-19 **Key observations** We obtained sufficient audit assurance to conclude that: • The Trust's disclosures are in line with the DHSC guidance relating to the impact of the COVID-19 pandemic • Financial forecasts and the cashflow analysis of the Trust supports the ability for the Trust to prepare the accounts on a going concern basis • Other than the material uncertainty attached to the valuation of land and buildings reported at risk 1 in this report, and the impact of Covid-19 on the Trust's going concern disclosure, any other risks in relation to Covid-19's impact for 2019-20 financial statements have been reduced to an acceptably low level.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

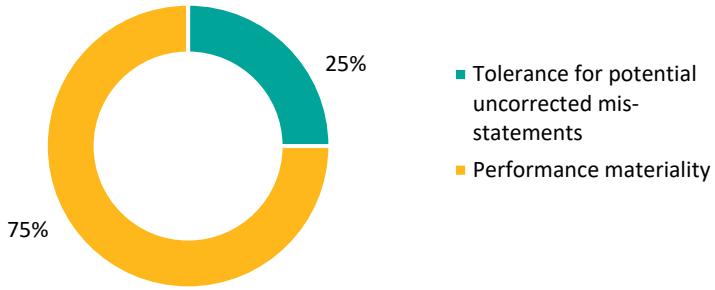
Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£ 4,233,000 which is 1.75% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2019

Materiality Measure	Trust
	as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	The senior officer remuneration disclosure in the remuneration Report has been identified as an area requiring specific materiality of £5,000 based on the disclosure bandings, due to its sensitive nature.
Communication of misstatements to the Audit Committee	£212,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality – Trust



An overview of the scope of our audit

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

The scope of our audit included:

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

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit Committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2019-20 or is misleading or

inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2019-20 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency**.**

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

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2019-20, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

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

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020**.**

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

Significant risks

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

Significant risks	How the matter was addressed in the audit
Risk 1 Financial Sustainability The Trust continues to operate under significant financial pressures. A deficit control total of £12m was agreed with NHSI for 2019-20, that entitled the Trust to £12m of PSF and FR funding to deliver a break-even position. The Trust had a CIP target of £11.25m (of which £5.9m was due to be delivered recurrently). Achieving the savings target was expected to be challenging. We will continue to monitor the Trust's financial position and consider the	Our audit work included, but was not restricted to: • assessing the Trust's arrangements for agreeing and reporting progress on the 2019-20 financial plan, including progress on achieving the required level of CIP savings. • scrutinising financial performance reports presented to the Board throughout the year to understand how management monitored the financial performance and addressed any emerging cost pressures. • meetings with senior management to discuss the forecast financial position for 2020-21 and the options being assessed to control the

Significant risks	How the matter was addressed in the audit
yearend outturn position to secure PSF & FRF funding. We will also look at the financial plan for the 2020-21 budget and beyond to consider financial sustainability, the adequacy of cash support and the level of CIP required to achieve targets. The Trust's 2020-21 planning is currently projecting a £10.8m deficit and a need to deliver a £9.3m CIP.	anticipated deficit (prior to the impact of Covid-19 and the centralised funding mechanism which is in place until 31 July 2020) • considering the Trust's arrangements for identifying a sustainable future service configuration in the medium term. **Key findings:** • Whilst the Trust is still facing some significant financial challenges in the year ahead, progress was made in 2019-20 to identify and implement measures to ensure that the control total was achieved allowing for central funding (PSF and FRF) to be awarded. • The CIP was a challenging target and was achieved. We have concluded the underlying arrangements in respect of the Trust's financial plans were adequate as were the arrangements to review, assess and implement savings required for the CIP. • We have nothing to report in our opinion in respect of this risk. Our opinion is on this risk is unqualified in relation to the Trust's sustainable resource deployment. • No issues have been identified that would suggest that the Trust does not have adequate arrangements in place for delivering economy, efficiency and effectiveness in the use of its resources.
Risk 2 Impact of the transfer of Community Services In December 2018, the Trust took the decision to work with partners to support the move to a new locality-based service model for community services. As a result, there has been a transfer of community services (and some other services such as dental) from the Trust to other providers. This has been staged throughout 2019-20 with separate tranches of services being transferred at 1 July 2019, 1	Our audit work included, but was not restricted to: • reviewed the Board papers and reporting processes, (set up to provide strategic oversight for the transaction), Terms of Reference and minutes of meetings • discussed the timetable and current progress of the transaction with the Trust's Executive Director of Finance • reviewed the calculation of the loss on transfer and the process for identifying which assets related to transferred service lines. **Key findings**

Significant risks	How the matter was addressed in the audit
October 2019 and 1 November 2019. The majority of services have now been transferred with small number of transfers remaining, and a post-project evaluation is underway. Approximately 2,300 staff have transferred to other providers.	No issues have been identified that would suggest that the Trust does not have adequate arrangements in place for delivering economy, efficiency and effectiveness in the use of its resources. Appropriate stakeholder engagement on this matter has taken place throughout the year and is ongoing.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Pennine Care NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Gareth D Mills

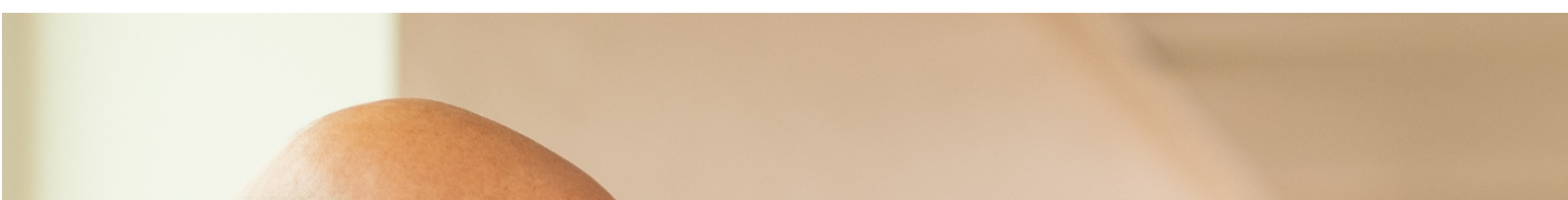
Gareth Mills, Key Audit Partner

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

Leeds

23 June 2020

Annual Accounts for the Year Ended 31 March 2020



Foreword to the accounts

Pennine Care NHS Foundation Trust

These accounts, for the year ended 31 March 2020, have been prepared by Pennine Care NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

