Lancashire Care NHS
NHS Foundation Trust

Teamwork

Compassion

Integrity

Annual Report and Accounts 2013/14

Respect

Excellence

Accountability

Children and Families | Community Services | Mental Health | Secure Services | Specialist Services

Supporting Health and Wellbeing

LANCASHIRE CARE NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS 2013/14

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

Contents

Chair and Chief Executive's Foreword

It is our pleasure to introduce this annual report and share with you the details of the Trust's performance over the last financial year. This report also serves to give you a flavour of our future direction of travel and our priority areas over the next 12 months.

It goes without saying that our main focus is on providing high quality care that is compassionate, safe, meets people's needs and exceeds expectations. Lancashire Care aims to provide for people at every stage of their life and not just at times when they are unwell. We recognise that as the major provider of health and wellbeing services in the county we have a vital role to play in supporting people to stay well in the first place. This is being progressed in a variety of ways including educating people to self-care, lead healthier lifestyles and working with the wider system and partners to ensure that the other building blocks such as housing, employment and education are in place to support people and communities to achieve wellbeing.

Our 6,650 employees have a huge reach into local communities. In the future we will be optimising this reach and focusing on making every contact count by offering health focused conversations with every interaction. This will mean training staff at all levels of the organisation to have conversations with people coming into contact with Trust services about their lifestyle choices and signposting to support services. There really are some big health gains to be made by making very small changes to our daily diet, routine and overall lifestyle. On average, a person can add an extra 14 years to their life by making sure that they eat their five a day, stay active, watch their alcohol intake and not smoking. It is vital that we use our position as the major health provider for Lancashire to raise awareness about this. We certainly want our 14 years and it is something that we want for the communities that we are here to serve too.

Our wider priorities include the on-going improvements to our mental health provision. This involves replacing existing outdated facilities with four purpose designed units and strengthening community services so that people can receive care at home as far as possible. We are also working with partners to develop support outside of hospital for people with long term conditions and to improve urgent care services. Increasingly the Trust will be looking at which of its services could be provided seven days a week and the responsiveness of the system overall to the people with the highest level of need. Engagement with partners is enabling the pursuit of joint priorities that will benefit whole communities.

In terms of the operating environment and the wider system, the Trust has established productive relationships with its commissioners and continues to respond well to the on-going financial challenge. Lancashire Care remains financially strong and we will continue to manage our finances robustly to ensure that we can respond to pressures, demonstrate value for money to commissioners and manage the increasing demand on services at a time when there is less money than ever in the pot. This is going to require on-going service changes and developments to manage the increasing pressure on services and to meet the needs of an ageing population in a way that is sustainable.

As with any complex organisation there will always be challenges. It is the responsibility of the Board to align the Trust's strategy to respond to the risks this poses to the organisation and to also seize opportunities as they arise. The Trust has robust and realistic plans in place to achieve its objectives and to mitigate against issues and risks that are known or emerging.

On behalf of our colleagues on the Board, we would like to take this opportunity to thank our employees for their continued efforts and living our values along with all of our stakeholders for their support in what has been another successful year for the Trust. We also thank our Council of Governors for representing the views of the wider public and ensuring that the services we deliver are meeting their needs.

Warmest regards

Derek Brown
Chair
28 May 2014

Professor Heather Tierney-Moore
Chief Executive
28 May 2014

1. Strategic Report

The Strategic Report has been prepared under direction issued by Monitor, the independent regulator for Foundation Trusts, as required by Schedule 7 paragraph 26 of the NHS Act 2006 and in accordance with:

- Sections 414A, 414C and 414D[5] of the Companies Act 2006, as interpreted by the FReM (paragraphs 5.2.6 to 5.2.11). Sections 414A(5) and (6) and 414D(2) do not apply to NHS Foundation Trusts ;and
- The NHS Foundation Trust Annual Reporting manual 2013/14 (FT ARM).

Further details of the areas included in this statement can be found on the Trust's website: www.lancashirecare.nhs.uk

1.1 Business Review

1.1.1 Trust Overview and Review of Business

Lancashire Care NHS Foundation Trust (LCFT) is the main provider of community, health & wellbeing and treatment services in the county. The service offering is diverse and delivered from over 700 premises across Lancashire in a range of settings to a population of 1.5 million people. Increasingly, the Trust is working with other providers to deliver integrated care and ensure that the needs of the community are met at every stage of life.

Lancashire Care was first established in April 2002 and has developed into a major provider of integrated care. As at 31 March 2014, the Trust employs 6,650 members of staff and has an annual turnover of over £325 million. The main source of income for the Trust is from contracts to provide health and wellbeing services in the community and specialist mental health services.

The majority of the Trust's services are commissioned by local Clinical Commissioning Groups (CCGs), which are detailed in the table below. Blackburn with Darwen acts as the lead commissioner for mental health and Chorley and South Ribble is the lead for community services. Another source of income for the Trust is for the provision of specialist services, which are commissioned by NHS England.

The CCGs share boundaries with Lancashire County Council social services with the exception of Blackburn with Darwen and Blackpool which align to their respective unitary authorities.

Clinical Commissioning Group	Areas Covered	Population Size	Number of GP Practices
Blackburn with Darwen	Blackburn with Darwen Borough Council Boundaries	167.450	30
East Lancashire	Burnley, Hyndburn, Pendle, Rossendale, Ribble Valley	371,073	65
Greater Preston	Preston, Longridge, Great Eccleston	178,942	32
Chorley and South Ribble	Chorley and South Ribble	225,529	36
West Lancashire	Ormskirk, Skelmersdale and surrounding communities	111,444	23
Lancashire North	Garstang (in the south) to Carnforth (in the North) and Morecambe (in the west) to Caton (in the east)	160,000	13
Fylde and Wyre	Fylde, Wyre and Fleetwood	182,000	24
Blackpool	Blackpool Borough Council Boundaries	152,968	22

Throughout the reporting period the Trust has delivered services through four clinical networks:

Adult Community provides community services (nursing, therapy and primary prevention services) and older adult mental health services. Management and support of people in the community with often multiple (physical and mental health) long term conditions is a key service element. There are close working relationships with local hospitals and social care providers and significant planning is being undertaken to develop person focused 'one stop services'.

Specialist Services are a major part of service provision comprising forensic and criminal justice services. Secure Services are provided for low and medium secure inpatients and services for five prisons in Lancashire.

Adult Mental Health provides inpatient and community services for adults aged 18-65. All adult mental health inpatient facilities are being redeveloped and it is planned that existing wards will be replaced with improved accommodation across the county by 2016/17.

Children and Families provides prevention and universal services for children and young people (including health visiting) and mental health and wellbeing services (including child and adolescent mental health services and early intervention services). Sexual health services are also within this network.

On 9 January 2014, the Board considered the business case relating to the

establishment of Academic Health Science Networks (AHSN) by NHS England and the opportunity and proposed arrangements for the Trust to host the AHSN (North West Coast). The Board agreed to this and to the establishment of a related scheme of delegation.

The Trust continues to play a major role in supporting research and innovation and is dedicated to improving the health of its patients, service users and the local population through developing and participating in high quality research and supporting new innovations. Developing a research active culture brings a host of benefits for service users, patients, clinicians and the NHS as a whole. It drives innovation, gives rise to better and more cost-effective treatments, and creates opportunities for staff development. Additionally, our clinical staff stay abreast of the latest treatment possibilities and the evolving evidence base and active participation in research leads to improved patient outcomes.

The Trust supports the Research and Innovation (R&I) department to work closely with clinicians, internal and external researchers to develop and deliver a range of research studies and increase the number of service users and patients participating in research each year. During 2013/14, over 925 service users or patients (receiving treatment or care from the Trust) were recruited to participate in research. In one particular study, COINCIDE (collaborative care for depression in people with diabetes and/or coronary heart disease), the Trust recruited 88 participants against a target of just 5, making it the top recruiting site in the country for that particular study.

The Trust continues to grow the number of research projects it is actively involved in, a total of 117 in 2013/14. Seventy of these were UK Clinical Research Network (UKCRN) portfolio studies, 37 were student studies (towards Masters and Doctorates) and ten were Trust funded pilot studies. The Trust has increased its activity in portfolio commercial clinical drug trials to five in 2013/14 and the Trust has plans to improve access to clinical trials for dementia and mental health service users during the forthcoming year.

The Research and Innovation department ensures that all regulatory requirements are met in relation to NHS research governance and the conduct of clinical trials. The Trust consistently outperforms the national requirement for permission times (to enable research to take place in the NHS). It has achieved an impressive median approval time of just seven days, against the national target of 30 days. The Trust supports researchers to apply for competitive research funding and currently leads on an NIHR Research for Patient Benefit Grant and has been awarded (as collaborator) a prestigious NIHR Programme Grant. A number of collaborative projects with local Universities have facilitated researchers at different stages of their research careers (from novice to post doctorate study) to develop their research skills further. Two clinicians have received support to submit doctoral and post-doctoral fellowship applications.

The Trust hosts the North West Coast Academic Health Science Network (NWC AHSN) and maintains close working relationships with a number of research networks to lead and host portfolio and National Institute for Health Research (NIHR)

funded projects, including the North West Coast Clinical Research Network, the Dementias and Neurodegenerative Diseases Research Network and continued to host the North West hub for the Mental Health Research Network until the new arrangements came into being on 01 April 2014.

The NWC AHSN officially launched on 12 March 2014 and is working to bring together NHS organisations, academia and industry to accelerate the adoption and spread of innovation and ensure that the most advanced treatments, technologies and medicines are available to healthcare service users.

The NWC AHSN has seven local clinical priorities – cancer, cardiac, child and maternal health, long-term conditions, muscular-skeletal services, mental health and stroke. It also holds the national support role for telehealth/telecare/telemedicine; infection and tropical disease; personalised medicine; and neurological conditions. In addition, the Network is undertaking a lead role in respect of good procurement practice, further developing and disseminating digital health solutions for residents and health professionals and reducing health inequalities focusing in 2014 on reducing stroke due to atrial fibrillation.

The NWC AHSN covers the areas of Cheshire, Merseyside, South Cumbria and Lancashire, serving a population of approximately four million residents.

The Trust is led by a strong Board of Directors comprising an Executive Management Team and Non-Executive Directors that contribute skills and experience gained in various sectors. The Board is responsible for defining and implementing strategy as well as for the operational performance of the Trust. More detailed information on the Board of Directors can be found from page 64.

The Board is held to account by the Council of Governors, comprising elected staff and public governors and appointed partnership governors. They act as a critical friend to the Board and ensure that the views of the Trust's members are represented at a strategic level. More information about the Council of Governors can be found from page 82.

1.1.2 Balanced and comprehensive analysis of the development and performance of the NHS Foundation Trust's business during the financial year, and of the position of the business at the end of the financial year

Operational results have been influenced by national and sector-specific challenges. Despite this the 2013/14 results reaffirm the Trust's strong track record of financial management in particular with the Trust continuing to perform well against its targets.

Monitor regulates NHS Foundation Trusts based on the risks they face and how well the risks are managed. Each Foundation Trust Board is required to submit a quarterly report to Monitor and performance is monitored against these reports to identify where potential and actual problems may arise.

With the publication of the Risk Assessment Framework, effective 1 October 2013, the Compliance Framework Financial Risk Ratings have been replaced by Continuity of Service Risk Ratings as detailed below.

Financial Risk Rating (Compliance Framework)

This is based on a series of performance measures and is rated 1 to 5, where 5 is the lowest level of financial risk and 1 the greatest level of financial risk.

Governance Risk Rating (Compliance Framework)

This is rated red, amber/red, amber/green and green, where green indicates compliance with the terms of authorisation, amber-green indicates limited concerns surrounding terms of authorisation, amber-red indicates a breach of terms of authorisation and red indicates a likely or actual significant breach in terms of authorisation.

Continuity of Service Risk Rating (Risk Assessment Framework)

This is based on two performance measures and is rated 1 to 4, where 4 is the lowest level of risk and 1 the most serious risk. Risk is not considered to be financial alone but a measure of the ongoing availability of key services.

Governance Rating (Risk Assessment Framework)

This is a measure of compliance with the governance condition of the Trust's licence. It is rated green to red, with green indicating no governance concern is evident to red which indicates regulatory action is being taken.

The table below summarises performance over the last two years. Despite the challenges faced by the Trust, the results were positive across these measures, resulting in an overall Financial Risk Rating of 3 and Continuity of Service Risk Rating of 4. Please note this represents Financial Risk Rating performance for the first six months of the year with Continuity of Service Risk Rating covering performance over the last six months of the year.

Current Year (under the Compliance Framework)	Annual Plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Financial Risk Rating	3	3	3		
Governance Risk Rating	Green	Green	Green		
Continuity of Service Rating				4	4*
Governance Rating				Green	Green*

Prior Year (under the Compliance Framework)	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Green	Green	Green	Green	Green

Performance Measure	2013/14	2012/13
EBITDA (Earnings before interest, tax, depreciation and amortisation)	2	2
I&E surplus	3	3
Return on assets	4	5
Achievement of plan	4	5
Liquidity	4	4
Overall Rating	3*	3*

**Overriding rules rating*

Financial Review

The Trust achieved an overall financial risk rating of 3 against a planned rating of 3 (2012/13 3). A rating of 3 indicates regulatory concerns in one or more components (significant breach unlikely). Under the new framework the Trust achieved an overall CoSRR of 4, indicating the lowest level of risk.

The Trust also reported green governance ratings under both the Compliance and Risk Assurance Frameworks, indicating no regulatory concerns (2012/13 green).

Financial Performance

The Trust has performed well against plan with a surplus (before impairments) for the year of £4.6m (2012/13 £6.5m), £0.6m ahead of the £4.0m planned.

EBITDA is used as a more meaningful identifier of an organisation's underlying profitability than raw surplus. The Trust has achieved an EBITDA of £14.1m against a plan of £13.9m (2012/13 £15.0m).

Income

Income totalled £325m (£322m 2012/13) an overall increase of 1% on prior year. The amount of money provided for existing services was reduced in line with national policy and some reductions in funding were made due to change in service requirements. This equated to a reduction of 2%. However, additional funding for new initiatives and service developments was received which offset this reduction. The additional income equated to 3% (of which 1% related to the Academic Health Science Network and 1% related to community based services). Patient care remains

the Trust's main activity, generating 93% (2012/13 94%) with non-patient care services being 3.7% (2012/13 3.0%) and Research & Development plus Education, Training and Research accounting for the bulk of the remaining 3.3% (2012/13 3%).

Expenditure

Operating expenditure totalled £317m (£314m 2012/13) a net increase of 1% on prior year. This was made up of a 1% increase in costs due to inflation including the cost of paying staff at nationally determined pay rates and 3% increase in costs due to new services and developments being established to meet national and local targets. The 4% total increase in costs was then offset by a requirement to deliver all services more efficiently thereby reducing costs by 3%.

The Trust has achieved productivity and efficiency savings of £9.7m (2012/13 £11.4m) through its cost improvement programmes (CIPs). The Board kept the overall programme under close review throughout the year and recognises the importance of delivering recurrent savings. This same focus will be taken forward into the next financial year.

Inpatient Capital Programme

The Trust has made significant progress with plans to improve its mental health inpatient facilities. Work is progressing on The Harbour development, a 154 bed inpatient hospital on the Fylde Coast which will become operational in early 2015.

We have arranged loan facilities with the Independent Trust Financing Facility (ITFF) totalling £60 million to fund The Harbour development. To date we have drawn £23 million with the balance to be drawn over the remaining course of the project.

In addition the Trust has invested £4m in redesigning existing facilities in North Lancashire. Planning for the improved facilities in the Central and East localities continues. Investment has also been made into developing community services so that people can receive care at home as far possible.

Balance Sheet

Strong balance sheet control is considered essential and liquidity in particular is vital to Foundation Trusts, ensuring both 'going concern' and assisting with the delivery of financial targets. The Trust has sustained a strong operating position which, together with effective working capital management, has improved its liquidity and consequentially its cash position. This has in turn enabled the Trust to better pursue its goals and facilitated compliance with the Better Payment Practice Code. Detailed information on the Trust's financial performance can be found in the annual accounts.

Relationship Management

Strong relationships with stakeholders exist throughout the organisation at many levels. A strategic approach to managing relationships is taken through an engagement matrix which aligns Executives, Senior Managers and the Engagement Team with specific stakeholders and geographical localities. Three Relationship Managers support the Trust to achieve its objectives and enhance the reputation of

the organisation by leading or supporting appropriate engagement with internal and external stakeholders.

The development of relationships with GPs and other commissioners is a key part of the Relationship Manager role. This involves co-ordinating visits to GPs in support of the GP Charter, ensuring Trust representatives are appropriately supported, feeding back intelligence in a robust and meaningful way and sharing intelligence with relevant networks and services.

The Trust continues to develop its relationships with:

- The new NHS healthcare commissioners
- Other NHS providers
- Local authorities
- Social enterprises
- Other local agencies including police and prisons

The aim of working closely with these organisations is to develop opportunities to enhance service provision to patients and deliver the efficiencies required by government.

The Trust has a variety of communication mechanisms to strengthen relationships by creating a dialogue with stakeholders. This is further enhanced by tailoring activity to specific audiences and localities. Stakeholder communications and meetings are managed through a Customer Relationship Management system which enables the Trust to monitor stakeholder engagement more effectively and identify key themes and issues that need to be addressed.

The aim of the communication and engagement activity is to position the Trust as the prime contractor or partner for health and wellbeing services in Lancashire and relevant geographies outside the county where strategically relevant.

During the year the Trust has invested considerable time in furthering the portfolio of its joint venture, Red Rose Corporate Services. 2014/15 will see the continued exploration of commercial opportunities.

Prudential Borrowing Limit

The requirement to disclose information concerning the Trust's Prudential Borrowing Limit is no longer required due to the Prudential Borrowing Code being repealed by the Health and Social Care Act 2012.

The Private Patient Income Cap (PPI Cap)

The Health and Social Care Act 2012 obliges Foundation Trusts to make sure that the income they receive from providing goods and services for the NHS (their principal purpose) is greater than their income from other sources.

The Trust had no Private Patient Income during the year to 31 March 2014.

1.1.3 Information about persons with whom the NHS Foundation Trust has contractual or other arrangements which are essential to the business of the NHS Foundation Trust (disclosure would, in the opinion of the directors, be seriously prejudicial to that person and contrary to the public interest)

Excepting the individuals included in the remuneration report, there are no other individuals on which the Trust is required to report.

1.1.4 An analysis using financial key performance indicators

This is addressed in section 1.1.2.

1.1.5 References to, and additional explanations of, amounts included in the NHS Foundation Trust's financial statement

This is addressed in section 1.1.2.

1.1.6 In relation to a Directors' report on consolidated accounts, these requirements apply to the activities and business of all entities included in the consolidation

As required by legislation Lancashire Care NHS Foundation Trust has included the results of its charity, Lancashire Care NHS Foundation Trust Charity and Other Related Charities, with its own accounts.

1.1.7 The main trends and factors likely to affect the future development, performance and position of the NHS Foundation Trust's business

The Trust has worked hard in the past year to develop strong relationships in line with new commissioning structures arising from the implementation of The Health and Social Care Act 2012. This will continue to be a priority and is likely to change further. This is due to NHS England, Lancashire County Council and Blackburn with Darwen Borough Council expressing an intention to withdraw as associates to the NHS Community and mental health contracts and operate under contracts of their own.

The Trust's initial experience of Any Qualified Provider (AQP) has been in relation to Musculoskeletal Services (MSK) physiotherapy services. Tier 1 MSK physiotherapy services are delivered via AQP from July 2014. Notice has been served on the Trust for this contract and Lancashire Care will no longer be a provider of tier 1 services after June 2014.