Claire Molloy
Chief Executive
22 June 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	229,727	271,701
Other operating income	4	21,132	14,136
Operating expenses	7, 9	(245,518)	(282,919)
Operating surplus/(deficit) from continuing operations		**5,341**	**2,918**
Finance income	12	104	126
Finance expenses	13	(1,023)	(1,062)
PDC dividends payable		(2,573)	(2,270)
Net finance costs		**(3,492)**	**(3,206)**
Other gains / (losses)	14	(4)	348
Gains / (losses) arising from transfers by absorption	44	(1,111)	-
Surplus / (deficit) for the year from continuing operations		**734**	**60**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	**-**	**-**
Surplus / (deficit) for the year		**734**	**60**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(2,287)	(1,223)
Revaluations	19	1,332	8
Total comprehensive income / (expense) for the period		**(221)**	**(1,155)**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	16	4,266	4,230
Property, plant and equipment	17	104,517	107,102
Receivables	25	1,843	1,645
Total non-current assets		**110,626**	**112,977**
Current assets			
Inventories	24	-	-
Receivables	25	17,447	21,809
Non-current assets for sale and assets in disposal groups	27	-	208
Cash and cash equivalents	28	11,487	8,632
Total current assets		**28,934**	**30,649**
Current liabilities			
Trade and other payables	29	(27,444)	(32,015)
Borrowings	32	(333)	(445)
Provisions	34	(3,385)	(3,368)
Other liabilities	31	(1,548)	(1,658)
Total current liabilities		**(32,710)**	**(37,486)**
Total assets less current liabilities		**106,850**	**106,140**
Non-current liabilities			
Borrowings	32	(14,386)	(14,719)
Provisions	34	(25)	(26)
Total non-current liabilities		**(14,411)**	**(14,745)**
Total assets employed		**92,439**	**91,395**
Financed by			
Public dividend capital		79,732	78,467
Revaluation reserve		9,029	10,196
Income and expenditure reserve		3,678	2,732
Total taxpayers' equity		**92,439**	**91,395**

The notes on pages 142 to 199 form part of these accounts.

Name	Claire Molloy
Position	Chief Executive
Date	22 June 2020

Statement of Changes in Equity for the Year Ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**78,467**	**10,196**	**2,732**	**91,395**
Surplus/(deficit) for the year	-	-	734	**734**
Impairments	-	(2,287)	-	**(2,287)**
Revaluations	-	1,332	-	**1,332**
Transfer to retained earnings on disposal of assets	-	(212)	212	**-**
Public dividend capital received	1,265	-	-	**1,265**
Taxpayers' and others' equity at 31 March 2020	**79,732**	**9,029**	**3,678**	**92,439**

Statement of Changes in Equity for the Year Ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**76,412**	**11,553**	**2,309**	**90,274**
Prior period adjustment	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2018 - restated	**76,412**	**11,553**	**2,309**	**90,274**
Impact of implementing IFRS 9 on 1 April 2018	-	-	221	**221**
Surplus/(deficit) for the year	-	-	60	**60**
Other transfers between reserves	-	(67)	67	**-**
Impairments	-	(1,223)	-	**(1,223)**
Revaluations	-	8	-	**8**
Transfer to retained earnings on disposal of assets	-	(75)	75	**-**
Public dividend capital received	2,055	-	-	**2,055**
Taxpayers' and others' equity at 31 March 2019	**78,467**	**10,196**	**2,732**	**91,395**

Information on Reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		5,341	2,918
Non-cash income and expense:			
Depreciation and amortisation	7.1	6,033	3,943
Net impairments	8	(139)	1,442
Income recognised in respect of capital donations	4	(175)	(30)
(Increase) / decrease in receivables and other assets		4,302	(8,621)
(Increase) / decrease in inventories		-	88
Increase / (decrease) in payables and other liabilities		(4,831)	730
Increase / (decrease) in provisions		16	1,802
Net cash flows from / (used in) operating activities		**10,547**	**2,272**
Cash flows from investing activities			
Interest received		104	126
Purchase of intangible assets		(1,684)	(3,065)
Purchase of PPE and investment property		(3,821)	(6,492)
Sales of PPE and investment property		292	1,140
Receipt of cash donations to purchase assets		-	30
Net cash flows from / (used in) investing activities		**(5,109)**	**(8,261)**
Cash flows from financing activities			
Public dividend capital received		1,265	2,055
Movement on loans from DHSC		-	(1,250)
Capital element of PFI, LIFT and other service concession payments		(445)	(382)
Interest on loans		-	(23)
Other interest		(4)	-
Interest paid on PFI, LIFT and other service concession obligations		(1,019)	(1,045)
PDC dividend (paid) / refunded		(2,380)	(2,151)
Net cash flows from / (used in) financing activities		**(2,583)**	**(2,796)**
Increase / (decrease) in cash and cash equivalents		**2,855**	**(8,785)**
Cash and cash equivalents at 1 April - brought forward		**8,632**	**17,417**
Cash and cash equivalents at 31 March	28.1	**11,487**	**8,632**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. This is as directed by the Department of Health and Social Care Group Accounting Manual 2019/20, whereby, unless the Trust expects that its services will cease to be provided to the public sector, the going concern basis for the preparation of the financial statements is assumed.

The Trust recognises that there are operational and funding factors that represent material uncertainties with regard to the adoption of the going concern basis. The draft plan submitted to NHSI on 5 March 2020 is achieving a breakeven control total. The Trust has signed up for a deficit position for 2020/21 of £10.8m with NHSI and will receive £10.8m of non-recurring Finance Recovery Fund.

In preparing the plan for the Trust, key areas of potential risk have been reviewed and mitigated:

- Cost Improvement Programmes, the Trust has a track record of delivering challenging efficiency programmes, with £11.25m delivered in 2019/20;
- The Trust has actively engaged in local strategic transformation planning with GM Health and Social Care Partnership and NHSI to develop models to deliver sustainable healthcare;
- The Trust has appropriate financial and operational risk management processes in place to support its operational plans.

In planning to achieve the control total i.e. break even position, a review of the Trust's cash position shows no requirement for a revenue loan in 2020/21.

As a consequence of the Covid-19 pandemic, all NHS Providers will be moving to block contract payments 'on account' for an initial period of 1st April 2020 to 31st July 2020, with suspension of the usual PBR national tariff payment architecture and associated administrative / transactional processes. The Operational Planning process has been suspended with immediate effect. A top up mechanism will be available and funded centrally to ensure all trusts make a break even position.

Therefore, although these factors represent material uncertainties that may affect the Trust's ability to continue as a going concern, the Board, having made appropriate enquiries, still have reasonable expectations that the Trust will have access to adequate resources to continue its operational existence for the foreseeable future, being a period of at least 12 months from the date of approval. On this basis, the Trust has adopted the going concern basis for preparing the financial statements.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust’s entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions

payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential be provided to the Trust;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably;
- The item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control;
- Form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use;
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their

depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

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

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

Donated and grant funded assets

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

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

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT 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 HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset.

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	4	50
Plant & machinery	5	25
Transport equipment	7	7
Information technology	2	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.9 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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Development expenditure	5	5
Software licences	2	7

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit losses are determined by applying 5% to relevant non-NHS receivables and a weighted loss for external staff debt applied to 30% of the outstanding amount.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.]

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

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

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

Note 1.10 Inventories

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

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all

other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit losses are determined by applying 5% to relevant non-NHS receivables and a weighted loss for external staff debt applied to 30% of the outstanding amount.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

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

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

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

The Trust does not have any finance leases as lessee.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over

the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

Finance leases

The Trust does not have any finance leases as lessee.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.55% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions

carried by NHS Resolution on behalf of the Trust is disclosed at note 34.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 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 in note 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

i. donated and grant funded assets,
ii. average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
iii. any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 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.

Note 1.18 Corporation tax

The NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of an NHS Foundation Trust (s519A[3] to [8] ICTA 1988). Accordingly, the NHS Foundation Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum.

Note 1.19 Foreign exchange

The functional and presentational currency of the Trust is sterling.

Note 1.20 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.22 Transfers of functions to other NHS bodies

For functions that the Trust has transferred to another NHS body, the assets and liabilities are de-recognised from the accounts as at the date of transfer. The net loss corresponding to the net assets transferred is recognised within expenses but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and the adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

IFRS 17 Insurance Contracts, application required for accounting periods beginning on or after 1 January 2023. Has been adopted by the FReM with an effective date of 1 April 2023. The application of IFRS17 is not anticipated to have an impact on the Trust.

Note 1.26 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- As required by IFRS 15 contracts have been grouped and each group is reviewed to determine the correct accounting treatment. This has resulted in material contracts being classified as contract receivables with the timing of the release of the income matching the fulfilment of the performance obligation.

Note 1.27 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- In making assumptions regarding redundancy costs (see note 34.1), the Trust has utilised actual estimates provided by payroll where applicable, where this is not possible the Trust has taken a prudent approach to estimating the likely costs of delivering the planned service redesign and potential redundancies.
- The Trust has an estimation of the valuation of land and building assets and their lives, based on the information provided by Cushman & Wakefield as at 31st March 2020. During 2019/20 a full valuation has been completed and the asset values have been adjusted in line with the revised valuation. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. See Note 19 for further details.

Note 2 Operating Segments

All activity at the Trust is health care related and a large majority of the Trust's income is received from within UK Government departments. The main proportion of the operating expenses are payroll related and are for staff directly involved in the provision of health care and the indirect and overhead costs associated with that provision. The Trust operates in a limited geographic area, primarily Greater Manchester, with some services delivered across North West England. Therefore it is deemed that the business activities which earn the revenues for the Trust and in turn incur the expenses are one provision, which it is deemed appropriate to identify as a single segment, namely 'healthcare'.

The Trust identifies the Trust's Board (which includes all Executive and Non-Executive Directors) as the Chief Operating Decision Maker as defined by IFRS 8. Monthly operating results are reported to the Trust's Board. The financial position of the Trust in month and for the year to date are reported, along with projections for the future performance and position, as a position for the whole Trust, rather than as component parts making up a whole. The Trust's Board does not have separate directors for particular service areas or divisions. The Trust's external reporting to NHSI (the regulator) is on a whole Trust basis, which also implies the Trust is a single segment.