The Tier 2 MSK physiotherapy service is subject to a tendering exercise with a new contract being issued in autumn 2014. It is possible that other services will be subject to AQP; for example podiatry and the Trust intends to respond robustly to the increasingly competitive market.

NHS England published its planning guidance in December 2013, 'Everyone Counts: Planning for Patients 2014/15 - 2018/19', which describes the incentives and levers

that will be used by commissioners to demonstrate service improvement. The new guidance reiterates five key messages:

- NHS services, seven days a week
- More transparency, more choice
- Listening to patients and increasing their participation
- Better data, informed commissioning, driving improved outcomes; and
- Higher standards, safer care.

A revised strategic and operational planning process to support achievement of these ambitions is outlined. The planning process is being overhauled with the following overarching features:

- Strategic plans covering a five year period, with the first two years at operating plan level
- An outcomes focused approach, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them
- Citizen inclusion and empowerment to focus on what patients want and need
- More integration between providers and commissioners
- More integration with social care – cooperation with Local Authorities on Better Care Fund planning
- Plans to be explicit in dealing with the financial gap and risk and mitigation strategies. No change is not an option.

This places a challenge on the whole health and social care economy across Lancashire to produce coherent and cohesive plans that demonstrate a single direction of travel. The plans will be assured at CCG, Health and Wellbeing Board or Local Area Team level for those services that are directly commissioned by NHS England and will directly test the strength of local relationships which are key to ensuring delivery.

The Trust is working with Lancashire County Council, NHS England, local CCGs and district councils in response to the planned implementation of the Better Care Fund in 2015. As partners in the Lancashire Health and Wellbeing Board, they have developed a plan to address the challenges currently affecting health and social care. This includes an ageing population, widening health gaps between different communities, financial constraints and an increase in demand for health and social care.

The plan will aim to proactively identify people at risk of crisis to coordinate their care, provide them with appointments closer to their homes, enable faster recovery from a hospital admission and improve administration systems.

The Trust's engagement in this planning is critical to ensure its strengthened viability and position in the market. Engagement will have additional importance from 2015 as the Better Care Fund will be given additional allocation of £1.9 billion nationally taken directly from core CCG funding.

As in previous years, service provision in this climate, alongside the financial deflator, will be challenging for the Trust and delivery of Quality, Innovation, Productivity and Prevention (QIPP) and Commissioning for Quality and Innovation (CQUIN) targets will continue to be a focus in the coming year alongside review and implementation of the Trust's Transformation Programme.

1.1.8 Principal Risks and Uncertainties Facing the NHS Foundation Trust

The Trust has effective mechanisms in place to manage risk, including a Risk Management Strategy which details the framework for managing risk and the continued development of a risk management process throughout the Trust, this enables the Trust to maintain an assurance framework and risk registers that detail the risks that could prevent the achievement of the strategic objectives.

The Trust Board fully understands the challenges it faces in the prevailing economic backdrop across the country and the changing policy environment in which it operates. It sees the need to further develop assurance systems that adds value by eliminating duplication of effort and resources, reducing the burden of bureaucracy and strikes the right balance of assurance, governance, performance, risk and control, crucial to its success.

The Trust has performed exceedingly well during the course of the year in the management of risks, the Trust Board has updated its risk appetite statement and strengthened its assurance committees.

The principal risks the Trust managed over the year included (amongst others):

- Ineffective systems & processes to establish the registration and revalidation of clinicians
- Inability to manage demand within available inpatient and community service capacity
- Insufficient leadership capacity and capability to deliver the Trust's Business Plan
- Lack of capacity of the Nursing and Governance Directorate to facilitate the roll out of the Quality Strategy to provide support to team leaders and service mangers
- Non achievement of its cost improvement programme (CIPs) target

Future development will encompass the Trust striving to become a risk mature organisation and having effective assurance and reporting systems. This will entail linking strategy, performance, governance, risk and assurance in a comprehensive reporting module. In addition the Trust aims to improve the scope and quality of assurances by developing an assurance directory and map.

Looking ahead, several overarching risks and uncertainties have been identified as key constraints to the development of plans and activities if the Trust is to take

advantage of emerging opportunities and maintain viability in the face of existing and potential future challenges. These are:

- Accuracy, timeliness and consistency of data and reporting
- Capacity and capability to deliver transformation
- Delivery of CIPs and impact on quality and safety
- Maintaining CQC standards
- Delivery of workforce transformation plans
- Business intelligence and management information systems
- Complexity and maturity of commissioning arrangements

Economic Situation

Whilst the UK economy as a whole is showing some signs of recovery, exemplified by falling unemployment, resurgence in the construction market and a pick-up in the service sector, the pressure remains intense on the public sector to make efficiencies.

Far reaching public sector cuts have been outlined by the government including the continuing pay freeze for public sector staff. This coupled with over inflation increase in private sector pay may have severe consequences to the NHS in the recruitment and retention of staff.

Despite NHS funding being protected for the next two years, cost pressures of circa 4% per annum and increased demand on services means the Trust faces significant challenges ahead. Whilst acknowledging the scale of the issues faced the trust is confident that using its robust financial and governance structures it will be able to effectively manage the forthcoming challenges and continue to deliver high quality services with patients' needs at their heart.

Each clinical network and the Trust's corporate services are tasked with making their contribution to the overall cost improvement programme in response to the Government's drive to achieve efficiency savings of 20% over five years. Any proposals for efficiencies relating to clinical service delivery must be approved by the Medical Director and Director of Nursing to ensure that quality standards are maintained. The on-going implementation of the Quality Strategy also serves to ensure that high standards of quality are sustained.

Quality of Services and Value for Money

As with many other NHS organisations, the Trust believes in an organisational quality improvement approach to healthcare and has introduced several programmes to help improve the quality of services delivered.

The Engaging for Excellence strategy focuses on transformational change, aiming to deliver high quality services and upper quartile performance within the financial resources available.

The Quality SEEL (Safety, Effectiveness, Experience, Leadership) is a tool that has been developed with the Networks to support teams in carrying out a self-

assessment against the CQC Essential Standards of Quality and Safety and internal standards. The assessments and validation meetings will act as enablers of an organisational wide picture of quality at team level. Further information on this can be found below and on page 41.

To inform the Trust's focus on quality and appraisal of the national quality reports published in 2013 was undertaken:

- Mid Staffordshire NHS Foundation Trust Public Inquiry
- Keogh Review
- Berwick Report

Common themes have been identified from the recommendations made and are reflected in the table. The themes have been used to develop expected outcomes within the Trust's Quality Strategy, which is supporting the Trust to continually improve and deliver high quality care. The expected outcomes are detailed in the Quality Account.

Francis – themes	Keogh – vision	Berwick - actions
Putting patients first & having common values	Demonstrable progress to reducing avoidable deaths in hospitals	Listen to & involve patients & carers
The importance of fundamental standards	Boards & leadership teams use data & other intelligence confidently a& competently to inform quality improvement	Constantly monitor the quality & safety of care
Non-tolerance of non-compliance	Listen to patient and carer feedback & act upon it	Respond directly, openly, faithfully & rapidly to early warning indicators eg. complaints
Openness, transparency and candour	Patients & clinicians are actively involved in CQC inspections	Embrace complete transparency
Compassionate, caring & committed staff	Organisations will not be isolated	Train & support all staff all the time
Patient centred leadership	Staffing levels & skill mix reflect patient needs	Create networks & learn from each other
Accurate, useful & relevant information	Junior doctors & student clinicians will be listened to	Use evidence based tools to ensure adequate staffing levels
	Happy & engaged staff positively affect patient outcomes	

The Trust has worked hard to embed a culture of openness and learning. During 2013/14 independent investigations were commissioned by NHS England in relation to two homicides. The Trust has agreed and implemented actions plans to address the recommendations and these have been published on the Trust's website.

The Appreciative Leadership programme is now in its fourth year. The programme aims to develop and empower managers so enabling them to take the lead in delivering the organisational transformation required in a manner that further embeds the values and builds a positive culture.

Financial pressures continue to challenge the Trust, therefore the need to obtain value for money from all of our expenditure remains. As such a continuous improvement philosophy continues to be embedded across the organisation which strives to deliver higher quality services at reduced cost. The in-house procurement function fully focused on helping the organisation maximise its procurement opportunities.

All clinical networks have undertaken an audit in relation to value for money and this will inform the development of a Trust wide strategy.

In short quality of service delivery and value for money are top priorities for the Trust. These priorities are also nationally recognised through the legislative requirement for trusts to prepare an annual Quality Account to sit alongside the Annual Report and Financial Accounts.

Ability to Manage Change

As discussed the Trust believes it has the right strategy in place to identify change initiating factors. Once identified, plans are formulated to manage the impact. Pragmatic in approach, they recognise the impact of the change as far as it can be, making assumptions on the levels of resource required to ensure successful change management. This approach is considered best to safeguard as much as possible against the unexpected.

With change in the NHS a regular occurrence, the Trust has had much experience in managing changes, both locally and nationally driven, and is confident in its own ability to respond to any future changes that may arise.

The Trust has sought to reposition itself to take advantage of emerging opportunities and maintain its viability in the face of major structural and policy change.

Following Transforming Community Services (TCS) in 2011/12 the Trust has continued embedding community services into the organisation. Internal management restructures have been put in place that support a strategy for building on success, further embedding changes already made, and creating efficiencies wherever possible through a programme that embraces change rather than merely coping with it.

A Programme Management Office (PMO) has been established to support transformation and change at network and organisational level. The PMO will establish standards, tools and processes to implement and embed transformation to meet the Trust's strategic goals and quality standards. The PMO is in the process of being re-launched with clear rules and talented people to lead, monitor and support

the largest change programs. These include the long term conditions programme in Central Lancashire and Blackburn with Darwen, the re-design of community services in the adult mental health network and the transformation of mental health inpatient services and related transitional arrangements. The Trust's transformation agenda also incorporates innovation, research activity and public health.

Ability to anticipate impact of environmental factors

The Trust recognises that for it to be able to continue to operate successfully in its environment it needs to be able to anticipate, rationalise and deal with changes that affect it.

In developing robust strategic plans the aim is to identify those internal and external factors that may impact on performance and develop plans to manage those factors, when necessary, to better position the Trust, so minimising any negative impact and maximising any opportunity.

Constant horizon scanning maintains a high state of alertness giving confidence that any potential impacts are picked up as early as possible, so allowing the maximum time possible to consider the potential impact and formulate a response to them.

This year has seen a major reconfiguration of the NHS with the dissolution of PCTs and the establishment of a range of new bodies including CCGs, NHS England, CSUs. This has had a significant impact on how the Trust operates now and in the future. Resource has been invested into relationship building with these new bodies to ensure the smooth continuation of frontline services.

In anticipation of the launch of the Better Care Fund in 2015/16 the Trust is working with its partners to plan for a major shifting of resources from the acute sector into social care. In Lancashire the allocations for the Better Care Fund amounts to £89million. The Trust is also a part of the Healthier Lancashire forum which comprises transformational and enabling projects, more information can be found on page 50.

Financial pressures exerted by government mean that creativity and innovation is strongly supported with the aim of generating efficiencies. This extends to looking at how the Trust operates with other local agencies with the aim of garnering efficiencies from joint working opportunities.

In summary the Trust remains alert to identifying changes and their potential impacts, whilst ensuring the flexibility to implement the best solutions. All of this is underpinned with maintaining a strong financial position that allows effective response.

Impact of recent inquiries

Recent independent reports into care in the NHS have highlighted that in many cases the current system has lost sight of the primacy of working with patients and carers to achieve health care goals, instead focusing on cost cutting, target achievement and processes.

Lancashire Care takes to its heart the underlying principle from these reports that people and healthcare must always take precedence to numbers. Targets, statistics and plans are only tools to support the primary purpose of healthcare provision. It remains committed to a patient focused management working to engender an organisational culture that supports the delivery of the very highest quality services.

1.1.9 Trust Strategy

The Trust has an established strategic planning framework and the Operational Plan for 2014-16 continues to be driven by the following vision, values and strategic priorities:

Vision *21st century healthcare with wellbeing at its heart*

Values *Compassion, Accountability, Respect, Excellence, Integrity and Teamwork*

Vision Strategic Priorities

- To provide high quality services
- To provide high quality accessible services delivering commissioned outputs and outcomes
- To become recognised for excellence
- To employ the best people
- To provide excellent value for money in a financially sustainable way
- To innovate and exploit technology to transform care

The delivery of the Operational Plan is governed through an accountability framework and a Board balance scorecard has been developed to provide oversight of the delivery of the plan.

The Board is taking the opportunity to review and refresh its strategic planning framework as part of the development of the Strategic Plan for 2014-19, that will be submitted to Monitor by 30 June 2014, which includes a self-assessment of the quality of its strategic planning

The Trust is taking a structured, evidence-based approach to its strategy development. Key steps in its strategy development process include:

Market Analysis

The Trust recently refreshed its market analysis in order to inform its current strategy review. The scope of this analysis includes both demand and supply-side drivers. On the market side, the Trust defined a market segmentation based on patient and service user needs, and assessed current market size and expected future growth in each segment. This required consideration of demographic and patient need drivers (to understand current and future levels of need), as well as local and national commissioning intentions (to understand the extent to which funding is expected to be available to meet current and future levels of need).

On the supply side, the Trust defined its set of local and regional competitors and assessed the level of competition in each market segment in which it operates. In analysing its competitive set, the Trust also sought to understand the market position and likely future strategies of existing competitors, and the likelihood of new market entrants.

Strategic Intent

The Trust has a defined vision, mission and set of core values and these will remain constant through the next strategic planning cycle. The Board is seeking to increasingly clearly articulate its ambition and strategic intent for the Trust by considering different future potential scales of operation (i.e. what it would take to achieve different levels of future turnover) and clarifying its view on likely trade-offs between future costs, quality levels and Trust portfolio.

Competitive Position

The Board is completing a process of reviewing the market segments in which it wishes the Trust to operate, and the strategies that will enable it to operate successfully in each market segment. A range of hypotheses are being defined that will be evidenced or supported by documented assumptions regarding likely future financial and non-financial performance of different services and the future commercial attractiveness of different market segments.

Strategic Options and Implementation

The Board will go through a structured process to define and prioritise its main strategic options, with a view to identifying the small number of key investment and divestment initiatives that it wishes to pursue over the next 3-5 years. The implications for the Trust's business model will be detailed and required changes will be translated into delivery plans to be owned and delivered within the Trust's clinical and corporate networks.

1.1.10 Environmental matters (including the impact of the NHS Foundation Trust's business on the environment)

Sustainability

The Trust recognises that sustainability goes far beyond just obeying legislation and preventing pollution and strongly believes that sustainable practices are a fundamental corporate responsibility.

To deliver an effective and efficient healthcare service, whilst delivering on the sustainability agenda, the Trust employs a full-time Environmental Manager and has an Environmental Policy and a Sustainable Development Management Plan (SDMP) in place. The SDMP sets out the Trust's commitments and proposed actions to achieve the NHS wide target to reduce carbon emissions by 10% by 2015. Some of the main actions being taken to achieve this goal are summarised below.

Carbon and Energy

The Trust is taking the following approach to carbon and energy; aiming to use less energy, supplying the required energy as efficiently as possible and supplying energy using low carbon and renewable sources.

The first step in good energy management is to closely monitor energy consumption and to breakdown the overall carbon target by setting building specific targets. Automatic utility metering is being rolled out across the estate and will provide half hourly gas, electricity and water consumption data for our buildings. Automatic meter reading (AMR) enables rigorous scrutiny of consumption patterns to identify and address inefficiencies whilst also enabling greater financial control of energy budgets by eliminating estimated reads.

The Trust's automated meter reading is supported by a dedicated energy monitoring and targeting (M&T) software package which allows the Trust to assess building specific energy performance and comparisons to be made with similar buildings and nationally recognised benchmarks on a year by year basis corrected for variances in weather. The information provided by the AMR and M&T systems allows the Property Services team to generate energy performance league tables and prioritise the investigation and elimination of energy waste.

Over the last 12 months Property Services have identified a number of financially and environmentally viable energy efficiency schemes including the installation of solar photovoltaic panels at Sceptre Point and Guild Park, the installation of a water supply borehole at Guild Park, the use of voltage optimisation, and the improvement of boiler plant controls.

Ensuring the environmental sustainability of refurbishment projects is a key aim of Lancashire Care as facilities are re-developed to deliver modern health care services. The Property Services Department have developed a Sustainable Building Design Guide for use on new build and refurbishment projects to ensure the estate is developed in the most environmentally efficient and sustainable manner as possible.

The Trust's commitment to using low carbon technologies is reflected in the specification and installation of a biomass-fuelled boiler plant at the The Harbour which is the Trust's new inpatient development at Blackpool. The biomass boiler system will reduce carbon emissions by 97% compared to a similar sized gas fired boiler plant. The North West is well served by local suppliers of wood chip and this building will take advantage of this low carbon fuel. The Harbour will also continue to follow the high standards set by the Building Research Establishment Environmental Assessment Method (BREEAM) to deliver a sustainable and low carbon building with a long future lifespan.

Water

The Trust actively works towards minimising water consumption and cost, and this is reflected in the upgrade of water using systems with water efficient technology across the estate when the opportunity arises, such as the installation of low flush WCs, reduced flow showers and sensors on taps to detect when they are not in use.

Rainwater is also collected and used within the building to offset the mains water consumed by the building.

A borehole at Guild Park will reduce water costs for the site and also help reduce the demand on the local water supply network. Over the last 12 months Property Services have investigated the use of waste food digesters in kitchens to eliminate food waste entering the waste water network. This technology creates financial and environmental benefits by removing the need to operate electrically driven macerators and the associated maintenance costs of repair and cleaning of macerators and the local drainage system of blockages created by waste food.

Waste

In order to ensure the best use of resources and compliance with environmental legislation, the Trust has a Waste Management Policy to minimise waste as well as maximise recovery, reuse and recycling rates.

Environmental Champions continue to support the improvement of recycling rates. The Trust has 17 different waste streams, and is recycling a varied range of items including general waste, batteries and oil from our kitchens to produce biofuel, which continues to be used in a number of Trust vehicles. Property Services work in partnership with client departments to review working procedures to ensure the latest legislation is reflected in the policy, and that correct segregation is employed in accordance with the regulations.

The monitoring of waste contracts and generation of revenue through recycling continues to reduce costs, as well as the Trust's environmental impact. A waste transfer station has been created at Guild Park which has further reduced the cost of waste disposal by helping increase recycling rates.

Summary of Performance	
Energy	
Total energy cost	£1,715,880
Electricity consumption	10,005,804 kWh
Gas consumption	18,362,748 kWh
Water	
Water consumption	37,981 m3
Water and sewage cost	£259,520

Grow Your Own

The Trust's Grow Your Own project was launched on 28 March 2013 to mark NHS Sustainability Day. This project is a partnership between volunteer staff from Property

Services and Secure Services at Guild Park and will provide staff and service users the opportunity to grow organic, fresh and local vegetables, whilst reducing carbon emissions associated with food miles. The Kitchen Garden section of the GYO project enables organic seasonal produce to be grown to supply the kitchens at Guild Park, reducing financial and environmental costs whilst helping deliver a variety of fresh crops for inpatient catering.

Since opening, the GYO project has proved innovative and successful, generating interest and input from staff, service users, volunteers and community groups. Recognised for the way the project delivers health and wellbeing benefits as well as environmental benefits, the Grow Your Own scheme has won a number of prestigious environmental awards including the NHS Sustainability's Best Community Engagement Initiative in April 2013 and the NHS Forest's Most Innovative Project award at the Clean Med Conference in Oxford in September 2013.