All decisions affecting the Trust's future direction and viability are made based on the overall total segment, presented to the Board. The Trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

Note 3 Operating Income from Patient Care Activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.1

Note 3.1 Income from patient care activities (by nature)

	2019/20 £000	2018/19 £000
Mental health services		
Cost and volume contract income	16,226	12,247
Block contract income	155,087	139,936
Other clinical income from mandatory services	7,576	6,973
Community services		
Community services income from CCGs and NHS England	35,972	91,207
Income from other sources (e.g. local authorities)	7,175	17,654
All services		
Agenda for Change pay award central funding*	-	3,684
Additional pension contribution central funding**	7,691	-
Total income from activities	**229,727**	**271,701**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20 £000	2018/19 £000
NHS England	28,057	19,904
Clinical commissioning groups	184,941	220,504
Department of Health and Social Care	59	3,685
Other NHS providers	2,832	2,695
NHS other	21	16
Local authorities	13,066	22,503
Injury cost recovery scheme	18	23
Non NHS: other	733	2,371
Total income from activities	**229,727**	**271,701**
Of which:		
Related to continuing operations	229,727	271,701
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

The Trust does not receive any income relating to overseas visitors

Note 4 Other Operating Income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	652	-	**652**	522	-	**522**
Education and training	4,027	262	**4,289**	4,216	-	**4,216**
Non-patient care services to other bodies	2,935	-	**2,935**	846	-	**846**
Provider sustainability fund (PSF)	2,429	-	**2,429**	6,986	-	**6,986**
Financial recovery fund (FRF)	9,596	-	**9,596**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	499	-	**499**	923	-	**923**
Receipt of capital grants and donations	-	175	**175**	-	30	**30**
Charitable and other contributions to expenditure	-	337	**337**	-	164	**164**
Rental revenue from operating leases	-	27	**27**	-	31	**31**
Other income	193	-	**193**	418	-	**418**
Total other operating income	**20,331**	**801**	**21,132**	**13,911**	**225**	**14,136**
Of which:						
Related to continuing operations			**21,132**			**14,136**
Related to discontinued operations			**-**			**-**

Note 5

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20 £000	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,473	2,106

Note 5.2 Transaction price allocated to remaining performance obligations

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2019/20 £000	2018/19 £000
Income from services designated as commissioner requested services	214,861	250,363
Income from services not designated as commissioner requested services	35,998	35,474
Total	**250,859**	**285,837**

The Income from services not designated as commissioner requested services for 2018/19 has been restated.

Note 5.4 Profits and losses on disposal of property, plant and equipment

The following land and building assets were used in the provision of commissioner requested services and have been disposed of during the year.

314-316 Oldham Road

- Net book value £208k
- Proceeds £291k

Whitehall Street

- Net book value £87k
- Proceeds £0k

These properties were disposed of following a review of other properties and service moves.

314-316 Oldham Road had been recognised as a Non-Current Asset Held for Sale as at 31st March 2019.

Whitehall Street was linked to the Community dental service transfers and ceased being used for services in February 2020. A lease had been in place from Rochdale MBC for the land which had expired. The building was transferred to Rochdale MBC with zero proceeds received as the Council and CCG had a need for the building to support Covid 19 activity.

Note 6

Note 6.1 Fees and Charges

No income has been received from fees or charges raised under legislation

Note 7

Note 7.1 Operating Expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	4,676	5,973
Purchase of healthcare from non-NHS and non-DHSC bodies	4,185	4,680
Staff and executive directors costs	193,350	218,020
Remuneration of non-executive directors	174	172
Supplies and services - clinical (excluding drugs costs)	3,011	5,523
Supplies and services - general	1,870	2,146
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,223	2,735
Consultancy costs	468	286
Establishment	2,859	3,513
Premises	11,436	13,168
Transport (including patient travel)	2,364	2,852
Depreciation on property, plant and equipment	4,403	3,146
Amortisation on intangible assets	1,630	797
Net impairments	(139)	1,442
Movement in credit loss allowance: contract receivables / contract assets	7	(531)
Increase/(decrease) in other provisions	(111)	-
Audit fees payable to the external auditor*		
audit services- statutory audit	54	47
other auditor remuneration (external auditor only)	-	7
Internal audit costs	95	96
Clinical negligence	779	923
Legal fees	441	866
Insurance	250	292
Research and development	894	585
Education and training	1,731	1,638
Rentals under operating leases	7,131	11,005
Early retirements	2	1
Redundancy	60	1,772
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	941	915
Hospitality	1	3
Losses, ex gratia & special payments	4	-
Other services, e.g. external payroll	42	35
Other	687	812
Total	**245,518**	**282,919**
Of which:		
Related to continuing operations	245,518	282,919
Related to discontinued operations	-	-

* Audit fees are disclosed above including VAT where this cannot be recovered.

Note 7.2 Other Auditor Remuneration

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	-	7
Total	**-**	**7**

Note 7.3 Limitation on Auditor's Liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 8 Impairment of Assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(139)	1,442
Total net impairments charged to operating surplus / deficit	**(139)**	**1,442**
Impairments charged to the revaluation reserve	2,287	1,223
Total net impairments	**2,148**	**2,665**

Note 9 Employee Benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages*	145,951	173,099
Social security costs *	13,013	15,316
Apprenticeship levy	729	856
Employer's contributions to NHS pensions	25,399	21,144
Pension cost - other	44	38
Temporary staff (including agency)	11,022	10,898
Total gross staff costs	**196,158**	**221,351**
Recoveries in respect of seconded staff	-	-
Total staff costs	**196,158**	**221,351**
Of which		
Costs capitalised as part of assets	1,429	2,101

* The split between Salaries and Wages and Social Security Costs for 2018/19 has been corrected with £874k reclassified from Salaries and Wages to Social Security Costs.

Note 9.1 Retirements Due to Ill-Health

During 2019/20 there were 3 early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £92k (£170k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9.2 Directors' Remuneration

	2019/20 Total £000	2018/19 Total £000
Director's remuneration	1,091	1,019
Employer contributions to the pension scheme	109	121
	1,200	**1,140**

	2019/20 Number	2018/19 Number
Total number of directors to whom benefits are accruing under:		
Defined benefit systems	6	9

No advances, credits or guarantees have been granted to any directors of the Trust.

Full disclosure of Directors' remuneration is given in the remuneration report section of the Annual Report.

Note 10 Pension Costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The employer contribution rate from April 2019 is 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Past and present employees are covered by the provision of the two NHS pension schemes or the National Employment Savings Trust (NEST). Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at:

- www.nhsbsa.nhs.uk/pensions
- www.nestpensions.org.uk

Note 11 Operating Leases

Note 11.1 Pennine Care NHS Foundation Trust as a Lessor

This note discloses income generated in operating lease agreements where Pennine Care NHS Foundation Trust is the lessor.