The Trust's Common Ground Project based at Guild Park in Goosnargh, received two awards at the national NHS Sustainability Awards 2014.

The project received the Sustainable Food Award which acknowledged their use of using locally sourced, seasonal produce on the menus at the hospital. They also won the Overall Project Award for incorporating a variety of elements including community involvement, encouraging behaviour change and carbon management amongst others.

Service user involvement into the project is key with outdoor activities supporting increased confidence and recovery. Following the success of the project at Guild Park, several sites therapeutic outdoor spaces for service users have now been established across the Trust. Work is also undertaken with local schools and community groups to educate them on the importance of sustainability.

The scheme grows from strength to strength, proving popular with LCFT service users and clinicians for the health and wellbeing benefits that the scheme delivers, and the GYO scheme's Project Manager has gained national recognition for her leadership in this field and is regularly asked to speak at events or is approached for advice and guidance.

Environmental Steering Group

In November 2013 the Property Services Director established the Environmental Steering Group to help improve the physical environment for service users, staff and visitors alike and making the Trust's estate a vibrant and pleasant place to be. The composition of the Environmental Steering Group includes staff from Property Services, Networks and service users. The remit of the group is diverse and includes the review of the internal and external environment, artwork, food quality, and environmental resource efficiency.

1.1.11 The NHS Foundation Trust's employees

During 2013/14, the Trust continued to embed its core values:

- Teamwork
- Compassion
- Integrity
- Respect
- Excellence
- Accountability

The Staff Awards categories are aligned to the values, so rewarding employees demonstrating these standards.

In addition, the induction programme includes discussion of the meaning of each of the values and there is a commitment to embedding them into the heart of the Trust's culture.

The move towards autonomous business units for Networks has continued during 2013/2014. While this has continued to be a period of change and reorganisation, the Trust remains committed to its principle of redeploying staff whenever possible.

Redeployment guidelines have been developed in partnership with Trade Union colleagues to clarify manager, individual and Trade Union responsibilities with the aim of keeping redundancies to an absolute minimum. In addition a comprehensive Organisational Change Policy has been produced supported by scripts, standard documents and management coaching.

This proactive approach has allowed the Trust to minimise compulsory redundancies to just 19 people in 2013/14 despite continuing change programs. Valuable skills have been retained and disruption to services have been kept to a minimum as a result.

The Appreciative Leadership management development program has continued as planned during 2013/14 with 222 people completing the training. This is further supported by a program for Aspiring Leaders which was introduced in 2013/14 and has already been completed by 40 people.

During 2013/14 the Trust has once again benefitted from an excellent working relationship with Trade Union colleagues. This has been particularly evident during periods of reorganisation, when the Trade Unions have been most supportive with communication to affected employees, and in assisting with the redeployment process. The continued positive relationship established over several years has provided the basis for ensuring that organisational change is undertaken in a supportive, fair and positive way that meets the needs of staff and service users.

Annual Staff Survey

The national NHS Staff Survey took place during October to December 2013 to

collect the views of staff about their workplace. The overall aim is to gather information to help provide better care for patients and improve the working lives of employees. The survey results are used by:

- The Trust to inform improvements in working conditions and practices
- The Department of Health to assess organisations' performance in terms of the NHS Constitution's staff pledges
- The Department of Health and other national bodies to assess the effectiveness of national NHS staff policies, such as training and flexible working policies, to inform future developments in these areas.

The Care Quality Commission benchmarked the survey based upon key findings which are grouped according to the NHS Constitution's four staff pledges:

1. To provide all staff with clear roles, responsibilities and rewarding jobs.
2. To provide all staff with personal development, access to appropriate education and training for their jobs and line management support to enable them to fulfil their potential.
3. To provide support and opportunities for staff to maintain their health, wellbeing and safety.
4. To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

Staff survey response rates against national average and comparison against 2012/13 rates

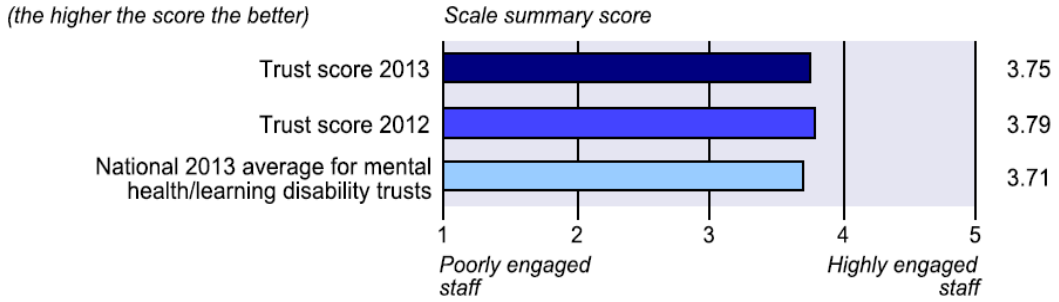
	2012/13		2013/14		
Response Rate	Trust	National Average	Trust	National Average	Trust improvement/deterioration
	48%	50%	41%	49%	8% lower than the national average and 7% lower than last year's response rate

The response rate for the Trust has decreased since last year and remains below the national average. The survey is a means of engaging with staff and improve how employees are supported in their work. Participation is actively encouraged by publicity the launch, and by taking steps for meaningful follow up on areas indicating a need for improvement in this survey.

Staff Engagement

The latest survey results published in February 2014, showed our overall staff engagement score of 3.75. Although this is slightly lower than last years' score of 3.79, it remains above the national average score for Mental Health/Learning Disability Trusts 2013, of 3.71. Within the staff engagement indicator, Lancashire Care Trust scores in the best 20% for staff ability to contribute towards improvements at work and staff motivation at work.

Overall Staff Engagement



The overall indicator of staff engagement has been calculated using the questions that make up key findings 22, 24 and 25 which relate to the following aspects of staff engagement:

- Perceived ability to contribute to improvements at work (Key Finding 22)
- Willingness to recommend the Trust as a place to work or receive treatment (Key Finding 24)
- The extent to which staff feel motivated at work (Key Finding 25)

Top and bottom Ranking Scores

Out of the 28 key findings, the Trust is in the top 20% nationally for 10 indicators and better than average for a further six. The top and bottom ranking scores are detailed in the tables below. In terms of the top ranking scores the Trust was in the top 20% for two out of the three key findings. In the bottom ranking scores, the Trust was below the national average in all indicators; percentage of staff suffering work-related stress in the last 12 months, percentage of staff reporting good communication between senior management and staff, percentage of staff receiving job-relevant training, learning or development in the last 12 months, work pressure felt by staff and percentage of staff appraised in the last 12 months.

	2012		2013		
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
% staff experiencing physical violence from staff in last 12 months	3%	4%	1%	4%	3% better than the national average and 2% better than 2012
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	25%	30%	24%	30%	6% better than the national average and 1% better than 2011
% of staff experiencing physical violence from patients, relatives or the public in the last 12 months	14%	20%	11%	19%	8% better than the national average and 3% better than 2012
% of staff witnessing potentially harmful errors, near misses or incidents in the last month	20%	27%	21%	26%	5% better than the national average and 1% worse than 2012

	2012		2013		
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
% of staff suffering work-related stress in last 12 months	41%	41%	48%	43%	5% higher than the national average and a 7% increase since 2012
% of staff reporting good communication between senior management and staff	38%	30%	27%	31%	4% lower than the national average and 11% lower than 2012
Percentage of staff receiving job-relevant training, learning or development in last 12 months	84%	82%	80%	82%	2% lower than the national average and 4% lower than 2012
Work pressure felt by staff	3.00	3.02	3.09	3.07	0.02 higher than the national average and 0.09 higher than 2012

A series of focus groups will be undertaken to discuss the findings of the top and bottom ranking scores to support the development of action plans. This will serve to generate ideas for change improvement and address local issues, concentrating specifically on workplace stress, workload and extra hours. Proposed actions in response to the survey results include:

- Increasing resources for mindfulness and resilience training
- Using return to work interviews after episodes of sickness absence to gain insight into underlying absence
- Introducing the 'Drop It' initiative to enable staff to assess the tasks that they do and give up the ones that don't add any value to increase productivity and efficiency
- Feeding back to staff about changes that have been made in response to their comments in the format of 'you said, we did.'

Ideas for improvement have been shared with the Trust's Senior Management Team and inspiration is also being taken from successful companies in the private sector.

1.1.12 Social, community and human rights issues

To ensure compliance with the Equality Act (2010), the Trust has adopted the Department of Health's Equality Delivery System (EDS). The EDS has four distinct Goals which are:

- Better health outcomes for all
- Improved patient access and experience
- Empowered engaged and well supported staff
- Inclusive leadership at all levels

The Equality Act sets out 'protected characteristics' which are; age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion

and belief, sex and sexual orientation. The Trust is committed to demonstrate that it provides equitable services and employment. The Trust acknowledges that the distinct Protected Characteristics are interdependent due to each individual's diversity.

The Trust's commitment to EDS is ensuring the involvement of key stakeholders in scrutiny events called Opportunity Knocks. These events take place twice a year and are held in partnership with external organisations, such as Lancashire Police, Lancashire County Council and third sector bodies which share the Trust's geographical footprint and serve the same community. The events are a great success with over 120 service users, staff, community members and partner agencies coming together to scrutinise the Trust's equality and diversity evidence. In 2013 the scrutiny of EDS Goals three and four showed an improvement in four of the nine areas with three rated 'excellent', five 'achieving' and only one 'developing'.

As a statutory sector organisation, the Trust is committed to eliminating unlawful discrimination and harassment and promoting equality of opportunity for all. This determination ensures equality runs through employment, service delivery and community engagement. Taking this into account will mean more targeted and effective use of resources, which makes sound business sense and leads to improved customer satisfaction.

The Trust's current activity in relation to Equality and Diversity is fully informed by service users and their carers, staff, local community members and partner agencies. This activity includes all services providing evidence of good practice for EDS, setting of equality targets and supporting operational action plans leading to demonstrable health outcomes for people from diverse groups. The Trust also carries out Equality Impact Assessments to ensure that everything that the Trust does is inclusive, the results of which are published on the Trust's website. New and reviewed policies, procedures and functions are not ratified without an accompanying Equality Impact Assessment.

The Trust is committed to supporting diversity and is taking a partnership approach to engagement with service users and carers, staff and communities from a variety of diverse backgrounds and communities across Lancashire. This in-depth work is helping the Trust to inform activity, identify gaps and carry out innovative projects and initiatives to reduce any potential or real identified inequities, and help to ensure all the Trust's services meet the diverse health needs of the population of Lancashire.

An example of this is the establishment of a person-centred empowerment group called 'Experts by Experience'. This group is made up of people who are living with dementia and their carers who have had recent experience of using the Trust's older peoples' mental health services. They work as a resource for the services they have previously used by influencing the planning, delivery and evaluation of services. This might include training and challenging negative stereotypes, 'mystery shopper' type audits, working in collaboration with teams and partnership agencies on specific projects e.g. MAS satisfaction questionnaire, Inpatient information booklet and involvement in recruitment and selection of staff.

The Trust has an Equality Strategy, which is called 'Transformation and Equality; A Statement of Intent'. This clearly lays out how the Trust is working strategically to ensure equality and diversity is embedded in all that it does. To support this, the Trust also has a sustainable structure to support the statement and to ensure the EDS is delivered effectively. Equality and Diversity and the delivery of EDS are built into Network business plans which ensure evidence comes forward for scrutiny twice annually.

Moving into 2014/15 there is a need to continuously refresh Equality and Diversity strategies with specific focus on improving workforce representation in relation to protected characteristics, encouraging commitment to the Personal, Fair, Diverse campaign and promoting inclusion through sharing stories.

The Trust is currently one of 20 that were accepted as Equality and Diversity Partners for 2013/14 which is a National Strategic support network for Trusts.

Workforce

Lancashire Care's headcount (HC) at the 31 March 2014 was 6,650 and whole time equivalents (WTE) were 6,418 (including bank and agency WTE). Over the past 12 months there has been a slight decrease in the number of substantive posts of the Trust. This is in line with service redesign programmes and improved productivity.

In terms of equality and diversity characteristics, the proportion of staff from Black or Minority Ethnic (BME) groups continues to slowly increase year on year with over 7% recorded as BME. This compares with 9.6% of the total population of Lancashire being BME (Lancashire census 2011) and a BME working age population of 5.3%. Compared with the working age population the Trust has a favourable representation of staff from a BME background but further analysis indicates that employees from an ethnic minority tend to occupy lower band roles or medical roles. The HR team will continue to work closely with the Equality and Diversity Lead to ensure that opportunities are equitable for all staff across the Trust.

Over recent years Lancashire Care has seen a gradual ageing of its workforce but with a slight increase in the number of employees aged between 17 and 21. The Trust has signed up to an Apprenticeship Promise to give young people the opportunity to participate in the Trust's Apprenticeship Scheme or volunteering and then gaining substantive employment. The age profile of the workforce must be carefully monitored to ensure career opportunities are provided for young people and that services are safeguarded against the increasing impact of retirements.

The Trust's proactive commitment to the Equality Delivery System continues to promote activity to redress the gender imbalance and attract more men into roles within the Trust. This remains a challenge due to limited external recruitment but the situation is improving and this year, the proportion of men working at LCFT has increased by a further 1%.

Disability is one of the most difficult equality areas to analyse as many people with a disability, as defined under the Equality Act 2010, do not regard themselves as having a disability, for example those who are deaf or those with blood borne viruses. Just over 4% of the workforce is recorded as having a disability which is a slight increase. The Trust will continue to endeavour to improve data on disability through awareness sessions with teams and communication across the Trust.

The diversity of religions amongst the workforce demonstrates that the Trust is attracting staff across all cultural and religious groups. This can only support the Trust in becoming more culturally sensitive to the needs of all service users regardless of their cultural or religious background. As with disability the Trust must continue to raise awareness of the importance of collecting diversity data to help improve services.

Data regarding sexual orientation is also limited by just under a third of staff who do not wish to disclose this information and the number of undefined records. Again the Trust will continue to improve the quality of sexual orientation data through awareness training across the Trust which may lead to greater understanding of the importance of collecting and analysing the data.

In spite of these difficulties, for the first time this year, there has been a reduction in the percentage of people who choose not to disclose information about their sexual orientation, disabilities and religion. The implementation of Self Service functionality means that employees are now able to input this data directly into their employee record themselves and it is a really positive sign that employees are beginning to feel more comfortable providing this information.

Following a review of the governance arrangements a Workforce Committee has been established as a formal sub-committee of the Executive Management Team. It will provide assurance in respect of workforce, organisational development and education strategies, all of which aim to develop a workforce (competencies, structure and numbers) that is motivated and capable of providing excellent, compassionate and safe care for every patient, every day.

Human rights is covered as part of the Trust's mandatory training programme. The Trust uses an Equality Delivery System to scrutinise outcomes in relation to equality, diversity and inclusion and this system has been designed with the FREDA (fairness, respect, equality, dignity and autonomy) principles compliance which ensure compliance with The Human Rights Act.

There is no specific reference to the Human Rights Act in the current Equality Statement of intent but this will be reviewed during 2014/15 and explicit reference will be made.

Membership

The Public Membership total at 31 March 2014 was 7610 members across the seven public constituencies of Lancashire Care. There has been a small increase in the number of new public members joining the Trust due to the continued focus on

positive engagement with members for example through membership engagement events.

The enhancement of the membership system allows the evaluation of membership data more accurately to reflect the demographics of public members. The analysis of Public Membership overleaf gives an overview of the current public membership population. The Trust is striving to ensure its public membership base continues to evolve and become more representative of the population within Lancashire which is served by Trust services.

Data about disability, religion/belief and sexual orientation has not been captured historically but since the Equality Act (2010) specific duties came into force in April 2011 the Trust is now required to demonstrate data quality improvements for all equality groups across the workforce and amongst service users.

The implementation of the Trust's membership engagement model is increasing dialogue with members and provides opportunities for them to be meaningfully involved in the development of the Trust's future plans. Affiliate membership formalises relationships with partner organisations and this will help the Trust to realise the potential and benefits of working with like-minded organisations to support the health and wellbeing of the people of Lancashire.

Analysis of Staff and Membership

Age	Staff 2012/13	%	Staff 2013/14	%	Membership 2012/13	%	Membership 2013/14	%
0 – 16	0	0	0	0	5	0.06	4	0.05
17 – 21	20	0.43	21	0.32	451	5.95	338	4.44
22+	6703	99.57	6627	99.68	6581	87.03	6740	88.56
Not provided	0	0	0	0	524	6.92	528	6.93
Total	6723	100	6648	100	7561	100	7610	100

Ethnicity	Staff 2012/13	%	Staff 2013/14	%	Membership 2012/13	%	Membership 2013/14	%
White	5976	88.64	5895	88.67	6611	87.44	6504	85.46
Mixed	41	0.62	47	0.70	38	0.50	108	1.41
Asian or Asian British	312	5.01	321	4.83	413	5.46	413	5.42
Black or Black British	92	1.55	95	1.43	94	1.24	83	1.09
Chinese	5	0.09	5	0.08	7	0.09	7	0.09
Other	16	0.22	2	0.03	25	0.33	117	1.53
Undefined	2	0.04	24	0.36	350	4.63	354	4.65
Not specified	279	3.83	259	3.90	23	0.31	24	0.31
Total	6723	100	6648	100	7561	100	7610	100

Gender	Staff 2012/13	%	Staff 2013/14	%	Membership 2012/13	%	Membership 2013/14	%
Male	1267	18.95	1319	19.84	2667	35.27	2683	35.25
Female	5456	81.05	5329	80.16	4790	63.35	4828	63.44
Not specified	0	0	0	0	104	1.38	99	1.30
Total	6723	100	6648	100	7561	100	7610	100

Recorded Disability	Staff 2012/13	%	Staff 2013/14	%	Membership 2011/12	%	Membership 2012/13	%
Yes	280	3.99	269	4.05				
No/ undefined	6344	94.21	6280	94.46				
Not declared	99	1.80	99	1.49				
Total	6723	100	6648	100				

Religion and Belief	Staff 2012/13	%	Staff 2013/14	%	Membership 2011/12	%	Membership 2012/13	%
Atheism	430	7.44	468	7.04				
Buddhism	23	0.33	26	0.39				
Christianity	3204	50.41	3232	48.61				
Hinduism	59	0.98	57	0.86				
Islam	170	2.95	179	2.69				
Jainism	1	0.01	1	0.02				
Judaism	3	0.05	6	0.09				
Sikhism	14	0.23	15	0.23				
I do not wish to disclose	2484	32.26	2331	35.06				
Other	332	5.30	320	4.81				
Undefined	3	0.04	13	0.2				
Total	6723	100	6648	100				

Sexual Orientation	Staff 2012/13	%	Staff 2013/14	%	Membership 2011/12	%	Membership 2012/13	%
Lesbian	29	0.46	26	0.39				
Gay	38	0.65	39	0.59				
Bisexual	14	0.22	17	0.26				
Heterosexual	4305	68.67	4377	65.83				
I do not wish to disclose	2286	29.44	2137	32.15				
Undefined	51	0.56	52	0.78				
Total	6723	100	6648	100				

1.1.13 Sickness Absence Figures

As per 2013/14 Treasury Financial Reporting Manual (FReM) guidance, the Trust is now required to report staff sickness data. Data for the Trust can be found on the table overleaf. This data has not been generated locally, it has been nationally generated by Health and Social Care Information Centre (HSCIC) – Sickness Absence Workforce Publications – based on data from the Employment Services Record (ESR) Data Warehouse. The figures are based on a calendar year from January – December 2013.