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	27	31
Total	**27**	**31**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	27	31
- later than one year and not later than five years;	108	124
- later than five years.	106	125
Total	**241**	**280**

Note 11.2 Pennine Care NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Pennine Care NHS Foundation Trust is the lessee.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	7,131	11,005
Total	**7,131**	**11,005**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	2,395	2,341
- later than one year and not later than five years;	7,082	7,878
- later than five years.	1,824	3,520
Total	**11,301**	**13,739**
Future minimum sublease payments to be received	-	-

The future minimum lease payments due as at 31st March 2019 have been restated to exclude arrangements where a formal signed lease agreement is not in place.

Note 12 Finance Income

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

	2019/20 £000	2018/19 £000
Interest on bank accounts	104	126
Total finance income	**104**	**126**

Note 13.1 Finance Expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2019/20 £000	2018/19 £000
Interest expense:		
Loans from the Department of Health and Social Care	-	17
Interest on late payment of commercial debt	4	-
Main finance costs on PFI and LIFT schemes obligations	1,019	1,045
Total interest expense	**1,023**	**1,062**
Total finance costs	**1,023**	**1,062**

Note 13.2 Better Payment Practice Code

Compliance with the Better Payment Practice Code in respect of invoices raised from both NHS and non-NHS trade creditors is included in the Annual Report.

Note 13.3 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20 £000	2018/19 £000
Amounts included within interest payable arising from claims made under this legislation	4	-

Note 14 Other gains / (losses)

	2019/20 £000	2018/19 £000
Gains on disposal of assets	83	480
Losses on disposal of assets	(87)	(132)
Total gains / (losses) on disposal of assets	**(4)**	**348**
Total other gains / (losses)	**(4)**	**348**

Note 15 Discontinued operations

	2019/20 £000	2018/19 £000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	**-**	**-**

Note 16

Note 16.1 Intangible assets - 2019/20

	Software licences £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - brought forward	**5,101**	**79**	**106**	**5,286**
Additions	1,666	-	-	**1,666**
Reclassifications	36	-	(36)	**-**
Disposals / derecognition	(31)	(79)	-	**(110)**
Valuation / gross cost at 31 March 2020	**6,772**	**-**	**70**	**6,842**
Amortisation at 1 April 2019 - brought forward	**993**	**63**	**-**	**1,056**
Provided during the year	1,614	16	-	**1,630**
Disposals / derecognition	(31)	(79)	-	**(110)**
Amortisation at 31 March 2020	**2,576**	**-**	**-**	**2,576**
Net book value at 31 March 2020	**4,196**	**-**	**70**	**4,266**
Net book value at 1 April 2019	**4,108**	**16**	**106**	**4,230**

Note 16.2 Intangible assets - 2018/19

	Software licences £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - as previously stated	**789**	**79**	**1,721**	**2,589**
Additions	2,837	-	106	**2,943**
Reclassifications	1,721	-	(1,721)	**-**
Disposals / derecognition	(246)	-	-	**(246)**
Valuation / gross cost at 31 March 2019	**5,101**	**79**	**106**	**5,286**
Amortisation at 1 April 2018 - as previously stated	**457**	**48**	**-**	**505**
Provided during the year	782	15	-	**797**
Disposals / derecognition	(246)	-	-	**(246)**
Amortisation at 31 March 2019	**993**	**63**	**-**	**1,056**
Net book value at 31 March 2019	**4,108**	**16**	**106**	**4,230**
Net book value at 1 April 2018	**332**	**31**	**1,721**	**2,084**

Note 17

Note 17.1 Property, plant and equipment - 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Valuation/gross cost at 1 April 2019 - brought forward	**14,651**	**86,437**	**306**	**1,973**	**106**	**6,907**	**110,380**
Transfers by absorption	-	(451)	-	(652)	-	(704)	**(1,807)**
Additions	175	1,644	642	346	-	1,026	**3,833**
Impairments	(25)	(4,991)	-	-	-	-	**(5,016)**
Reversals of impairments	-	1,204	-	-	-	-	**1,204**
Revaluations	456	219	-	-	-	-	**675**
Reclassifications	-	222	(222)	-	-	-	**-**
Disposals / derecognition	-	(104)	-	(8)	-	(360)	**(472)**
Valuation/gross cost at 31 March 2020	**15,257**	**84,180**	**726**	**1,659**	**106**	**6,869**	**108,797**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**532**	**-**	**588**	**68**	**2,090**	**3,278**
Transfers by absorption	-	(266)	-	(283)	-	(147)	**(696)**
Provided during the year	-	2,715	-	132	11	1,545	**4,403**
Impairments	-	(1,365)	-	-	-	-	**(1,365)**
Reversals of impairments	-	(299)	-	-	-	-	**(299)**
Revaluations	-	(657)	-	-	-	-	**(657)**
Disposals / derecognition	-	(17)	-	(7)	-	(360)	**(384)**
Accumulated depreciation at 31 March 2020	**-**	**643**	**-**	**430**	**79**	**3,128**	**4,280**
Net book value at 31 March 2020	**15,257**	**83,537**	**726**	**1,229**	**27**	**3,741**	**104,517**
Net book value at 1 April 2019	**14,651**	**85,905**	**306**	**1,385**	**38**	**4,817**	**107,102**