The ESR system does not hold details of the number of days worked by each employee (data on days lost and days available produced in reports are based on 365-day year). The number of full-time equivalent (FTE) days available has been

estimated by multiplying the average FTE for 2013 (from March 2014) by 225. The number of FTE days lost to sickness absence has been estimated by multiplying the estimated FTE days available by the average sickness absence rate. The average number of sick days per FTE has been estimated by dividing the estimated number of FTE days sick by the average FTE. Sickness absence rate is calculated by dividing the sum total sickness absence days (including non-working days) by the sum total days available per month for each member of staff.

		Statistics Produced by HSCIC from ESR Data Warehouse		Figures converted by DH to Best Estimate of Required Data items		
		Quarterly Sickness Rate	Monthly Workforce Publication			
Name	OCS Code	Average 12 Months (2013 Calendar Year)	Average FTE (2013)	FTE days available	FTE days lost to sickness absence	Average sick day per FTE
Lancashire Care NHS Foundation Trust	RW5	5.3%	5,889	1,325,115	69,907	11.9

1.1.14 Trust Business Model

A breakdown of the number of male and female employees at 31 March 2014 is detailed in the table below.

Group	Male	Female
Executive Directors (including the Chief Executive)	3	3
Non-Executive Directors (including the Chair)	4	3
Other Senior Managers	68	195
Employees	1207	5164

1.2 Going concern

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

2. Directors' Report

The Directors' Report has been prepared under direction issued by Monitor, the independent regulator for Foundation Trusts, as required by Schedule 7 paragraph 26 of the NHS Act 2006 and in accordance with:

- Sections 415, 416[5] and 418 of the Companies Act 2006 (section 415(4) and (5) and section 418(5) and (6) do not apply to NHS Foundation Trusts);
- Regulation 10 and Schedule 7 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 ("the Regulations");
- Additional disclosures required by the FReM; and
- The NHS Foundation Trust Annual Reporting manual 2013/14 (FT ARM).

Further details of the areas included in this statement can be found on the Trust's website: www.lancashirecare.nhs.uk

2.1 Patient Care

2.1.1 Descriptions of how the NHS Foundation Trust is using its Foundation Trust status to develop its services and improve patient care

The Trust's Joint Venture Partnership with Ryhurst, Red Rose Corporate Services (RRCS) has continued to support the Trust with its capital developments, property services, facilities management, space utilisation and changes to Trust accommodation. Key projects underway are the development of new mental health inpatient facilities; The Harbour in Blackpool, The Orchard in Lancaster and a rehabilitation unit, Moss View in Heysham.

In March 2014 arrangements were put in place to put RRCS on a more formal contractual basis in terms of its relationship with the Trust. This will support the venture to have a stronger commercial focus and provide a greater degree of independence that is supportive of the pursuit of creativity and innovation.

In the future, RRCS will be supporting the Trust in its plans to develop mental health inpatient facilities in East and Central Lancashire. It will also support the progression of plans to improve mental health inpatient services for children and young people, further to on-going dialogue with commissioners. RRCS will continue to support the Trust to achieve optimal space utilisation in its facilities and the improvement of accommodation used to deliver community services. RRCS uses its experience and shares good practice with other Trusts to develop their own JV solutions in line with their emerging needs.

Within the Trust's clinical networks the following initiatives are underway, taking advantage of the opportunity that Foundation Trusts have to income generate. The Contraceptive and Sexual Health Service has developed a workshop to provide knowledge and understanding about the changing face of sex and relationships in relation to social networking and other digital media. This workshop is available to

anyone that has a remit to support sexual health in their client group. Specialist services have developed a sex offender treatment programme. The intention is to provide the treatment programme and also offer training to other clinicians.

The range and breadth of services provided in the adult community network provides the opportunity for clinicians and wider health professionals to share their expertise through the provision of training to other providers as a means of income generation.

The ADEPT team within the Trust's substance misuse service also provides commissioned training places and bespoke, individually tailored training in relation to drugs and alcohol to any agency that wishes to procure it.

Similarly, the Early Intervention Service within the Children and Families Network have developed training packages that enable the sharing of knowledge and are income generating or have the potential to be. Training in routinely making enquiries into childhood adversity has been designed to inform the potential impact of experiencing adversity in childhood on health and wellbeing in later life and to develop the skills and confidence in enquiring routinely. Training has been successfully delivered to health visitors/school nurses, family intervention practitioners and substance misuse workers and has the potential to be offered wider to a variety of sectors. The intention is to now develop a business model to income generate from offering the training as a leader in the field.

The service has also developed and evaluated training in psychosocial interventions. After receiving the training staff feel more confident and competent in delivering psychosocially informed care to service users and carers. The training has been bought by several Trusts from across the country.

Governors and members continued to be engaged in relation to the Trust priority areas. Engagement panels and conferences are used as a means of getting their feedback to inform future service developments. During 13/14 engagement themes included wellbeing and long term conditions. Public health will be the focus of future engagement activities, aligned to the Trust's strategy.

2.1.2 Performance against key patient targets

The Trust has continued to perform well against the Monitor Compliance Framework throughout 2013/14. For Q3 however, the Trust initially reported breaches of two of the key indicators - Delayed Transfers of Care, and CPA 12 Month reviews. The latter was subsequently identified as a data quality rather than a service quality issue and following validation the Trust was confirmed as compliant with the target. The Delayed Transfer of Care (DTOC) figures highlighted some issues to be addressed in ensuring that discharges are managed as efficiently as possible. Discharges frequently involve multiple agencies, can be very complex and the Trust is taking strong action to address performance. A number of workstreams have been initiated, centred on better coordination of agencies, and better recording of data. It is anticipated that performance on this metric will improve in Q1 2014/15. All other Monitor service targets were achieved in year.

The failure of the DTOC metric has also resulted in the Trust re-examining how it goes about monitoring performance, and an improvement plan has been implemented to ensure compliance in the future.

2.1.3 Arrangements for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets, incorporating Care Quality Commission assessments and reviews and the NHS Foundation Trust's response to any recommendations made

The implementation of the Quality Strategy continues with a specific focus on; electronic reporting, refinement of the Quality SEEL (QSEEL) functionality, improvements to the self-assessment tool, enhanced governance processes in relation to 'real time update' functionality and further development of the quality assurance processes in relation to the QSEEL validation. The QSEEL is a tool which has been developed for teams to assess themselves against the Care Quality Committee (CQC) 'Essential Standards for Quality and Safety'. CQC style quality visits are built into monitoring standards and clinical teams are involved in the development of team information boards to support on-going conversations about the quality of services.

The enhanced QSEEL will form the foundation of the Quality Map from clinical team to organisational level. Quality SEEL findings are collated to provide the Board with intelligence and assurance about quality standards across the organisation.

The ultimate aim of the Quality Strategy is to support the delivery of high quality healthcare to people using the Trust's services. The strategy has been designed and implemented to involve and empower staff from frontline services to deliver care that is consistently person-centred, clinically effective and safe, for every person, every time.

The Executive Quality Committee provides assurance that the Quality Strategy is being deployed throughout the organisation and that the key actions are being progressed:

- Collecting useful information on quality (safety, effectiveness, and patient experience)
- Sharing this information quickly with the people who are best placed to improve care.
- This has been facilitated by the development of electronic team information board with access to real-time data. Team leaders have access to this data to facilitate conversations about quality.

The data currently includes:

- Safety – Quality SEEL data, incidents, harm free care data
- Effectiveness – Quality SEEL data and will incorporate friends and family results, NICE Quality Standards and Advancing Quality data
- Experience – Quality SEEL data, complaints and compliments

- Leadership –Quality SEEL data, staff absence, mandatory training data

A Quality Analysis Group has been established which advises the Executive Quality Committee in relation to themes highlighting good quality care or signalling areas where improvements are needed.

A theme highlighted in recent national review reports reflects the need to effectively analyse, monitor and learn from quality information from clinical team to Board level. Within this the ability to focus on individual areas of performance is maintained.

The Quality Analysis Group brings together sources of data and intelligence to present a comprehensive picture of quality. Members have the appropriate knowledge and skills to challenge the data and ensure that outcomes for patients are understood. The findings are used to inform the focus of quality improvements feeding back to the Executive Quality Committee.

The Quality and Governance Directorate have facilitated 'Leading for Quality' Development Days with clinical leaders from across the organisation. The purpose of these development days is to improve the quality of care provided, enable the Director of Nursing to engage with clinical leaders across the organisation to lead for quality and provide a forum for feedback relating to the national quality agenda. Additionally, they provide an opportunity to influence standards, provide a strategic, open forum, working in partnership with the Clinical Directors, to share and show case good practice to promote the rapid spread of innovation and organisational learning

The Quality Strategy and Quality Priorities continue to inform the content of the 2013/14 Quality Account. The Standards and Assurance Committee (SAC), a sub-group of the Council of Governors (CoG), has continued to review a sample of evidence against each quality priority during the year. The SAC determine whether they are assured or not by the evidence they have seen and report back to the CoG. At the end of the year the SAC also reviews the draft Quality Account in detail and reports back to the CoG.

The Trust has received a number of CQC unannounced visits and Mental Health Act Visits throughout the year and has responded to feedback from these visits. Since the beginning of October 2013 there have been a number of CQC inspections which have had elements of the newly proposed inspection style. These include:

- Bigger visiting teams with expert input
- Arrival out of hours
- Longer visits
- The CQC inspection teams arrive on the units with knowledge of recent incidents and concerns
- The CQC ask staff to talk them through patient records looking in detail at admission, assessment, formulation, care planning, checking safety profiles and how the formulations from these were reflected in the care plans

- They triangulate evidence by speaking to staff, checking documentation and speaking to service users
- Inspectors met up regularly during the day to discuss what they had found to determine their next steps

The inspection visits to Ridge Lea, Lancaster Unit, Offender Health - HMP Kirkham' and The Wordsworth centre resulted in positive outcomes. A visit to the Acquired Brain Injury Service identified that four of the standards required further assurance in relation to: respecting and involving people who use services, ensuring the care and welfare of people who use services, assessing and monitoring the quality of service provision and records. An action plan was put in place to address the areas of development with progress reported to the Executive Quality Committee.

Following CQC inspection visits, the Quality & Experience Team complete debriefs with the clinical teams to share the learning organisationally.

2.1.4 Progress towards targets as agreed with local commissioners, together with details of other key quality improvements

As part of the contractual arrangements for Community and Mental Health services, as well as those services defined as specialist, the Trust has a number of targets to meet relating to CQUIN (Commissioning through Quality and Innovation) and the Quality Schedule of the contract. The objective for the indicators under the CQUIN scheme is to incentivise quality improvement within priority service delivery areas.

These targets are service specific, locally agreed and based on quality initiatives. The performance for these indicators is reported to commissioners on a quarterly basis and additional income is secured should the quality of services improve through demonstrable achievement of these challenging targets.

Dementia inpatient services are working to fully comply with the AQuA standards which set out the assessment framework for every person admitted to hospital with dementia. The standards were not fully met in 2013/14 and a plan is in place to ensure that the standards are met during 2014/15.

Key priorities reflected in the CQUIN indicators for 2013/14 for the community and mental health contracts included:

- The delivery of the Harm Free Care physical health programme
- The introduction of the Friends and Family Test
- The implementation of the Quality SEEL assessment and the development of team information boards.

In 2014/15 for all contracts, the CQUIN amount that providers can earn remains at 2.5% on top of actual outturn value. 2014/15 CQUIN indicators for both the community and mental health contracts are being agreed with the organisations Quality Leads and Clinical Commissioning Group representatives.

Initial proposals include the introduction of the Harm Free Care programme mental health, the extended implementation of the Friends and Family Test and a focus on 'making every contact count'.

2.1.5 Any new or significantly revised services

During 2013/14 the Trust has continued to develop its services to improve the health and wellbeing of people in Lancashire. The Trust's focus is on providing services that are safe, high quality and that meet the needs of people in the right place at the right time. Another priority is on ensuring that services are sustainable and able to meet the changing needs of a population that is diverse and ageing.

In the Trust's specialist services improvements have been made to the Acquired Brain Injury Service and women's service. This has included introducing new models of care and reviewing the staffing models in both areas.

Within prison healthcare there has been the development and implementation of the abdominal aortic aneurism (AAA) screening pathway. This was initiated by HMP Wymott and the shared pathway is now being rolled out across the wider prison network. Wymott initiated & shared pathway with other prisons. Health and wellbeing checks are also being rolled out across all prisons and there are Health and Wellbeing practitioners in post. The HMP Kirkham healthcare team have been shortlisted for Clinical Team of the year. They have the highest compliance rate of Hepatitis C screening across all prisons in England (81%), and have 100% uptake of Hepatitis B vaccinations.

Adult mental health services have developed their Eating Disorders service over the year, expanding services from Lancaster and Morecombe into Fylde and Wyre and East Lancashire. The network has also secured agreement that the service provided in West Lancashire will be funded recurrently.

Improvements have been made to Improve Access to Psychological Therapies. This has radically reduced waiting times and improved prevalence targets. Additionally, a proposed new model of care has been developed with commissioners in East Lancashire which increases clinical input at triage stage. The model will be piloted in the area with a view to rolling it out across Lancashire in the future.

Community adult mental health services continue to work with Lancashire County Council to develop a Community Rehabilitation Team. Their remit is to ensure the appropriate placement and support is in place in the community to encourage independence and rehabilitation. The model began in the East and has now expanded to cover Greater Preston, Chorley and South Ribble. Staff from Lancashire County Council transferred into the Trust's Specialist Rehabilitation Services on 1 December 2013. Providing rehabilitation services for people that are ready to be discharged from mental health wards is another priority area that the Trust is addressing with commissioners. This will serve to ensure that people don't have to stay in hospital for longer than they need to in the future and to support their recovery.

Increasingly, there is a shift to providing care at home which is in line with national drivers and in response to recommendations arising from public consultations. To achieve this and enable a reduction in the number of mental health beds provided, the whole system has to work effectively. Going forwards, a total re-design of community mental health services will be undertaken to address inefficiencies, gaps and ensure that resources are allocated to support people with the greatest level of need. This will also support the Trust to achieve the target of providing 262 mental health beds, which has been agreed with commissioners.

Adult community services also have a focus on increasing the infrastructure of the services they provide to people via community teams. Providing high quality dementia care is a priority and progress has been made in several areas. Hospital liaison services have been set up in Central and East Lancashire and care home liaison has commenced in Central and North Lancashire in addition to the existing service in East Lancashire. These services provide specialist training and input to ensure that people with dementia receive high quality care. Intermediate support teams have also been established across Lancashire to provide care for people with dementia in their usual place of residence seven days a week. Collectively, these services have dramatically reduced the number of people with dementia requiring an admission to hospital. Thirty specialist mental health beds will be provided for people with dementia from The Harbour in Blackpool.

The network has also been focusing on improving access to musculoskeletal services and has led on the development of a tool which aims to improve the quality of wound care for patients. The Wound Healing Assessment and Monitoring (WHAM) tool aims to improve wound care assessment and has received national recognition. Implementation of the WHAM tool has improved record-keeping and enabled clinicians to measure and monitor wound healing rates within their teams across the locality. The project was implemented in a staged approach across clinical settings which ensured consistently high standards for patients and enables people to receive care from different locations.

Improving services for people with long term conditions in Blackburn with Darwen and Central Lancashire is progressing. Work is taking place alongside the CCGs and local authorities to provide virtual wards and integrated neighbourhood teams to reduce the number of unplanned admissions to hospital and also enable people to be discharged faster. Another priority is to educate people to manage their symptoms and self-care. The prevention of long term conditions is linked to the Trust's public health agenda and working to reduce the unhealthy behaviours that are associated with the prevalence of disease.

The Trust aims to provide community services that are responsive and accessible to people when they need them. A pilot to provide seven day treatment room and minor injury services has been implemented in Blackburn with Darwen and Central Lancashire. In line with national policy, the Trust will be considering which elements of its service provision are needed on a seven day basis and planning accordingly. Service lines are also developing other means of increasing accessibility for patients.

The Contraceptive and Sexual Health Service has introduced a telephone consultation service for contraceptive advice. In excess of 80 patients a month are using this service, which enables them to book a phone call with a nurse at their convenience for advice and support. A single point of access phone line has also been set up for people to book appointments from a choice of 32 locations.

The Trust's universal services have also made developments. In East Lancashire funding has been agreed to pilot a Respiratory Nursing Service for two years. The Health Improvement Service (HIS) has worked proactively with colleagues in children's centres to co-ordinate a tooth brushing and toothpaste scheme in East Lancashire which is contributing to a reduction in decayed, missing and filled teeth in the area. In addition to supporting the Smile4Life programme the HIS is also working with the Trust's dental service to provide a dental access pathway via children's centres.

Child and Adolescent mental health services (CAMHS) are a priority area for the Trust. The Early Intervention Service remains a beacon of good practice as a national pilot site for Improving Access to Psychological Therapies (Severe Mental Illness). Additional funding has been granted which will allow the project to continue to increase access to therapies for people with psychosis and regularly assess service user progress to ensure that the therapies are useful and effective. The service accommodated a visit from Norman Lamb in the autumn; who was very complimentary about the service and referred to it as an exemplar for other areas. The service has further extended its offer during this financial year with the delivery of psychosocial intervention training.

Dialogue is on-going with commissioners in relation to CAMHS Tier 4. This is specifically to address further enhancing community services and increasing the number of specialist mental health beds for young people under the age of 18. This will involve the future re-provision of the Trust's existing inpatient services, The Junction and The Platform.

2.1.6 Service improvements following staff or patient surveys/comments and Care Quality Commission reports

The Patient Opinion website is used to collect and respond to feedback about the Trust's services. It is a national platform which is independently run and validated by the CQC, Department of Health and Health Commissioners. In 2013/14 there was a significant rise in the number of postings about the Trust, with more than 120 items posted which were viewed nearly 15,000 times. Most of these stories reflected a high level of appreciation for the Trust's staff and quality of care. All the items posted were shared with managers and frontline staff. Six in total directly led to a reported change in service and many more have been used to build on existing good practice.

As part of the Quality Strategy each clinical team complete their Quality SEEL annually. This tool enables teams to self-assess the quality of care at the point of care provision. As part of the Quality SEEL service users and carers are asked a

range of questions under the domains of safety, experience, effectiveness and leadership. Any issues highlighted by this feedback is fed into the team's risk register and actions developed.

In response to a CQC report published 2012/13, the Trust demonstrated its commitment to delivering quality services by the decision to temporarily close an inpatient ward following the identification of concerns that could impact on the quality of care provided. An improvement plan for reopening was developed which focused on eight key themes; patient carer experience, staff/team communication, care planning, record keeping, physical health, medicines management environment, assurances, audit and effectiveness. The ward was reopened in September 2013 following the implementation of the improvement plan.

2.1.7 Improvements in patient/carer information

The Trust continues to work closely with service users and carers to improve their experience of services and ensure that they are involved and well-informed. In 2012 the Trust signed up to the Lancashire Multiagency Carers Strategy and continues to work collaboratively with partner organisations to support carers. In addition to this, the Trust has its own Mental Health Carers Strategy which was launched in 2010. Services that implement the Mental Health Carers strategy have undertaken further work to ensure that the recommendations in the strategy are embedded. Examples of this include: Providing carers and confidentiality training for staff in community and inpatient settings, having carer's champions in each community mental health team who meet on a quarterly basis to share good practice, cascade information to teams and develop services to include carers issues, and embedding the carers strategy into the inpatient standard operating procedures.

The Trust continues to provide a portfolio of patient information leaflets. Services involve service users and carers in reviewing the leaflets. The inpatient ward information booklets for Parkwood and Lancaster Units were updated and amended with service user involvement in 2013. A service user and carer newsletter is produced on a quarterly basis with service users and carers being part of the editorial team and contributing to the publication.

The on-going development of the Trust's website continues to improve access to information including self-help materials. A small user group supported the re-design of the website and this has improved accessibility, navigation and the overall design of the site to make it more patient focussed. Enhanced features have also been added including an A-Z of services, a location finder and improved search functionality. The further development of the website will continue to provide a more interactive platform for patients including the provision of online booking, online therapy, access to records and a directory of services by locality is also under development.

An easy read summary of the Quality Account was published in the August edition of Voice News, the Trust's service user and carer newsletter. The Quality Account and summary are also uploaded to the Trust internet site.

2.1.8 Information on complaints handling

The Trust works hard to listen and respond openly to complaints to ensure resolution where possible. There is a positive attitude to complaints as they provide an opportunity to review how things may have gone wrong, enable the chance to put things right, learn lessons and improve services for the future in relation to service users, their carers and families. A review of the Trust's Complaint Handling Policy and Procedures was undertaken this year which has been implemented and is now subject to audit.

The department works to achieve standards set out by the CQC, Trust Policy, Department of Health guidance and adheres to the NHS Complaints Handling Regulations (2009) including the acknowledgement of formal complaints within three working days. The complainant can then expect a full response within 25 working days or within a timescale agreed between the complainant and the investigation lead. Whenever any delays are encountered within the investigation the complainant is advised.

During the year 2013/14 the Trust received a total of 643 formal complaints, 130 concerns, 20 comments and 2,392 compliments. There were 14 enquiries from GPs and 51 from MPs.

In relation to the lower figure of 130 concerns received, these were logged onto the Datix system only until 30 June 2013. Following this and in line with the revised Policy (1 July 2013) verbal concerns resolved within 24 hours are not recorded as a complaint; however, if learning opportunities are identified, lessons learned are shared.

Following the restructure of the Customer Care team in January 2014 to include a PALs function, the team is now working to offer Rapid Resolution for queries which do not formally constitute a complaint and could be resolved within five working days. This allows a quick resolution for service users, carers and families. It is anticipated this will improve arrangements for networks and offer service users a satisfactory and timely resolution. This pilot was started in February 2014 and will run for three months before being evaluated with the networks and potentially service users. This data will be included in future reports.

The department provides more detailed quarterly and annual information to the Trust Board on achievement of targets, the main themes from complaints, and lessons learned and improvements made as a result of complaints. Further, the Non-Executive Director led panel for Complaints Reviews undertakes an in depth review of randomly selected complaints from all Networks.

The top themes of complaints during the year were:

- Care and treatment
- Communication
- Staff relate issues including attitudes/behaviour
- Medication

The feedback from people who have used services is an important part of the Trust's Quality Strategy. The Networks now have access to dashboards and reporting systems that allow them to monitor their complaints, identify themes and manage complaints.

Recent developments within the department include the reviewing and piloting of Complaints Process Survey, building quality into the consenting requirements in managing complaints and developing strong support for Networks and Investigation Leads.

Parliamentary and Health Service Ombudsman (PHSO) summary

Number	Current Status
14	The PHSO declined to investigate
2	Referred back to the Trust for a further attempt at resolution.
8	PHSO investigated – now closed.
7	Currently with the PHSO

2.2 Stakeholder relations

2.2.1 Descriptions of significant partnerships and alliances entered into by the NHS Foundation Trust to facilitate the delivery of improved healthcare. These should be described together with the benefit to patients and the methods used to fund these activities

The ultimate aims of the Trust's approach to stakeholder relations are to support the business objectives of the Trust by strengthening relationships with key stakeholders, engaging them in working in partnership to address the challenges faced in the health economy and to gather intelligence on opportunities and threats to the Trust's income.

The Trust's engagement team links closely with the Clinical Networks and corporate office to lead the delivery of an increasingly strategic approach to stakeholder engagement which is supported by Executive and Network colleagues. The framework for this approach is provided by key principles which include a commitment to ensuring that stakeholder engagement is clinically led where possible and that it is aligned to the service user and carer involvement work of Clinical Networks.

A common theme emerging from conversations with Clinical Commissioning Groups is the desire for service provision to be modelled on a locality approach. This is a priority going forward in relation to the development and delivery of services across

Lancashire. The geographical focus of the engagement team's Relationship Managers is supporting work being undertaken by the Clinical Networks such as the Long Term Conditions programme.

Supporting people with long term conditions is a priority area for the Trust and work is progressing with partners in Central Lancashire and Blackburn with Darwen to improve the support that is available to this patient group. The focus is on supporting people to manage their conditions, self-care, building community assets and providing an alternative to hospital admission by providing an enhanced service from integrated neighbourhood teams. More information is available on page 45.

Additionally a large scale programme is underway in Central Lancashire, involving key partners from across the health economy to transform urgent care services. The programme comprises 6 projects that collectively aim to provide a more responsive and quality service to patients from various settings; reducing pressure on hospital beds and increasing accessibility for patients by ensuring that services are designed to meet better meet their needs at all times.

The Trust's partnership approach to stakeholder relations as a means of shaping models of service delivery which are sensitive to local needs and will maximise patient benefit is exemplified by a recent engagement conference focusing on the Central Lancashire long term conditions programme. The conference, held in November 2013, was jointly hosted and financed by the Trust with Preston, Chorley and South Ribble Clinical Commissioning Groups, Lancashire Teaching Hospitals, Lancashire County Council and Healthwatch Lancashire. Public members of the host organisations and forums representing communities of interest were invited to participate in the conference. The conference has been used as a springboard by the hosting stakeholders to launch more longstanding engagement structures which will ensure that the development of the long term conditions programme is co-produced with people living with long term conditions and their carers. These structures include an 'experts by experience' patient group for the programme as a whole and user-led projects which support particular programme outcomes such as successfully combatting social isolation.

The Trust is a key player in the Healthier Lancashire Forum, which comprises seven projects that are either enabling or transformational. The Trust's Chief Executive is the lead for Collaborative Leadership and the Engagement Team is supporting the Listening to Lancashire Project, which includes close involvement with the Third Sector and an Exposition will take place in September 2014. The aim is to demonstrate the contribution of the third sector to a 'Healthier Lancashire' in the context of reduced resources in public services and the use of new technology. Technology will play a major supporting role in the future; enabling an increase in personalised health care, new innovations and the sharing of information between different health care organisations.

The Trust's Chief Executive sits on both the Lancashire County Council and Blackpool Health and Wellbeing Boards. They are established and hosted by local authorities and bring together the NHS, public health, adult social care and children's

services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population. Tackling health inequalities, increasing life expectancy and improving health outcomes are amongst the shared goals of the local boards that the Trust supports.

A proposal for involving Governors more in Trust engagement was approved by the Membership and Governance Committee and by the Council of Governors. The proposal is based on three training sessions for governors planned for the first three months of the calendar year 2014 focusing on wellbeing, long term conditions and dementia. This support will enable public governors to improve their knowledge in these areas and be able to better represent the views of the public and members.

The Executive engagement matrix continues to be used to take a more strategic approach to attending meetings and a geographical map of meetings is being developed in partnership with the Clinical Networks to provide a more robust model for ensuring that LCFT is part of every conversation that the organisation needs to be involved with.

GPs have provided positive feedback on the impact that the Relationship Managers are having. The Relationship Managers have been responding to individual requests around contact details and service information on a practice by practice basis, sharing information across the locality where appropriate. GP feedback has included issues of communication and an understanding of which services are offered in their localities plus contact names and numbers for those services. Work is taking place with the Relationship Managers and the Trust's corporate communications team to provide this information in an accessible way that GPs want.

Relationships with the third sector were developed by supporting a number of significant events such as the Leyland Health Mela and the Open Mind Festival based in Preston.

The Leyland Health Mela provided a great opportunity for Lancashire Care teams to showcase their work to the local community. Close to 600 members of the public attended the event which was supported by four separate teams from the Trust. The event also provided opportunities for enhancing the Trust's reputation with key stakeholders, including borough councils and the local Clinical Commissioning Group. Co-ordinating a strategic approach to the various health melas in Lancashire will form a key part of the stakeholder engagement strategy looking forwards.

The Open Mind Festival is a service user led annual event which uses music as a medium to challenge discrimination and promote anti-stigma messages about members of the community with significant mental health needs. The Trust made financial and inkind contributions to the Festival which both included musical performances and managerial/clinical contributions to workshop discussions about the causes of, and possible solutions to, discrimination against people with mental health issues.

At a strategic level, the Trust's relationships with stakeholders from the third sector have been developed by active support for initiatives to ensure that local, frontline third sector organisations in Lancashire have the appropriate infrastructure support to thrive and prosper as part of the new landscape for commissioning health and social care.

2.2.2 Development of services involving other local services/agencies and involvement in local activities

As the major health and wellbeing provider for Lancashire the Trust works in partnership with numerous organisations to plan, provide and develop services. The Trust's aspiration is to deliver integrated care. This does not mean that the Trust will provide every service in every area; it means using its position as an expert in the health and wellbeing system to act as a conduit and signposting to other providers when appropriate. The Trust is well placed to help people to navigate the complex health and wellbeing system and recognises the unique input and expertise that other agencies contribute to the wider health needs of individuals and wider communities.

At a corporate level the Trust's affiliate membership scheme serves to strengthen and formalise partnerships with organisations. At an operational level the Trust's clinical networks work in partnership to provide services to local people and communities.

The input of Lancashire County Council's Connect 4 Life programme is integral to the development of local integrated neighbourhood teams to support people in Central Lancashire that are living with a long term condition. Connect 4 Life provides vital input within multi-disciplinary teams, advising on social issues including bereavement, low level mental health problems and social isolation. The ability to maximise resources within a local community is key to meeting the needs of individuals, families and communities. Achieving the right support, in the right place, at the right time, with the right outcome at the right cost is essential.

Community assets will play an increasing role alongside commissioned services, making a major contribution to the 'wellbeing & prevention' agenda in local communities. The focus on supporting people to become involved in their communities will improve outcomes, reduce health inequalities, develop capacity and resilience and reduce financial impact on long term support needs on primary and secondary care activity.

In the specialist services network the Acquired Brain Injury (ABI) service has worked with charity Headway to provide support and highlight the issues surrounding caring for someone with a brain injury. The network also brought together mental health professionals and service users in Lancashire to talk about the importance of recovery orientated secure mental health services. The Recovery Orientation in Secure Services (ROSS) conference showcased some of the innovative work the Trust undertakes in relation to mental health and recovery. It also served to share best practise with other NHS Trusts and organisations from the private sector.

In the prison service, HMP Wymott is undertaking an end of life joint research project with Marie Curie. Over 50 members of staff from across the prison have been recruited to be part of the research and focus group interviews have been undertaken. HMP Preston has rolled out medical student placements. This has been very positive and will be replicated across other prisons.

The adult mental health network is involving service users, carers and third sector partners in the preparations for The Harbour becoming operational in 2015. These include; carers support organisations, housing services and benefits advice agencies amongst others. By collating feedback from service user and carer consultations, the network will ensure the right agencies and providers are accessible on site. Alongside this, work is on-going with the third sector to secure a provider for the café at Minerva and shop at The Harbour.

The improvements made to IAPT services referenced in section 2.1.5 have been supported by working with community assets and partners to increase access to appropriate services. IAPT has a network of local initiatives to support wellbeing including Women's Centres and MIND. Similarly, Restart services continue to work with partners such as Richmond Fellowships and Making Space. They also support many local initiatives and service user led groups within specific areas of interest such as music, sports and ecology. The Trust continues to work in partnership with Burnley Football Club and the It's a Goal! Foundation to use the positive and encouraging aspects of football to help men in the area deal with their depressive problems in a different way. Horticulture is another area of interest provided from Grange Gardens in West Lancashire and the Eco Centre project in partnership with MIND.

In addition to MIND, another major national partner is the national charity Rethink Mental Illness. The Trust is working with the charity on a ground-breaking project to improve services for people with schizophrenia and psychosis. The Rethink Mental Illness Innovation Network was launched in the Houses of Commons and will test new and innovative services for people affected by severe mental illness. It will focus on issues like improving the physical health of mental health patients, improved hospital care, and helping people with mental illness get into employment. The Trust is supportive of charities and also works closely with the mental health charity, Breakthrough of which the Trust's Chief Executive Heather Tierney-Moore is a patron.

Child and Adolescent Mental Health Services (Tier 3) in North and Central Lancashire have completed year 1 of the national IAPT (Improving Access to Psychological Therapies) programme, which is a two year service transformation project. The aim is to provide better access to evidence based psychological treatments with the focus being on Cognitive Behavioural Therapy and specialist parenting in the first two years. This has been undertaken in collaboration with Barnados, NCompass (leading on service user participation) and Lancashire County Council, specifically in relation to developing effective pathways for young people with anxiety/depression and conduct disorder. Barnados are also a partner in the

‘Edge of Care’ initiative, which is to provide therapeutic support to young people with the potential of being taken into care. The programme is aimed at providing early access to psychological support to prevent the need for care proceedings.

The continued involvement of partners in the development of future plans will be key to the Trust’s success.

2.3 Statement as to disclosure to auditors

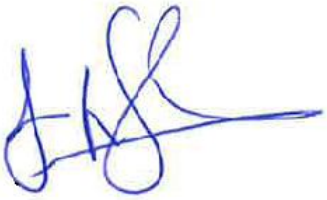
Each of the people who are directors at the date of approval of this report confirms that:

- 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 of which the company's auditors are 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 auditors are aware of that information.

This confirmation is given and should be interpreted in accordance with the UK Corporate Governance Code 2012, para. C.1.1.

This confirmation is given and should be interpreted in accordance with the provisions of s415-s418 of the Companies Act 2006.

For and on behalf of the Board



Mr Derek Brown
Chair
28 May 2014

Professor Heather Tierney-Moore
Chief Executive
28 May 2014

2.4 Additional disclosures

Pensions Disclosure

The accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts and details of senior employees' remuneration can be found in the remuneration report on page 57.

Statement on accounts preparation

The accounts have been prepared under direction issued by Monitor, the independent regular for Foundation Trusts, as required by paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14 (FT ARM).

Statement on register of interests' information

Company directorships and other significant interests held by Directors (or Governors) which may conflict with their management responsibilities are detailed in a Register of Interests maintained by the Trust. Access to the information in the register can be obtained by written request to the Trust's Company Secretary.

3. Remuneration Report

The Trust has prepared this report in compliance with:

- Sections 420 to 422 of the Companies Act 2006 (section 420(2) and (3), section 421(3) and (4) and section 422(2) and (3) do not apply to NHS Foundation Trusts);
- Regulation 11 and parts 3 and 5 Schedule 8[5] of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations") and;
- Elements of the NHS Foundation Trust Code of Governance.

[6] Schedule 8 as substituted by The Large and Medium-sized Companies and Groups (Accounts and Reports) (Amendment) Regulations 2013 (SI 2013/1981)

Professor Heather Tierney-Moore
Chief Executive
Lancashire Care NHS Foundation Trust
28 May 2014

Salary and Pension entitlements of Senior Managers

(The tables below have been subject to audit review)

a) Remuneration

Employee Name and Title	Period 1April 2013 - 31 March 2014						Period 1 April 2012 - 31 March 2013					
	Salary (bands of £5,000)	Taxable Benefits (nearest £100)	Annual performance related bonus (bands of £5,000)	Long term performance related bonus (bands of £5,000)	Pension related benefits increase # (bands of £2,500)	Total (bands £5,000)	Salary (bands of £5000)	Taxable Benefits (nearest £100)	Annual performance related bonus (bands of £5,000)	Long term performance related bonus (bands of £5,000)	Pension related benefits increase (bands of £2,500)	Total (bands £5,000)
Professor Heather Tierney-Moore OBE Chief Executive (01/04/2013 - 31/03/2014)	195-200	500	0-5	0	0	195-200	190-195	200	10-15	0	0	205-210
Mr David Tomlinson Director of Finance (01/04/2013 - 31/03/2014)	135-140	4,500	0-5	0	17.5-20	160-165	135-140	4,200	5-10	0	32.5-35	175-180
Mr Mark Hindle Director of Service Delivery and Transformation (01/04/2013 – 21/09/2013)	55-60	400	0-5	0	265-267.5	320-325	115-120	300	10-15	0	70-72.5	200-205
Professor Max Marshall Medical Director (01/04/2013 - 31/03/2014)**	190-195	1,100	0-5	0	1,447.5-1,450	1,645-1,650	135-140	2,000	0-5	0	0	145-150
Miss Hazel Richards Director of Nursing (01/04/2013 – 01/06/2013)	20-25	1,000	0-5	0	10-12.5	35-40	100-105	6,000	0	0	0	105-110
Mr Craig Barratt Director of Workforce, Innovation and Transformation (27/08/2013 – 31/03/2014)	85-90	300	0	0	47.5-50	85-90	0	0	0	0	0	0
Mrs Sue Moore Chief Operating Officer (10/02/2014 – 31/03/2014)	15-20	300	0	0	850-852.5	15-20	0	0	0	0	0	0
Mrs Denise Roach Director of Nursing (30/12/2013 – 31/03/2014)	30-35	100	0	0	905-907.5	30-35	0	0	0	0	0	0
Mr Colin Dugdale Acting Director of Nursing (01/06/2013 – 29/12/2013)	60-65	400	0	0	1,240-1,242.5	60-65	0	0	0	0	0	0
Mr Dominic McKenna Acting Director of Finance (06/03/2014 – 31/03/2014)	5-10	300	0	0	0	5-10	0	0	0	0	0	0

Appointees Name and Title ^	Period 1April 2013 - 31 March 2014						Period 1 April 2012 - 31 March 2013					
	Salary (bands of £5,000)	Taxable Benefits (nearest £100)	Annual performance related bonus (bands of £5,000)	Long term performance related bonus (bands of £5,000)	Pension related benefits increase (bands of £2,500)	Total (bands £5,000)	Salary (bands of £5,000)	Taxable Benefits (nearest £100)	Annual performance related bonus (bands of £5,000)	Long term performance related bonus (bands of £5,000)	Pension related benefits increase (bands of £2,500)	Total (bands £5,000)
Mr Stephen Jones CBE Chair (01/04/2013 - 31/05/2013)	5-10	400	0	0	0	5-10	45-50	600	0	0	0	45-50
Mr Derek Brown Chair (26/06/2013 – 31/03/2014) Non-Executive Director (01/04/2013 – 25/06/2013)	35-40	0	0	0	0	35-40	15-20	0	0	0	0	15-20
Mrs Teresa Whittaker Non-Executive Director (01/04/2013 - 31/03/2014)	20-25	500	0	0	0	20-25	20-25	200	0	0	0	20-25
Professor Christopher Heginbotham Non-Executive Director (01/04/2013 - 31/03/2014)	10-15	0	0	0	0	10-15	15-20	0	0	0	0	15-20
Mr Peter Ballard Non-Executive Director (01/04/2013 - 31/03/2014)	10-15	900	0	0	0	15-20	15-20	400	0	0	0	15-20
Mr James Taylor Non-Executive Director (01/04/2013-31/07/2013)	0-5	200	0	0	0	5-10	5-10	300	0	0	0	5-10
Mr Gwynne Furlong Non-Executive Director (01/04/2013 - 31/03/2014)	10-15	800	0	0	0	15-20	5-10	300	0	0	0	5-10
Ms Naseem Malik Non-Executive Director (29/10/2013 – 31/03/2014)	5-10	0	0	0	0	5-10	0	0	0	0	0	0
Ms Louise Dickinson Non-Executive Director (29/10/2013 – 31/03/2014)	5-10	0	0	0	0	5-10	0	0	0	0	0	0

Pension related benefits is determined in accordance with the HMRC method. The lack of prior year information for some individuals has distorted reported figures for 2013/14.