Note 17.2 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**14,746**	**86,779**	**410**	**2,254**	**106**	**4,732**	**109,027**
Prior period adjustments	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2018 - restated	**14,746**	**86,779**	**410**	**2,254**	**106**	**4,732**	**109,027**
Additions	-	2,893	1,413	312	-	3,020	**7,638**
Impairments	-	(4,349)	-	-	-	-	**(4,349)**
Reversals of impairments	-	1	-	-	-	-	**1**
Revaluations	-	(16)	-	-	-	-	**(16)**
Reclassifications	-	1,514	(1,517)	-	-	3	**-**
Transfers to / from assets held for sale	(95)	(117)	-	-	-	-	**(212)**
Disposals / derecognition	-	(268)	-	(593)	-	(848)	**(1,709)**
Valuation/gross cost at 31 March 2019	**14,651**	**86,437**	**306**	**1,973**	**106**	**6,907**	**110,380**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**326**	**-**	**969**	**53**	**2,072**	**3,420**
Prior period adjustments	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2018 - restated	**-**	**326**	**-**	**969**	**53**	**2,072**	**3,420**
Provided during the year	-	2,097	-	168	15	866	**3,146**
Impairments	-	(1,624)	-	-	-	-	**(1,624)**
Reversals of impairments	-	(59)	-	-	-	-	**(59)**
Revaluations	-	(24)	-	-	-	-	**(24)**
Transfers to / from assets held for sale	-	(4)	-	-	-	-	**(4)**
Disposals / derecognition	-	(180)	-	(549)	-	(848)	**(1,577)**
Accumulated depreciation at 31 March 2019	**-**	**532**	**-**	**588**	**68**	**2,090**	**3,278**
Net book value at 31 March 2019	**14,651**	**85,905**	**306**	**1,385**	**38**	**4,817**	**107,102**
Net book value at 1 April 2018	**14,746**	**86,453**	**410**	**1,285**	**53**	**2,660**	**105,607**

Note 17.3 Property, plant and equipment financing - 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Net book value at 31 March 2020							
Owned - purchased	15,082	74,356	726	1,229	27	3,741	**95,161**
On-SoFP PFI contracts and other service concession arrangements	-	9,181	-	-	-	-	**9,181**
Owned - donated	175	-	-	-	-	-	**175**
NBV total at 31 March 2020	**15,257**	**83,537**	**726**	**1,229**	**27**	**3,741**	**104,517**

Note 17.4 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Net book value at 31 March 2019							
Owned - purchased	14,651	77,360	306	1,385	38	4,817	**98,557**
On-SoFP PFI contracts and other service concession arrangements	-	8,545	-	-	-	-	**8,545**
NBV total at 31 March 2019	**14,651**	**85,905**	**306**	**1,385**	**38**	**4,817**	**107,102**

Note 18 Donations of property, plant and equipment

Land and Buildings at The Children's Hospice, Dumers Lane, Radcliffe were donated to the Trust in year without restriction via a Deed of Surrender from The Forget Me Not Children's Hospice Limited.

Note 19 Revaluations of property, plant and equipment

A full valuation exercise of the Trust's Land and Buildings was carried out by Cushman & Wakefield in February and March 2020 with a valuation date of 31 March 2020. This valuation provided estimated financial values and estimated remaining useful economic lives for the Trust's Land and Buildings by applying a modern equivalent asset method of valuation.

This valuation, based on estimates provided by a qualified professional led to an overall decrease of the Trust's Land and Building asset values of £816k. Of this decrease, a net £955k decrease (impairments net of impairment reversals and revaluation gains) has been charged to the Revaluation Reserve and a net increase of £139k (impairments net of impairment reversals) has been recognised in the Statement of Comprehensive Income.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The material valuation uncertainty disclosure by the valuer is as follows:

"*The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries. Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence and published build costs for comparison purposes, to inform opinions of value. Indeed, the current response to COVID 19 means that we are faced with an unprecedented set of circumstances on which to base a judgement. Our valuations are therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation of these properties under frequent review. For the avoidance of doubt, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. This clause is a disclosure, not a disclaimer. It is used in order to be clear and transparent with all parties, in a professional manner that – in the current extraordinary circumstances – less certainty can be attached to the valuation than would otherwise be the case."*

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

- The valuation report has not indicated the range of uncertainty attached to the report.
- For illustrative purposes however, a 10% change in the valuation would have a £9,814k impact on the statement of financial position with a £172k impact on the PDC dividend due to be paid next year and accrued in these financial statements.
- Of the £98,140k net book value of land and buildings subject to valuation, £91,250k relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced. It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

Note 20

Note 20.1 Investment Property

The Trust does not hold any investment property.

Note 21 Investments in associates and joint ventures

The Trust does not have any investments in associates and joint ventures.

Note 22 Other investments / financial assets

The Trust does not have any other investments / financial assets.

Note 22.1 Other investments / financial assets (current)

The Trust does not have any other investments / financial assets (current).

Note 23 Disclosure of interests in other entities

The Trust does not have any interests in other entities.

Note 24 Inventories

Inventories recognised in expenses for the year were £2,223k (2018/19: £2,813k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

Due to the quick and regular turnover of Inventory items, all Inventory items are expensed on purchase.

Note 25

Note 25.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	16,381	19,965
Allowance for impaired contract receivables / assets	(163)	(167)
Prepayments (non-PFI)	845	1,313
PDC dividend receivable	-	60
VAT receivable	384	638
Total current receivables	**17,447**	**21,809**
Non-current		
PFI lifecycle prepayments	1,843	1,645
Total non-current receivables	**1,843**	**1,645**
Of which receivable from NHS and DHSC group bodies:		
Current	14,450	16,193
Non-current	-	-

Note 25.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	**167**	**-**	**-**	**1,012**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-	-	791	(1,012)
New allowances arising	7	-	-	-
Changes in existing allowances	-	-	(523)	-
Reversals of allowances	-	-	(8)	-
Utilisation of allowances (write offs)	(11)	-	(93)	-
Allowances as at 31 Mar 2020	**163**	**-**	**167**	**-**

Note 25.3 Exposure to credit risk

The Trust is not exposed to significant credit risk

Note 26 Other assets

The Trust does not have any other assets.

Note 27

Note 27.1 Non-current assets held for sale and assets in disposal groups

	2019/20 £000	2018/19 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**208**	**660**
Assets classified as available for sale in the year	-	208
Assets sold in year	(208)	(660)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**208**

Note 27.2 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 28

Note 28.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2019/20 £000	2018/19 £000
At 1 April	**8,632**	**17,417**
Net change in year	2,855	(8,785)
At 31 March	**11,487**	**8,632**
Broken down into:		
Cash at commercial banks and in hand	61	73
Cash with the Government Banking Service	11,426	8,559
Total cash and cash equivalents as in SoFP	**11,487**	**8,632**
Total cash and cash equivalents as in SoCF	**11,487**	**8,632**

Note 28.2 Third party assets held by the Trust

Pennine Care NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020 £000	31 March 2019 £000
Bank balances	296	296
Monies on deposit	-	-
Total third party assets	**296**	**296**

Note 29

Note 29.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	3,211	4,995
Capital payables	2,300	2,283
Accruals	16,415	17,386
Social security costs	1,761	2,607
Other taxes payable	1,174	1,594
PDC dividend payable	133	-
Other payables	2,450	3,150
Total current trade and other payables	**27,444**	**32,015**
Of which payables from NHS and DHSC group bodies:		
Current	8,356	7,759
Non-current	-	-

The payables from NHS and DHSC group bodies balance as at 31 March 2019 has been restated.

Note 29.2 Early retirements in NHS payables above

The Trust does not have any early retirements in the NHS payables.

Note 30 Other financial liabilities

The Trust does not have any other financial liabilities.

Note 31 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	1,548	1,658
Total other current liabilities	**1,548**	**1,658**

Note 32

Note 32.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Obligations under PFI, LIFT or other service concession contracts	333	445
Total current borrowings	**333**	**445**
Non-current		
Obligations under PFI, LIFT or other service concession contracts	14,386	14,719
Total non-current borrowings	**14,386**	**14,719**

Note 32.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	**-**	**15,164**	**15,164**
Cash movements:			
Financing cash flows - payments and receipts of principal	-	(445)	**(445)**
Financing cash flows - payments of interest	-	(1,019)	**(1,019)**
Non-cash movements:			
Application of effective interest rate	-	1,019	**1,019**
Carrying value at 31 March 2020	**-**	**14,719**	**14,719**

Note 32.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	**1,250**	**15,546**	**16,796**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,250)	(382)	**(1,632)**
Financing cash flows - payments of interest	(23)	(1,045)	**(1,068)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	6	-	**6**
Application of effective interest rate	17	1,045	**1,062**
Carrying value at 31 March 2019	**-**	**15,164**	**15,164**

Note 33 Finance leases

The Trust does not have any finance leases either as lessor or lessee.

Note 34

Note 34.1 Provisions for liabilities and charges analysis

	Pensions : injury benefits £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2019	**28**	**689**	**2,677**	**-**	**3,394**
Arising during the year	2	804	-	558	**1,364**
Utilised during the year	(3)	(54)	(60)	-	**(117)**
Reversed unused	-	(562)	(669)	-	**(1,231)**
At 31 March 2020	**27**	**877**	**1,948**	**558**	**3,410**
Expected timing of cash flows:					
- not later than one year;	2	877	1,948	**558**	**3,385**
- later than one year and not later than five years;	9	-	-	**-**	**9**
- later than five years.	16	-	-	**-**	**16**
Total	**27**	**877**	**1,948**	**558**	**3,410**

Pensions: injury benefits

These are commitments made to a former member of staff who receives Injury Benefits through NHS Resolution. Payments are handled by NHS Resolution and recharged quarterly. It is expected the cash flows will continue annually for at least twelve years.

Legal claims

The legal claims provision includes the excess payable on Employer Liability and Public Liability claims being handled by NHS Resolution where the cases have been notified to the Trust as outstanding at 31 March 2020. The legal claims figure also includes provision for a number of specific employment tribunals. It is expected that these balances will be settled within one year.

Redundancy

The redundancy provision includes estimated costs for service areas restructuring as a result of the transfer of community services.

Other

Other provisions relate to NHS Pensions final pay controls expected charges and provision for enhanced Agenda for Change statutory and contractual holiday pay relating to non-guaranteed and voluntary overtime.

Note 34.2 Clinical negligence liabilities

At 31 March 2020, £1,816k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Pennine Care NHS Foundation Trust (31 March 2019: £773k).

Note 35 Contingent assets and liabilities

The Trust does not have any contingent assets and liabilities.

Note 36 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	1,664	244
Total	**1,664**	**244**

Note 37 Other financial commitments

The Trust does not have any other financial commitments.

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

The Etherow Unit - this scheme is for the provision of specialist mental health care for the elderly population of Tameside and Glossop and forms part (22%) of the overall 'Health in Tameside' PFI scheme situated on the hospital site in Tameside.

As at 31 March 2020 the current net liability of the scheme is £14,719k and current unitary payments are £2,602k per annum.

The contract commenced in September 2009 and is due to expire in August 2041.

There are no deferred assets or residual interests associated with the Trust's section of the PFI transaction.

Note 38.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**32,921**	**34,385**
Of which liabilities are due		
- not later than one year;	1,500	1,464
- later than one year and not later than five years;	6,152	6,114
- later than five years.	25,269	26,807
Finance charges allocated to future periods	(18,202)	(19,221)
Net PFI, LIFT or other service concession arrangement obligation	**14,719**	**15,164**
- not later than one year;	333	445
- later than one year and not later than five years;	1,784	1,502
- later than five years.	12,602	13,217

Note 38.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**58,293**	**60,885**

Of which payments are due:		
- not later than one year;	2,657	2,592
- later than one year and not later than five years;	10,893	10,826
- later than five years.	44,743	47,467

Note 38.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	**2,602**	**2,535**
Consisting of:		
- Interest charge	1,019	1,045
- Repayment of balance sheet obligation	445	383
- Service element and other charges to operating expenditure	941	915
- Addition to lifecycle prepayment	197	192
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**2,602**	**2,535**

Note 39 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no PFI schemes deemed to be off-Statement of Financial Position.