^ The Chair and Non-Executive Directors are not employees of the Trust, they are appointed by the Council of Governors to provide leadership, strategic direction and independent scrutiny. In this context, 'salary' relates to the amounts paid as remuneration for this provision.

** The amount disclosed above represents Professor Marshall's total remuneration. For his Medical Director post he received £30,000-£35,000 (2012/13 £25,000-£30,000)

The Board of Directors directs the operations of the Trust and is appointed as follows. The Chairman and the Non-Executive Directors are appointed by the Council of Governors' Nomination/Remuneration Committee. Remuneration, allowances and terms and conditions of office of the Chair and Non-Executive Directors are also directed by the Committee. The Chair and Executive Directors appoint the Chief Executive. The Chair, Non-Executive Directors, Chief Executive and the Executive Directors appoint the other Executive Directors.

Executive Directors positions are on substantive contracts. Remuneration, allowances and terms and conditions of all executive directors, including the Chief Executive, is directed by the Board of Directors Nomination/Remuneration Committee. The Nomination/Remuneration Committee approved the Performance Related Pay framework, awards are made against performance at period end. Posts are advertised in relevant media and interviews are undertaken by a panel comprising members of the Board of Directors Nomination/Remuneration Committee and external assessors. Non-Executive Directors positions, including the Chair, are terminable by the Council of Governors Nomination/Remuneration Committee. Executive Director positions are terminable by the Board of Directors Nomination/Remuneration Committee. In the case of directors other than the Chief Executive, the Chief Executive would also take part in the decision.

Details of the both the Board of Directors and Council of Governors Nomination/Remuneration Committee can be found on page 76.

Benefits in kind relate to the provision of a lease car or taxable mileage benefits.

a) Pension

Name and Title of Senior Manager	Real Increase in Pension (Bands of £2,500)	Real Increase in Lump Sum (Bands of £2,500)	Pension at 31 March 2014 (Bands of £2,500)	Lump Sum at 31 March 2014 (Bands of £2,500)	CETV at 31 March 2014 (Rounded to nearest £1,000)	CETV at 31 March 2013 (Rounded to nearest £1,000)	Real Increase in CETV as funded by employer (Rounded to nearest £1,000)	Employers contribution to stakeholder pension
Mr David Tomlinson Director of Finance (01/04/2013 - 31/03/2014)	0-2.5	2.5-5	40-42.5	120-122.5	802	746	27	0
Professor Max Marshall Medical Director (01/04/2013 - 31/03/2014)**	10.12.5	187.5-190	62.5-65	187.5-190	1,237	0	0	0
Mr Mark Hindle Director of Service Delivery and Transformation (01/04/2013 – 21/09/2013)	5-7.5	32.5-35	57.5-60	175-177.5	1,154	858	194	0
Miss Hazel Richards Director of Nursing (01/04/2013 – 01/06/2013)	0-2.5	0-2.5	32.5-35	100-102.5	472	455	5	0
Mr Craig Barratt Director of Workforce, Innovation and Transformation (27/08/2013 – 31/03/2014)	0-2.5	2.5-5	0-2.5	2.5-5	28	0	20	0
Mrs Sue Moore Chief Operating Officer (10/02/2014 – 31/03/2014)	2.5-5	110-112.5	35-37.5	110-112.5	629	0	440	0

Name and Title of Senior Manager	Real Increase in Pension (Bands of £2,500)	Real Increase in Lump Sum (Bands of £2,500)	Pension at 31 March 2014 (Bands of £2,500)	Lump Sum at 31 March 2014 (Bands of £2,500)	CETV at 31 March 2014 (Rounded to nearest £1,000)	CETV at 31 March 2013 (Rounded to nearest £1,000)	Real Increase in CETV as funded by employer (Rounded to nearest £1,000)	Employers contribution to stakeholder pension
Mrs Denise Roach Director of Nursing (30/12/2013 – 31/03/2014)	7.5-10	117.5-120	37.5-40	117.5-120	632	0	442	0
Mr Colin Dugdale Acting Director of Nursing (01/06/2013 – 29/12/2013)	30-32.5	160-162.5	52.5-55	160-162.5	1,028	0	719	0
Mr Dominic McKenna Acting Director of Finance (06/03/2014 – 31/03/2014)	0.00	0.00	0.00	0.00	0	0	0	0

The lack of prior year information for some individuals has distorted reported figures in 2013/14.
* Mr Dominic McKenna was appointed during the final month of the year and as so was after the NHSPA information request date re: pension figures.
As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Other Remuneration Disclosure	2013/14 £'000	2012/13 £'000
The highest paid senior manager in the organisation is the Chief Executive, being:	202	207
The median remuneration of full time Trust staff is:	27	27
The ratio therefore highest and the median salary is:	7.5	7.8

*The calculation is based on full-time equivalent staff of the Trust at 31 March 2014 on an annualised basis

Reporting high paid off-payroll arrangements

Table 1 – For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last for long than six months

Number of existing engagements as of 31 March 2014	**38**
Of which:	
Number that have existed for less than one year at the time of reporting	7
Number that have existed for between one and two years at the time of reporting	31
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of report	0

Table 2 – For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	**27**
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number of whom assurance has been requested	0
Of which:	
Number of whom assurance has been received	0
Number of whom assurance has not been received	27
Number that have been terminated as a result of assurance not being received	0

Table 3 – For any pay-roll engagement of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2014

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year	**0**
Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year (this figure includes both off-payroll and on-payroll engagements	**0**

In any cases where individuals are included within the first row of this table the Trust would have set out:

- Details of the exceptional circumstances that led to each of these engagements;
- Details of the length of time each of these exceptional engagements lasted.

Expenses Disclosure

As required by section 156 (1) of the Health and Social Care Act 2012, the following expenses were remunerated.

Reporting Group	2013/14		2012/13	
	Number in group	Travel expenses £'00	Number in group	Travel expenses £'00
Executive Directors	10	270	8	283
Appointees (Chair and Non-Executive Directors)	9	29	9	43
Council of Governors	21	215	34	55

4. Disclosures set out in the NHS Foundation Trust Code of Governance

4.1 Description of how the Foundation Trust applies the main and supporting principles of the Code

Lancashire Care NHS Foundation Trust is committed to maintaining high standards of corporate governance. It endeavours to conduct its business in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership *(The Nolan Principles).* In setting its governance arrangements, the Trust has regard for the provisions of the UK Corporate Governance Code 2012 issued by the Financial Reporting Council, the Code of Governance issued by Monitor and other relevant guidance where provisions apply to the responsibilities of the Trust. The following paragraphs together with the Annual Governance Statement and Corporate Governance Statement explain how the Trust has applied the main and supporting principles of the Code.

4.2 The role of the Board of Directors

Lancashire Care NHS Foundation Trust's Board of Directors is made up of 13 Directors, six Executive Directors, six independent Non-Executive Directors plus a Non-Executive Chair. The Board of Directors is responsible for a range of matters including the operational performance of the Trust, the definition and implementation of strategy and for ensuring that its obligations to regulators and stakeholders are met. The Board of Directors reserves some decisions for itself but delegates the remaining discharge of its responsibilities under a formal Scheme of Delegation.

The Board of Directors has established a committee structure that compromises of three sub-committees of the Board (Audit, Strategy and Policy Development and Joint Nomination/Remuneration). Each sub-committee has a responsibility for the delivery of aspects of the Board's remit under delegated authority and recommendations are made to the Board of Directors on areas of specialisation. Each sub-committee has clear written terms of reference that are refreshed and approved on an annual basis to ensure the effective discharge of duties. Details of the work and membership of these committees can be found from page 76.

Following a review of information flows to and from the Board it became apparent that the requirement for the Cost and Resource Effectiveness Committee was no longer needed. At the formal Board of Directors meeting in October 2013 the Board of Directors approved the disestablishment of this sub-committee. All actions were closed off and a proposed execution of reporting produced to ensure functions detailed in the terms of reference were undertaken elsewhere in the governance structure.

Role descriptions for each of the key roles of Chair, Chief Executive, Non-Executive Director and Senior Independent Director are in place and provide clarity of role and purpose. All of the Directors on the Board meet the 'fit and proper' persons test as

described in the Monitor provider licence. Two of the Directors on the Board are appointed Directors on the Board of Red Rose Corporate Services LLP, a joint venture with Ryhurst. Another member of the Board of Directors is an appointed Director to the Board of the North West Coast Academic Science Health Network. More information around this can be found on page 9. These posts are non-remunerated and represent the Trust in those ventures. 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.

The Board of Directors meets on a quarterly basis to formally transact its business in accordance with an agreed agenda setting process and an annual cycle of business which ensures that standard items of accountability and assurance are addressed but also that sufficient time is set aside to focus on quality and appropriate strategic development. The Board of Directors has introduced a standard 'Quality Improvement' agenda item and welcomes clinical staff to share their experiences of good improvements being made across the organisation but also areas that require support to make necessary improvements and ensure the highest possible standard of care is provided.

Board meetings are held in public unless restrictions under the Freedom of Information Act 2002 require discussions to take place privately. This is detailed on the Boards agendas which are published on the Trust's internet site one week prior to the meeting and circulated to its Council of Governors. Papers are issued to Board members seven days in advance of the meeting and are made available on the internet following each Board meeting. Unconfirmed minutes of the Board meetings are circulated to the Council of Governors as soon as practically possible following each meeting. At the request of the Chief Executive and with the consent of the Chair, members of the senior management team attend Board meetings where necessary in order to help inform debate and discussion. Governors have a standing invitation to each formal Board meeting to observe the work of the Board of Directors.

Regular informal briefings and presentations on specific topics or services are provided outside of the formal Board meetings at the Strategy and Policy Development Committee to explore in more depth complex issues in preparation for discussion at future Board meetings.

The Board of Directors as a whole agrees and sets the performance monitoring regime on the advice and recommendation of the Chief Executive. Non-Executive Directors have a duty to exercise appropriate constructive challenge against the performance of the Executives in meeting agreed objectives and receive regular assurance reports, including strategic, financial, operational and clinical performance and compliance, to allow them to discharge that duty. A Board level Balanced Scorecard is currently being developed to enhance the measurement of organisational performance at a strategic level. Indicators and measures for six priority domains have been identified and these are mapped to the Executive Performance Dashboard. The completion of this work in 2014/15 will provide the Board of Directors with the access and opportunity to electronically monitor key

aspects of Trust performance 'Ward to Board', and most cases on a real time basis. This will provide a greater transparency than currently available through paper based reporting.

The Trust has introduced standard operating guidance and corporate branding for all meetings that form part of the formal governance structure.

The Board of Directors gives clear direction in relation to its information requirements necessary to facilitate proper and robust discussions to reach informed and strategic decisions. Decisions made by the Board of Directors are tracked and the execution of those decisions monitored at each meeting. The Board of Directors agrees and tracks actions to ensure completion and close out.

The Board of Directors reports to a range of regulatory bodies as required on relevant performance and compliance matters and in the prescribed form. The Board of Directors meets its reporting requirements under the Monitor Risk Assessment Framework and provides notifications under that regime on a quarterly basis. The Board of Directors is responsible for ensuring compliance with its licence, its constitution, mandatory guidance issued by Monitor and other relevant statutory requirements. A Board Assurance Framework has been developed to identify the potential risks to achieving that compliance and provides the Board with a framework of assurance to mitigate those risks. The Board reviews evidence of assurance received against that framework on a quarterly basis.

The Board of Directors sets the Trust's strategic priorities on an annual basis. The risks to the operational delivery of those priorities are again monitored by the Board of Directors through the Board Assurance Framework and the Executive Risk Register.

A Risk Management Strategy has been agreed and operational risk management processes are embedded throughout the organisation. The level and nature of operational risk information that should be subject to Board scrutiny has been determined by the Board of Directors within its Risk Appetite Statement and the Board receives regular updates on the status of those risks. The strategy contains an escalation process for the rapid identification and reporting to the Board of emerging risks or concerns around risk mitigation.

The Board of Directors has overall responsibility for providing leadership of the Trust and endeavours to ensure that it represents a balanced and understandable view of the Trust's position and prospects in all of its communications and publications to regulators and stakeholders.

All members of the Board receive induction training on joining the Trust and undertake a personal induction programme during the first 12 months of appointment. Board members are also encouraged to attend relevant external training, briefing seminars and networking events relevant to their role.

The Board continues to review the effectiveness of its processes in the light of experience as an Foundation Trust and has undertaken a number of board development sessions in the year as part of a fundamental review of its own effectiveness and efficiency. In addition, the Board of Directors has commissioned two pieces of work to help inform its understanding of its effectiveness in the area of Quality Governance. A number of recommendations were made which have been incorporated into the Trust's forward plan of continuous improvement on Board governance. An external independent assessment aligned to the Board leadership and governance framework produced by Monitor has taken place during 2013/14. The assessment will review the effectiveness of the Board of Directors and the outcome will be reported during quarter one of 2014/15. The next externally facilitated evaluation will be in 2016/17. The Board continues to progress a culture of continuous improvement in its process and operation. During the year it instigated reviews of the effectiveness of the governance structure, the Accountability Framework and the Decision Rights Framework. The outcome of these reviews was reported to the Board of Directors.

All new developments that might affect the Trust's financial or service performance or reputation are brought to the attention of the Council of Governors and Monitor in accordance with the Risk Assessment Framework as appropriate. Whilst not a significant transaction requiring formal report, it is worth noting that the Trust now hosts the North West Coast Academic Science Health Network. This was approved by the Board of Directors following careful consideration and an in depth report detailing the governance arrangements.

During the period there were no matters that the Board or the Council of Governors considered should be brought to the attention of the public that had an overall detrimental impact on the Trust's financial or performance position.

4.3 Appointments to the Board of Directors

Lancashire Care NHS Foundation Trust Board of Directors can be found on page 70.

All Non-Executive Directors, including the Chair, serve for a defined and renewable term of office. Following the resignation of two Non-Executive Directors during the reporting period, one of whom was the Chair, an in depth review of the Board's skills, experience and the continuing independence of the Non-Executive Directors took place with the Council of Governors Joint Nomination/Remuneration Committee and Lead Governor. Governors reviewed the process for recruitment and appointment of Non-Executive Directors and the Chair of the Trust. Job descriptions and person specifications for both roles were also reviewed and refreshed. The importance of independent challenge from Non-Executive Directors on the Board was acknowledged by the Governors who had raised concerns around the potential risks of knowledge gaps because of a higher than planned turnover of Non-Executive Directors in the period. The Council of Governors Joint Nomination/Remuneration Committee had previously recognised the need to ensure continuity of knowledge and organisational memory within the Non-Executive Director community of the Board. The further loss of key skills and knowledge occasioned by the planned retirement of Non-Executive Director, Derek Brown (Deputy Chair) and Teresa

Whittaker (Chair of Audit Committee) who would have both reached the end of their second and final term of office was taken into account. Previous attempts to secure the required relevant and recent financial background necessary to replace the Chair of Audit Committee had been disappointing. On this basis the Council of Governors Joint Nomination/Remuneration Committee recommended to the full Council the extension of Teresa Whittaker's terms of office for a period of up to two years and appointed Derek Brown as Chair of the Trust for the remaining unserved period left by the previous Chair. Governors were assured about the ongoing independence of both Non-Executive Directors on re-appointment and noted that both appointments would be subject to annual re-appointment. The full Council approved these extensions on the basis of exceptional circumstances. The post of Deputy Chair was combined with the Senior Independent Director post and is held by Non-Executive Director, Peter Ballard. This subsequently left two vacant Non-Executive Director posts. Following a skill set review and the formal recruitment process two new Non-Executive Directors have been appointed, Naseem Malik and Louise Dickinson. Louise has been appointed as designate Chair of Audit Committee and will shadow the current Chair of Audit Committee until it is deemed appropriate for Teresa Whittaker to step down. The Board of Directors alongside the Council of Governors Joint Nomination/Remuneration Committee continues to consider and monitor the skills and experience of the Board and clear succession planning is in place and is reviewed regularly. The term of office of Non-Executive Director, Chris Heginbotham is due to expire at the end of August 2014 and as a result the Trust is currently recruiting for a Non-Executive Director with relevant and recent clinical experience.

The Council of Governors Governance Handbook details the accountability framework for the discharge of Council of Governors statutory duties, the procedures for the discharge of those responsibilities and the terms of reference for all committees. During the reporting year an extensive review of the Governance Handbook took place and was approved by the Council of Governors in June 2013. The handbook includes arrangements for the appointment, evaluation and remuneration of the Chair and Non-Executive Directors.

A formal appraisal process for the evaluation of the performance of the Chair, Chief Executive and Non-Executive Directors has been reviewed and approved during 2013/14 by the Council of Governors which is closely aligned to the organisation's values. Objectives for each Director are set as part of the performance appraisal process and a personal development plan for each Director is agreed on an annual basis.

The Board of Directors has established a Joint Nomination/Remuneration Committee to determine the pay and conditions of service for the Executive Directors including the Chief Executive. In setting the level of remuneration, consideration is given to the market position of the Trust and its ability to attract and retain the calibre of individuals needed in these key leadership roles. This is achieved by reference to a range of comparator materials including internal pay scales and awards and externally commissioned market and sector benchmarking information. A small element of the executive remuneration package is directly linked to the achievement of personal and organisational performance.

2013/14 has seen three new appointments to the Executive Management Team. Craig Barratt joined the Trust on 27 August 2013 as the Executive Director of Workforce, Innovation and Transformation. Colin Dugdale became the Acting Director of Nursing following the resignation of Hazel Richard. Denise Roach took the permanent Director of Nursing role on 30 December 2013. Sue Moore joined the Trust on 10 February 2014 taking over from the interim Chief Operating Officer, Jon Tomlinson who had been in post since 2 September 2013 following the promotion to Chief Executive and subsequent resignation of Mark Hindle. Dates of appointment can be seen on page 76.

4.4 The Chair

The Chair of the Board of Directors was appointed on 26 June 2013 and met the independence criteria set out in the Monitor Code of Governance. He also chairs the Council of Governors and provides the link between the two bodies. The responsibilities of the Chair are set out in the Constitution and a clear role description and person specification has been agreed by the Council of Governors.

The Board of Directors meets regularly with the Council of Governors to ensure they work together effectively and promote clear communication. The Chief Executive, Senior Independent Director and Company Secretary have particular roles in the management of the relationship between the two bodies and have a standing invitation to attend Council of Governors meetings. The Chief Executive holds informal briefing sessions with Governors on a regular basis.

The Council of Governors has a duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. This includes providing feedback as part of the annual appraisal process. To allow for more informed feedback the Chair invited each Non-Executive Director to present on their area of expertise and individual contribution to the work of the Board of Directors.

The Chair sets and agrees the agenda for the Board of Directors and Council of Governors on the advice of the Chief Executive and the Company Secretary; members of both have the opportunity to suggest agenda items for inclusion through the Chair and the Lead Governor in the case of the Council of Governors. The Chair through the Company Secretary is responsible for producing minutes of all meetings of the Board, the Council of Governors and their sub-committees.

The Trust publishes an Annual Plan which contains details of its vision, strategy and priorities. The Council of Governors have a number of opportunities to contribute and input to elements of the development of the Annual Plan and are kept informed of its progress through an iterative process and this is formally scheduled into the Annual Cycle of Business. The Trust engages with stakeholders through its governors and members and through other partnerships. Membership conferences take place to engage members and wider stakeholders in the development of Trust plans.

The Trust holds an Annual Members Meeting and the majority of the Board of Director attend. The Trust's Annual Report and Accounts are presented along with the auditors report.

In the event of a vote being necessary the Chair carries a casting vote.

4.5 Meet the Board of Directors

Membership of the Board of Directors at 31 March 2014 was:

Chair: Derek Brown

Derek served as a Royal Air Force Officer and pilot for 14 years until joining BAE Systems. He spent 14 of his 28 years with the Company overseas directing and managing large scale programmes for customers. These included delivery of design and construction projects and running a flying training academy. On his return to the UK he was appointed Director New Programmes in which role he developed, contracted, managed and delivered high value projects. He retired in 2007 and joined the Trust in November of that year.

Executive Directors

Chief Executive: Heather Tierney-Moore

Professor Heather Tierney-Moore OBE joined the Trust in January 2009 with a background in nursing, a distinguished track record of achievement in the NHS at board and national level in England and Scotland. She has an MSc in Managing Change and is a visiting professor at Edinburgh Napier University.

Over the past twelve months she has focused on the delivery of high quality integrated services. Working with partners across the health and social care economy. She has recruited and developed a high calibre Executive team and overseen enhancements in an open and transparent culture, quality, governance and assurance across the organisation following the Francis & Berwick reports.

Medical Director: Max Marshall

Max Marshall has been the Trust's Medical Director since it was established in 2002. He is currently an honorary professor of community psychiatry at the University of Manchester.

Over the last 12 months he has concentrated on improving safety and effectiveness, and in delivering the Trust's quality and innovation strategies. In his role as Responsible Officer for medical revalidation, Max has led in the development and

implementation of a systematic process to support revalidation and appraisal of Trust doctors. He was responsible for the launch of the Trust charter for Primary Care and has been working to improve the Trust relationships with local General Practitioners.

Since February 2014, Max became the full time Medical Director of the Trust taking responsibility for: research, clinical audit, Caldicott issues, revalidation and appraisal, Making Every Contact Count (the Trust public health initiative), medical education, and the Blueprint for adult mental health services, whilst continuing his focus on quality.

Acting Director of Finance: Dominic McKenna

Dominic assumed Acting Director of Finance status from early February 2014. The position includes responsibility for the Trusts Property and Health Informatics functions.

Dominic has been the Trust's Financial Management Director since May 2012, with additional responsibility for Contracts and was Assistant Director of Finance prior to that. Previous experience for the Trust has been gained from being part of the team which established the Trust and was also heavily involved in the Trust assuming Foundation status and the Transforming Community Services project. Prior to Lancashire Care, Dominic was employed by Guild Community Healthcare having entered the NHS as a Regional Trainee. He is a member of the Chartered Institute of Public Finance Accountants (CPFA).

Director of Workforce, Transformation and Innovation: Craig Barratt

Craig joined the Trust from global consulting firm AT Kearney where as part of the Organisation & Transformation practice he worked with healthcare leaders in the UK and abroad to answer the most difficult questions they face and support them to deliver the change required. Between 2008 and 2012 he was one of the two founding Directors of the Healthcare Advisory Practice at BDO, the world's 5th largest professional services firm.

Prior to building the BDO Healthcare Advisory Practice Craig had worked in healthcare consultancy since 2003, firstly as a healthcare consultant with Tribal and latterly as an Assistant Director with Ernst & Young. He began his career as an NHS Financial Management Trainee in 1998 and held a variety of NHS financial management posts. When leaving the NHS over 10 years ago he held the post of Assistant Director of Finance at a £350m acute healthcare Trust in Kent.

Craig graduated with an LLB in law from Lancaster University,

subsequently gaining a certificate in legal practice from Chester College of Law. He is a member of the Chartered Institute of Public Finance Accountants (CPFA) and holds a postgraduate certificate in Project Management.

Director of Nursing, Quality and Governance: Dee Roach

Dee Roach was appointed as Director of Nursing at the Trust in January 2014 after working as the Executive Director of Quality, Improvement and Patient Experience at Birmingham and Solihull Mental Health NHS Foundation Trust. During her four years at the Trust Dee led on the development and implementation of nursing strategy, the development of nursing care metrics across mental health services and strategies for service user involvement and experience, Recovery, Carers. Dee had previously worked in Lancashire in a number of senior clinical and operational management roles across inpatient and community settings. Prior to her first Executive post in Birmingham Dee was the Deputy Director of Nursing for Lancashire Care.

As a mental health nurse by background, at the forefront of Dee's work is an enthusiasm for improving quality and passion for ensuring the best patient experience. Dee also has an exceptional track record of developing strong nursing leaders within organisations. In her role, Dee is responsible for professional leadership, clinical governance, patient safety and service user and carer involvement. She is passionate and committed to about improving outcomes, exceeding standards and delivering compassionate care.

Chief Operating Officer: Sue Moore

Sue Moore joined the Trust as Chief Operating officer in February 2014, prior to this she worked for the Heart of England NHS FT as Managing Director of Good Hope Hospital in Sutton Coldfield, West Midlands. A particular highlight in this role was the development of the Collaborative Care Programme, which comprises of multiple agency providers who all support the patients on a frailty pathway in and out of hospital. Sue has also commissioned several commercial partnerships including the innovative Healthcare at Home collaboration, which delivered early supported discharge from hospital for patients in orthopaedics, vascular and acute medicine. Recently this has also expanded to include a partnership with a housing association to provide elderly transitional care, post discharge from the acute inpatient setting.

Sue joined the NHS in 1989, having qualified as both a therapy

and diagnostic radiographer. She worked in a variety of hospitals in the East Midlands before relocating to Hampshire to become Head of Radiotherapy in 2003. In 2007 Sue became Divisional Director of Operations at Southampton University Hospital Trust, with responsibility for regional trauma and orthopaedics, neurosciences, cardiovascular and thoracics.

Non-Executive Directors

Senior Independent Director and Deputy Chair: Peter Ballard

Peter has a long history of developing partnerships with Local Authorities, Statutory Bodies, Regional and Central Government Departments and many of the newer private sector service providers. He has supported charities, and not for profit companies, in establishing links with major consulting and contracting company's links which have provided them with professional support and services which otherwise would be beyond their means.

He is currently Chief Executive of DBE Services a company founded to deliver high quality bespoke services to public bodies on a not for profit basis. The company has doubled its turnover in each of the last four years.

He has focused in the last year on the transfer and integration of community services into the Trust and developing new partnership opportunities.

He holds a number of local and national trusteeships and non-executive roles. He has recently been appointed as the national treasurer of a large education charity.

Gwynne Furlong

Gwynne has over 40 years' experience as a qualified professional in business, involved primarily in the commercial property industry. He has been a partner in professional practice and has been a director and MD of both private and publically listed companies. Gwynne's last post prior to retiring in 2008 was as a director within the Asset Management division of Close Brothers Plc. Merchant Bank.

Gwynne is also a Non-Executive Director with two north-west based Housing Associations one of which specialises in providing independent living for the disabled and people with learning difficulties.

Gwynne is a Trustee of a locally based charity providing

opportunities for the local community to become involved in Art, Dance, Music and Drama, and he has recently taken over as part time CEO of the national charity Regain which specialises in helping those who have become paralysed/tetraplegic through sporting accidents.

Teresa Whittaker

Teresa has over 30 years of industry experience, primarily in the complex, highly regulated nuclear sector. Her experience at board and senior executive level in industry has given her extensive knowledge of internal control, risk management and corporate governance, as well as acquisition integration and change management.

Over the past year Teresa has continued to support the organisation in the further development of the risk management approach and of the management systems in general, to ensure they fully reflect the enlarged organisation.

Teresa is the Chair of the Trust's Audit Committee.

Chris Heginbotham

Chris Heginbotham is Emeritus Professor of Mental Health Policy and Management at the University of Central Lancashire and Visiting Professor at the University of Cumbria. He is also a Director of Values Based Commissioning Ltd. Working in the field of health and social care for most of his career, Chris has been Chief Executive of both mental health and acute trusts, in addition to leading the National Association for Mental Health (Mind) for much of the 1980s. Later, he was Chief Executive of the Mental Health Act Commission from 2003 to 2008. He has a strong commitment to service user and carer engagement, chairs the Mental Health Act Manager's Forum and the Mental Health Act/Mental Capacity Act Committee, and is a member of the Trust's Audit Committee.

Naseem Malik

Naseem began her public sector career as a solicitor in Local Government. In 2003 she was appointed a founding Commissioner for the Independent Police Complaints Commission, responsible for the North West region, a position she held for ten years. Naseem has previously held a Non-Executive Director role at Blackburn with Darwen PCT. She brings a wealth of experience from the public sector. Naseem no longer practices as a solicitor.

Louise Dickinson

Louise is a Fellow of the Institute of Chartered Accountants in England & Wales. She worked in professional services for 16 years, initially with Ernst & Young in London and Sydney, in audit and corporate finance, and then as a Corporate Finance Partner with Grant Thornton in the North West. During this period, she advised clients in both the public and private sectors on strategy and business planning and implementation, including acting as lead external adviser on a wide range of corporate transactions. Since leaving Grant Thornton in 2004, Louise has undertaken a number of board level executive roles in the financial services industry with key leadership responsibilities in Finance, Commercial and Supply Chain, Business Intelligence and Risk Management. She has considerable experience at successfully managing and delivering complex change programmes in highly regulated environments.

** A number of individuals held interim of permanent posts as members of the Board during the year and details of their terms of appointment can be seen on table below

Attendance at Board of Director Meetings and Sub-Committees
01 April 2013 – 31 March 2014

Board Member	Term of Appointment	Trust Board	Audit Committee	Strategy & Policy Development Committee	Nomination/ Remuneration Committee
		Attendance (actual/max)			
Non-Executive Directors					
Derek Brown	01/10/06 – 31/03/16	7/7	3/3	3/3	5/5
Peter Ballard	01/06/09–31/05/15	7/7		3/3	5/5
Teresa Whittaker	01/10/06 – 30/09/15	6/7	6/6	3/3	5/5
Chris Heginbotham	01/09/08 – 31/08/14	7/7	6/6	2/3	4/5
Gwynne Furlong	01/10/12 – 31/08/15	7/7	3/3	3/3	5/5
Naseem Malik	29/10/13 - 31/10/16	1/1		1/1	1/2
Louise Dickinson	29/10/13 – 31/10/16	1/1	1/1	1/1	1/2
Steve Jones *(resigned from the Trust)*	01/04/10 – 31/05/13	2/3			
James Taylor *(resigned from the Trust)*	01/10/12 – 31/07/13	4/4	3/4		1/1
Executive Directors					
Heather Tierney-Moore		7/7	4/6	3/3	4/5
Max Marshall		6/7	3/6	3/3	
Craig Barratt	*(in post 27/08/13)*	2/3	1/1	3/3	
Dominic McKenna	*(in post 06/03/14)*			1/1	
Dee Roach	*(in post 01/02/14)*	2/2		1/1	
Sue Moore	*(in post 10/02/14)*			1/1	
Mark Hindle	*(left the Trust 20/09/13)*	4/4	1/1	1/1	
Colin Dugdale	*(end of post 31/01/14)*	6/6	1/2	1/2	
Hazel Richards	*(resigned 31/08/13)*	0/1			
Dave Tomlinson	*(left the Trust 23/04/14)*	7/7	6/6	2/3	

4.6 Sub-Committees of the Board of Directors

The Board of Directors has established the following sub-committees:

- Audit Committee
- Strategy and Policy Development Committee
- Joint Nomination/Remuneration Committee

Strategy and Policy Development Committee

The Strategy and Policy Development Committee has been established by the Board of Directors to help facilitate informed decision making at formal Board meetings. It provides an opportunity for Board members to review outline plans and contribute to their development at an early stage and explore complex issues in more depth.

Nomination and Remuneration Committee

The Board of Directors Joint Nomination/Remuneration Committee is constituted as a standing sub-committee of the Board of Directors. It is responsible for identifying and appointing candidates to fill Executive Director positions on the Board of Directors and for determining their remuneration and other conditions of service.

Audit Committee

The Audit Committee is responsible on behalf of the Board of Directors for independently reviewing the systems of governance, control, risk management and assurance. The Committee's activities cover the whole of the organisations governance agenda, not just finance.

The Audit Committee membership consists of four Non-Executive Directors and attendance can been seen on page 76. The Chief Executive and Director of Finance have a standing invitation to attend all meetings and in addition members of the senior management team, internal auditors, external auditors and Local Counter Fraud attend as appropriate to the agenda.

The Audit Committee is required to report annually to the Board of Directors and to the Council of Governors outlining the work it has undertaken during the year and where necessary highlight any areas of concern. The latest Annual Report of the Audit Committee can be viewed on the Trust's website. The Board of Directors also receives copies of Audit Committee minutes following each meeting and these can be viewed within the Board packs published on the Trust's website.

Throughout 2013/14 the Committee reported on the nature and outcomes of its work to the Board of Directors highlighting any areas that should be brought to its attention.

There were no significant issues raised by the Committee to the Board of Directors or the Council of Governors during the year. However, an area of concern was raised during the last quarter of the reporting period and due to its potential to impact on the year end process, the Audit Committee Chair commissioned a review of the control environment regarding this specific transaction, further testing of similar transactions and associated activity. The Trust's Internal Auditors were appointed to carry out the review, and have since reported their findings. The Trust's External Auditors were kept informed throughout. Some immediate corrective actions were put in place, and the Audit Committee Chair confirmed that the control failings identified were limited to non-core business and did not have a material impact on the financial results or the quality of care provided. Management plan to carry out an in depth review producing a corrective action plan, the implementation of which will be monitored by the Audit Committee on behalf of the Board of Directors.

Other key development themes featured at meetings were:

- Ensuring that the audit arrangements are sufficient to meet the future requirements of the Trust, particularly in respect of quality and capital programmes;
- The further development of risk management and assurance framework;
- The development and application of change controls specifically HR functions;
- Robustness of data quality;
- Development of local management systems as a first line of assurance and general strengthening of the control environment;
- Changes to regulator environment and compliance;
- The development of 'deep-dive' Network audits;
- Governance arrangements for novel business;
- Asset management;
- The development of Value for Money reporting;
- The on-going monitoring of the implementation of improvement actions.

The Audit Committee takes a holistic approach in discharging its accountability in relation to the Annual Report and Financial Statements and the Quality Account. Holistic in that its scope is across the whole of the system of risk and internal control, with a focus on clinical systems and quality as well as the traditional domains of finance and business systems.

Holistic also, in that the Trust aims to create the right environment which ensures for example, that we consider emerging regulatory requirements and best practice in order to ensure that the scope of work is appropriate, that enough time is planned to consider issues appropriately, and that support and training is made available to committee members.

The Trust aims to create an environment where employees feel it is safe to raise and discuss concerns and weaknesses openly so that the appropriate action plans can be established and monitored through to implementation. The Audit Committee reviews the system for raising concerns as part of its normal cycle of business. During 2013/14 an independent review of the arrangements was commissioned by the Chief Executive. This was tied into the wider Trust reviews following the publication of the Francis and Keogh reports. The results of that review were considered by the Board and therefore, this work has not been duplicated at the Audit Committee. However, an update will be reported to Board during 2014, and the implementation of any resulting action plans will be monitored by the Committee.

Audit Committee encourages frank, open and regular dialogue with the Trust's internal and external audit teams. A risk based approach runs throughout all the planning activity.

Throughout the year the Committee receives received reports from the internal audit, clinical audit and the external audit teams on both their audit findings, and updates

on action implementation. Additional reports are received from our Network and Clinical Directors, the Finance Directorate and other contributors as required. The Committee has continued to promote the importance of the clinical audit function as a key element of the Trust's quality improvement activity. We have been pleased to receive, in addition to the results of the clinical audit work, regular updates on the clinical audit development plan.

The Audit Committee Chair has undertaken a number of activities outside of the formal meetings on matters relating to Committee and these are reported in the Annual Report of the Audit Committee.

The Audit Committee is required to demonstrate how it has tested the robustness of the financial statements, operations and compliance. Examples of specific activity that the Audit Committee has undertaken to facilitate an informed identification, review and assessment of significant issues to the 2013/14 annual report include:

- The Director of Finance is required to bring to the attention of the Committee, on an ongoing basis, any changes to accounting policy, significant financial reporting issues, estimates and judgements, or significant transactions.
- At the start of the year external audit provide their view on the risk profile and areas of focus in its audit planning, and updates the Committee on an ongoing basis. The key risks identified that might impact the financial statements included:
    - Use of resources;
    - Quality Account;
    - Financial pressures;
    - Changing commissioning arrangements;
    - New regulatory requirements;
    - Local commissioner intension;
    - Transformation programme;
    - Capital developments;
    - Information systems.
- The Audit Committee identified risks relating to data quality, procurement process and contracting for novel business that emerged from reports provided to Audit Committee during the year.
- Additional independent reviews and testing were undertaken to assess the extent and potential impact of issues those issues. This work is complete and has concluded that there was no significant impact on the Trust's financial position or the quality of care provided.
- A technical update session was delivered by the External Auditor on 22 April 2014. It was open to all Non-Executive Directors and was well attended. The External Auditors provided their updated view on the risk based audit approach & their key areas of focus in the year end audit, enabling the Non-Executive Directors to ask questions and seek advice as necessary.
- The production of the Quality Account is supported by the attendance of a Non-Executive Director (Audit Committee Chair) at the Executive Quality Committee to provide oversight on behalf of the Board of Directors.

- The draft Annual Report, Financial Statements and Quality Account were tabled for the 30 April 2014 Committee meeting and in good time to ask questions and seek advice on any issues. A number of additional questions were submitted to management in writing after the meeting that were subsequently addressed in the Director of Finance report at the 21 May 2014 meeting. Key areas of enquiry were:
    - Carrying values of fixed assets, the basis of valuation and how we have satisfied ourselves that there are no impairments;
    - Nature and basis of provisions, judgements exercised and professional advice sought were relevant;
    - Security of cash deposits and associated risks;
    - Debtor write-offs including the potential for bad debts arising out of recent control issues.
- The Committee is also required to review the report and financial statements in the round to provide a consistency and reasonableness check. Some minor changes were made as a result of this process.
- The Audit Committee Chair has reviewed a more detailed balance sheet in order to form her own view of any areas requiring further enquiry.
- The Director of Finance provided a detailed variance analysis between 2012/13 and 2013/14 accounts and 2013/14 plan to actual out-turn, this enabled the Committee members to carry out a high level review and triangulate this against other sources of information, to ensure that all items of a significant nature had been captured and discussed.
- The Director of Finance provided a detailed report to the committee on 21 May 2014, confirming all previous verbal representations on areas of estimate and judgement, and provided further information on the basis of estimates and key sensitivities, including responses to specific enquires made by Audit Committee members. The Committee reviewed the key judgements applied by management in assessing asset carrying values, provisions, debtors and cash deposits.
- The Committee checked that the results presented are consistent with the figures reported to Monitor in year.
- The Committee considered the Head of Internal Audit opinion that provided overall substantial assurance.
- The Committee considered the External Auditors ISA260 report and unqualified audit opinion. No differences of opinion with the key management judgements were highlighted.

From its work the Audit Committee was able to conclude that:

- The Annual Report and Financial Statements represent a fair and reasonable view of the Trust's financial position.
- There were no significant or unusual transactions in the year.
- The Committee is sighted on the accounting treatment of the joint venture with Red Rose Corporate Services, and the integration of the Academic Health Science Network as they will become more significant in due course.

- There were no accounting policy changes as such, but the committee noted the change in method of calculation required for Public Dividend Capital dividends, which did not have a significant impact on the Trusts financial statements.
- A prudent approach has been taken to provisioning in line with the Trust's accounting policy. There is one notable provision of £1.5M for a potential VAT liability. Other provisions were reviewed and noted. We are satisfied that appropriate external advice was sought where necessary.
- Assets values are fair and reasonable.