Note 40 Financial instruments

Note 40.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Commissioners and the way those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities, rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies, agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors, Mersey Internal Audit Agency.

Currency risk

The Trust is a domestic organisation with transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

If required the Trust would borrow from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. Borrowings would be for 1-25 years, in line with the life of the associated assets, and interest would be charged at the National Loans Fund rate, fixed for the life of the loan. The Trust has borrowing related to the PFI building. The contract relating to the PFI building is inflated each year based on the Retail Price Index. 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 2020 are in receivables from customers, as disclosed in the receivables note.

The Trust's objective is to minimise credit risk, which it achieves by a programme of proactive credit control and internal controls.

Liquidity risk

The Trust's operating costs are incurred under contracts with Commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

Note 40.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	**Held at amortised cost £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	16,218	**16,218**
Cash and cash equivalents	11,487	**11,487**
Total at 31 March 2020	**27,705**	**27,705**

Carrying values of financial assets as at 31 March 2019	**Held at amortised cost £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	19,798	**19,798**
Cash and cash equivalents	8,632	**8,632**
Total at 31 March 2019	**28,430**	**28,430**

Note 40.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	**Held at amortised cost £000**	**Total book value £000**
Obligations under PFI, LIFT and other service concession contracts	14,719	**14,719**
Trade and other payables excluding non financial liabilities	22,461	**22,461**
Provisions under contract	3,410	**3,410**
Total at 31 March 2020	**40,590**	**40,590**

Carrying values of financial liabilities as at 31 March 2019	**Held at amortised cost £000**	**Total book value £000**
Obligations under PFI, LIFT and other service concession contracts	15,164	**15,164**
Trade and other payables excluding non financial liabilities	27,814	**27,814**
Provisions under contract	3,366	**3,366**
Total at 31 March 2019	**46,344**	**46,344**

Note 40.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	26,204	31,625
In more than one year but not more than two years	396	306
In more than two years but not more than five years	1,388	1,196
In more than five years	12,602	13,217
Total	**40,590**	**46,344**

Note 40.5 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 41 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	45	11	165	92
Total losses	**45**	**11**	**165**	**92**
Special payments				
Ex-gratia payments	17	57	8	23
Total special payments	**17**	**57**	**8**	**23**
Total losses and special payments	**62**	**68**	**173**	**115**
Compensation payments received		-		-

Note 42 Gifts

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Gifts made	-	-	-	-

Note 43 Related parties

Pennine Care NHS Foundation Trust is a public interest body authorised by NHS Improvement, the Independent Regulator for Foundation Trusts.

During the year none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with Pennine Care NHS Foundation Trust.

One Non-Executive Director is an Independent Member on the Board of Governors at Manchester Metropolitan University and is an Associate Community Governor at St Mary's Church of England Primary School. There have been non-material transaction during 2019/20 with these organisations. All of these transactions are considered to be at arms length.

The Department of Health and Social Care is regarded as a related party and the parent organisation of the Trust. During the year Pennine care NHS Foundation Trust has had a significant number of material transactions with the Department itself, and with other NHS bodies for which the Department is also regarded as the parent Department. These entities include:

- NHS England
- Clinical Commissioning Groups including:
    - NHS Bury CCG
    - NHS Heywood Middleton and Rochdale CCG
    - NHS Manchester CCG
    - NHS Oldham CCG
    - NHS Stockport CCG
    - NHS Tameside and Glossop CCG
    - NHS Trafford CCG
- Health Education England
- NHS Property Services
- Community Health Partnerships
- Pennine Acute Hospitals NHS Trust
- Salford Royal NHS Foundation Trust
- Local Authorities:
    - Bury MBC
    - Rochdale BC
    - Stockport MBC
    - Trafford MBC
- HMRC
- NHS Pensions Scheme

Note 44 Transfers by absorption

Where functions transfer between public sector bodies within the Department of Health and Social Care group, absorption accounting is applied. Absorption accounting requires that the Trust accounts for these transactions in the period in which they took place. Where assets and Liabilities have transferred, the gain or loss resulting is recognised in the Statement of Comprehensive Income and is disclosed separately from operating costs.

The following transfers took place during 2019/20:

Counterparty	Date of Transfer	Divesting / Receiving	Function Transferred
Salford Royal NHS Foundation Trust	01/07/2019	Divesting	Community Services (North East Sector - Oldham, Bury & Heywood Middleton & Rochdale)
Manchester University NHS Foundation Trust	01/10/2019	Divesting	Community Services (Trafford)
Salford Royal NHS Foundation Trust	01/10/2019	Divesting	Child Health Information System (Oldham, Bury & Heywood Middleton & Rochdale, Trafford)
Salford Royal NHS Foundation Trust	01/11/2019	Divesting	Children's Community Services (Heywood, Middleton & Rochdale)

	31 March 2020 £000	31 March 2019 £000
Value of property, plant and equipment transferred:		
- Salford Royal NHS FT - 01/07/2019	(476)	-
- Manchester University NHS FT - 01/10/2019	(635)	-
- Salford Royal NHS FT - 01/10/2019	-	-
- Salford Royal NHS FT - 01/11/2019	-	-
	(1,111)	**-**

The transfer of Community Services in 19/20 has also had the impact of significantly reducing the Trust's operating income and operating expenditure shown with the Statement of Comprehensive Income (SOCI). Further details are included within the Financial performance and information section of the Annual Report.

The Trust continues to transfer services including properties relating to Community Services to other NHS bodies in the following financial year - 2020/21.

Note 45 Events after the reporting date

There were no events after the reporting date that require disclosure.