Internal Audit

The Trust's internal audit function is performed by Deloitte LLP who was appointed by the Council of Governors in 2010 for a term of three years. The annual audit plan is risk based and is part of a three-year programme. The plan is designed to complement and support the work performed by the external auditors and is approved by the Audit Committee. A report is taken to every Audit Committee meeting detailing progress against the plan and drawing attention to any concerns. The internal auditors have the opportunity to meet with Audit Committee members in private (without executives present) to discuss any concerns relating to the performance of management.

This work is detailed in the Audit Committee Annual Report which is presented to the Council of Governors by the Chair of Audit Committee.

In 2013 the contract for supply of Internal Audit services by Deloitte LLP was extended for a further 2 years in line with tender provisions following a review of performance by the Audit Committee.

External Audit

The contract for external audit services was awarded to KPMG LLP effective from 1 April 2010 following a rigorous competitive tendering process. The contract was awarded for three years with an option to extend for a further two. Trust Board members carried out a review of the performance and effectiveness of its auditor after three years, and following consultations with key stakeholders, including the Council of Governors, the decision was taken to extend for a further two years. The contract is due for an open tender process again in 2015, and the procurement process will begin in the near future.

A declaration of auditor independence and objectively is provided to the Committee on an annual basis, and as part of the tendering process the Trust tests how the professional firms manage this process internally.

There are clear policy guidelines in place around the provision of non-audit services by the External Auditor. Additional work has been commissioned from the External Auditors during the year and there are safeguards in place that ensure that the Committee are kept informed of the scope and value of such work. The additional

work in year related to a review of data quality at a cost of £21,000 plus VAT. The Committee is satisfied that no conflicts of interest will arise as a result of this work.

The Committee has reviewed the work of external audit and is satisfied that the external audit service is of a sufficiently high standard and that fees are appropriate and reasonable. The external audit fees for 2013/14 were £74,179.

The External Auditor attends a Council of Governor meeting following the production of the Annual Report and Financial Statements to ensure Governors are assured by the process undertaken to audit the accounts. They also attend the Annual Members Meeting.

Local Counter Fraud

Local Counter Fraud services were provided by Deloitte LLP during 2013/14.

The role of the Local Counter Fraud Service assists in creating an antifraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud.

The Audit Committee receives regular progress reports from the Local Counter Fraud Service during the course of the year and also receives an annual report.

4.7 Council of Governors

The Council of Governors is a statutory part of an NHS Foundation Trust governance structure, whose role is to hold the Non-Executive Directors of the Board to account for the performance of the Trust Board and to represent the interests and views of the Trust's members and partner organisations in the governance of the Trust. The Trust is accountable to members via the Council of Governors.

Members of the Trust, both public and staff, are able to stand as a Governor candidate in order to be elected onto the Council by the members, providing they are 16 years of age and are resident in the constituency for which they are standing. The Council also includes appointed representatives from partner organisations and stakeholders from the local area to ensure a representation of views from the community.

The Council of Governors meet formally in public four times per year and six times informally with the Trust's Board of Directors to facilitate meaningful engagement, listening and to exercise the responsibility to hold the Non-Executive Directors to account for the performance of the Trust. The Chair of the Council of Governors is also the Chair of the Trust Board.

With the introduction of the Health and Social Care Act in 2012 a number of new Governor duties have come into force during the year. The additional responsibilities for NHS Foundation Trust Governors are as follows;

- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors
- Represent the interests of the members of the Trust as a whole and the interests of the public
- Approve significant transactions
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Decide whether the Trust's non-NHS work would significantly interfere with its principle purpose
- Approve amendments to the Trust's Constitution

Governors are supported in discharging these responsibilities through a comprehensive training programme delivered by the Trust, with opportunities for bespoke training around specialist areas such as Chairperson Skills, Peer Mentoring and Effective Questioning & Challenge. Opportunities for external training and networking are also provided to Governors. Governors have been integral in developing a new format of informal discussion meetings to build positive Non-Executive Director and Governor relationships with a focus around holding to account.

The work of the Council of Governors is supported by the Lead Governor, whose role includes liaison with Monitor on issues or concerns related to the Trust where it would be inappropriate to contact the Chair or Senior Independent Director. The Trust has chosen to expand the role of the Lead Governor to promote Governor involvement in Non-Executive Director appraisals and together with the Chair, leadership of the Council.

During the reporting period the Council of Governors conducted a review of its effectiveness and subsequently approved a three year reduction plan which gradually decreases the number of Governors and promotes high levels of Governor participation and attendance at meetings. The effectiveness review also included realigning the constituencies which Public Governors represent to reflect the geographical footprint of the Clinical Commissioning Groups. Once the full reduction has been achieved, the new breakdown of Governors and constituencies will be as follows:

Area (CCG & Constituency)	Number of Governors
NHS East Lancashire	3 Public Governors
NHS Lancashire North	2 Public Governors
NHS Blackburn with Darwen	1 Public Governor
NHS Blackpool	1 Public Governors
NHS Central Lancashire	3 Public Governor
NHS Lancashire West	1 Public Governor (currently vacant)
Out of Area	1 Public Governor

A key area of work for the Trust is the production of the Annual Plan. Governors input in relation to feeding in the views of the members and local communities is a critical part of the development of the plan. The Governors met informally with Executives and Non-Executive Directors to inform the early stages of the Annual Plan and received progress updates on how their views have been reviewed and incorporated throughout the process. Governors formally received the Annual Plan in May 2014.

Governors can be contacted by emailing membership@lancashirecare.nhs.uk.

Membership of the Council of Governors and Sub-Committees during the reporting period

Governor	Term expires	Council of Governors	Membership Committee	Patient Experience Oversight Group	Standards & Assurance Committee	Remuneration Committee
		Attendance (actual/max)				
Chair						
Derek Brown	31/03/2016	9/9				5/5
Steve Jones (resigned 31/05/13)	31/05/2013	1/1				1/1
East Lancashire						
Catherine Dobson	15/12/2014	10/10			5/7	5/6
Tom Lawman	26/11/2015	9/10			4/7	
Alan Ravenscroft	26/11/2015	10/10		5/5	4/6	6/6
Mike Wedgeworth	26/11/2015	7/10	4/5			
Hilary Whitworth	15/12/2014	7/10		4/5		
North Lancashire						
David Jackson	26/11/2015	6/10		4/5		
John MacLeod	26/11/2015	8/10		4/5		
Christina McKenzie-Townsend	22/04/2013	1/1			1/1	
Blackpool						
Linda Jones	26/11/2015	9/10	5/5			4/6
Andrea Walker	26/11/2013	2/7				
Central Lancashire						
Bill Coulton	02/12/2016	3/3	1/1	1/1	1/1	
Jane Kay	02/09/2013	4/4	1/3			
Frances Maguire	21/04/2013	0/1	0/1			
Mike Marsden	26/11/2015	10/10		5/5		
Selvizhi Subramanian	10/09/2013	1/4	0/3			
Brian Taylor	26/11/2015	9/10	2/5			5/6

Governor	Term expires	Council of Governors	Membership Committee	Patient Experience Oversight Group	Standards & Assurance Committee	Remuneration Committee
		Attendance (actual/max)				
Blackburn with Darwen						
Brian Spencer	02/12/2016	10/10			5/7	
Out of Area						
Tahir Khan	15/12/2014	5/10	1/5			
Staff Governors						
Graham Ash	02/12/2016	8/10			4/7	
Lynne Bax	02/12/2016	2/3		1/1	1/1	
Barbara Hummer	15/12/2014	9/10	4/5			5/6
Caroline Johnson	09/12/2013	5/7		3/4		
Andrew Kirkby	20/02/2014	6/8		3/5		
Paul Morris	02/12/2016	10/10	5/5			
Linda Ravenscroft	02/12/2016	8/10			5/7	
Appointed Governors						
David Jones Making Space	n/a	7/10		1/1		
Nigel Harrison UcLan	n/a	7/10				5/6
Steve Sansbury Lancashire Constabulary	n/a	3/10				
Valerie Wilson Lancashire County Council	02/05/2013	0/1				

4.8 Sub-Committees of the Council of Governors

The Council of Governors have four sub-committees which are used for reviewing specific areas of Trust activity. Using a working group approach Governors are allocated to relevant sub-committees according to areas of interest and expertise;

- Membership & Governance Committee
- Standards and Assurance Committee
- Patient Experience Oversight Group
- Nomination/Remuneration Committee

The purpose of sub-committees is to allow the Council of Governors to delegate specific areas of work to small groups of Governors to receive assurance on behalf of the Council of Governors and if required, make recommendations to the full Council, for example around Non-Executive Director pay or recruitment.

Each committee is made up of Public, Appointed and Staff Governors, and chaired by either a Public or Appointed Governor to ensure independent scrutiny of reports and information.

Each sub-committee reports directly to the full Council of Governors through minutes and key message reports presented by each sub-committee Chair. A Chair's Group also meet prior to each formal Council of Governor meeting to ensure any issues raised by individual Governors are brought to the attention of the Trust Chair for appropriate discussion at the full Council meeting.

4.9 Membership

The membership of Lancashire Care is made up of public and staff members as well as affiliates or stakeholder groups. To become a public member of the Trust you must be at least 14 years of age and live within the North West. Staff members employed by the Trust are automatically entered into the Trust membership. There are some exemptions to becoming a member and these can be found within the Trust Constitution.

Members are encouraged to engage with Trust activities throughout the year and each member receives a bi-annual magazine and invitations to events and conferences. Governors also play a role in engaging with Trust members to discharge their responsibility to represent the views and interests of members. Governors take opportunities to meet with members face-to-face during elections, conferences and in their local communities as well as attending meetings to engage with stakeholder partners too.

4.9.1 Eligibility requirements

The Trust has a public and staff constituency. The public constituency is divided into six voting areas to represent the geographical area served by the Trust.

Public Constituency	Electoral divisions comprising the electoral boroughs, cities or districts as set out in The County of Lancashire (Electoral Changes) Order 2005, The Borough of Blackburn with Darwen (Electoral Changes) Order 2002 and The Borough of Blackpool (Electoral Changes) Order 2002	Minimum number of Members
NHS East Lancashire	Hyndburn, Ribble Valley, Burnley, Pendle and Rossendale	75
NHS Lancashire North	Lancaster, Wyre and Fylde	60
NHS Blackburn with Darwen	Blackburn with Darwen	30
NHS Blackpool	Blackpool	30
NHS Central Lancashire	Preston, Chorley and South Ribble	75
NHS Lancashire West	West Lancashire	30
Out of Area	All electoral divisions within the boundaries of the following counties: Cheshire, Cumbria, Greater Manchester, Halton, Merseyside and Warrington	15

4.9.2 Number of members

As of 31 March 2014, the Trust had a total of 14,263 members.

Area	Public Member	Staff
NHS East Lancashire	1557	-
NHS Lancashire North	1081	-
NHS Blackburn with Darwen	713	-
NHS Blackpool	722	-
NHS Central Lancashire	2225	-
NHS Lancashire West	249	-
Out of Area	1063	-
Medical Staff	-	199
Nursing Professions & Support Staff	-	2350
Other Clinical & Social Care Professionals and Support Staff	-	2486
Corporate Staff	-	1613

The Trust also has schemes for non-voting members drawn from key stakeholders (Affiliate Members) and young people under 14 (Junior Members).

4.9.3 Membership Strategy

The Trust's current membership strategy runs for the period 2013-17. A process of annual incremental revision of the strategy has been introduced to prevent any drift in the implementation of the strategy and to ensure that the strategy is flexible and responsive to changes in the priorities of the Trust and in the wider health economy.

The membership strategy is aligned to the Trust's wider stakeholder engagement strategy and the framework for its implementation is set by six objectives. Taken together, the achievement of these objectives will ensure that the profile of the Trust's membership is representative of the diversity of users of the Trust's services and that there is an increase in the proportion of the membership who are actively engaged in shaping the priorities of the Trust. As examples, in the past year the Trust has re-launched its Junior Associate Membership scheme and has exceeded the target for the recruitment of stakeholder organisations to its affiliate membership category. In terms of engagement, the Trust has hosted two successful membership conferences on wellbeing and, jointly with several commissioner and provider partners, on long term conditions and has recently run a workshop programme with public governors designed to ensure that governors make a clear and valuable contribution to the Trust's overall engagement activity.

4.9.4 Contact procedures for members

Members are encouraged to contact the Trust and local Governors with enquiries or questions about the running of the Trust, or to request further information on how to get involved in schemes such as volunteering, membership panel surveys, conferences and events. The contact details for the Membership Support Office are publicised on the Trust website with a dedicated inbox for member queries, the electronic application form to become a Trust Member can also be found online. Raising the profile of the Trust's Governors has progressed over recent months with an improved website offering members more information about their local Governors and prospective members are also welcome to enquire about getting involved.

4.10 Risk and Control

A Risk Management Policy and process has been agreed and operational risk management processes are embedded in the organisation at all levels. The level and nature of operational risk information that should be subject to Board scrutiny has been determined and the Board receives regular reports on the status of those risks. The policy contains escalation processes for the rapid identification and reporting to the Board of emerging risks or concerns about risk mitigation. The Executive Risk Management Committee reviews the Executive Risk Register on a quarterly basis. The Board of Directors reviewed and refreshed its Risk Appetite Statement during the reporting period.

4.11 Statement of Compliance with the Code of Governance Provisions

Last year the Trust declared compliance with the Monitor Code of Governance and an evidence based statement against each provision was provided to Audit Committee for assurance.

In December 2013, Monitor re-issued the NHS Foundation Trust Code of Governance. The revised code originally applied from 1 April 2014 but has been brought forward to 1 January 2014 and is reflected in this report. The changes include a more prescriptive approach to how the Code is discharged and more granularity around reporting. An evidence based statement against the new code has been fully disclosed and reported to Audit Committee for assurance.

Last year the Board of Directors identified four areas where further attention would improve the governance practice and process:

- Effectiveness of the Council of Governors with plans to reduce the overall number of Governors; strengthen the subcommittee governance structure and realign the constituencies to Clinical Commissioning Group areas
- The Constitution was reviewed and revised in line with the requirements of the Health and Social Care Act 2012 during 2012/13 but a further review and revision will be necessary during 2013/14 following implementation of the above plan regarding changes to Council of Governors
- Implementation of a Balanced Score Card for data reported to Board

- Introduction of standard operating procedures and corporate branding for all meetings that form part of the formal governance structure of the Trust.

All of these areas have been addressed and the outcomes reported in the relevant areas of this disclosure.

In the spirit of continuous improvements three further areas of development will be addressed during 2014/15:

- Progress the recommendations from the effectiveness of the Board of Directors evaluation
- Further embed the changes to the Monitor Code of Governance
- Implementing the first electronic version of the Board level Balanced Scorecard

For 2013/14 the Trust can declared compliance with all of the statutory provision of the Monitor Code of Governance and with all but one provision in the remaining provisions in the code. The Trust is not compliant with the provision B.7.1 that outlines the expectation of Non-Executive Directors not to be appointed for a period for longer than six years. The Council of Governors Nomination/Remuneration Committee gave significant consideration to this area of non-compliance in particular the review of continued independence of the two Non-Executive Directors currently serving over six years. The explanation detailed in the reporting to Monitor highlights the rigorous annual re-appointment process for both Non-Executive Directors currently serving a term longer than six years to ensure the Council of Governors remain satisfied with the decision.

Conversations and reporting to Monitor in relation to this area have taken place and although the Trust is not compliant with the specifics of provision B.7.1 the Trust continues to demonstrate compliance with the spirit of the code provisions in relation to the need for independence of Non-Executive Directors, refreshing of the Board as a whole and a rigour approach to the review of the Board skill mix and the annual re-appointment process. The Trust recognises that this is a temporary position and intends to return to a compliant position in the future.

5. Other disclosures in the public interest

5.1 Action taken by the NHS Foundation Trust to maintain or develop the provision of information, and consultation with, employees

A range of internal communication channels are in place to provide staff with information and the opportunity to feedback on key issues. These include a quarterly staff newsletter, the Chief Executive's monthly team talk, the weekly email bulletin and the intranet, which has been re-launched during the year to provide a new and improved platform for staff to access information. This builds on the successful development of the e-HR portal for staff to access HR information 24/7 and self-serve in relation to straightforward queries. During 2013/14 improvements have been made to internal communication channels following feedback from staff that took part in a communication audit. Staff also receive information through their line managers, team meetings and Engage events.

Engage events are held quarterly for the Trust's top leaders to provide information and a forum to discuss the Trust's strategic plans. A similar event for the Trust's aspiring leaders was launched in 2013/14 to support their development and increase staff engagement.

The Trust's membership strategy provides opportunities for staff, alongside members of the public, to receive information, attend events and take part in surveys as members of the Foundation Trust. More information can be found in section 4.9.3.

The Trust has successfully embraced partnership working with the staff unions. There is a Partnership Forum which meets regularly and represents all staff groups excluding medical staff, who are represented through the Joint Local Negotiating Committee (JLNC). Both committees have a partnership agreement in place. Representatives from the JLNC attend the Partnership Forum to enable effective communication between both groups.

5.2 The NHS Foundation Trust's policies in relation to disabled employees and equal opportunities

The Trust has adopted the Department of Health's Equality Delivery System (EDS) and carried out the first of its regular scrutiny events in 2012. This activity involves Trust services providing evidence to demonstrate inclusion for all diverse groups, including service users and staff with disabilities in terms of equitable access and engagement. In relation to disability, all EDS action plans across the organisation include 'reasonable adjustments' as defined within the Equality Act 2010. The Trust is also committed to ensuring Equality Impact Assessments are carried out on all policies, procedures and other activities strategically. Access Audits are carried out on all new buildings and refurbishments which address access for service users, carers, other visitors and staff.

Further information can be found on page 30.

5.3 Information on Health and Safety Performance and Occupational Health

The Trust continues to promote and develop a maturing safety culture across all areas of the organisation. The emphasis on patient safety continues to focus on transparency and enabling an open learning environment as an essential aspect of improving care. A key component of patient safety is providing a system for comprehensive incident reporting and risk management across the Trust.

Work has been completed to improve the incident reporting system and process including the procurement and roll out of one new Datix system across the whole organisation. The Datix system has been enhanced through new risk modules and enhanced server capacity to provide improved capability. This includes the support of risk data, including health and safety information on team information boards in each clinical area.

This will support the Trust to further enhance its approach to risk assessment and management to assist in sustaining a risk management culture.

The Trust's Occupational Health Service is currently provided by People Asset Management (PAM), with the service specification being closely monitored through bi-monthly contract monitoring meetings. The key performance indicators contained within the contract have regularly been met.

The (Physiotherapy Information Line – PhIL), provided via People Asset Management is a telephone-triage service run by qualified physiotherapists which allows for rapid access to physiotherapy services with immediate interventions for acute conditions. Feedback from this has been very encouraging, with staff reporting positive experiences and earlier than anticipated improvements in medical conditions.

Last year a new Employee Assistance Provider, called PAM Assist was introduced, this is a free confidential life management and personal support service available to staff and their immediate family, with access available 24/7, 365 days a year via a telephone helpline or on-line.

The Trust and PAM, along with PhIL and PAM Assist, continually work together to provide health promotion activities and advice to underpin and complement the Trust's Health and Wellbeing agenda. On an annual basis, PAM provide support to the National Flu campaign and also regularly provide further health promotion and prevention activities.

The Occupational Health contract with PAM ends in June 2014, prior to this a competitive exercise will take place with a series of providers who can be selected from a supplier list to determine which service best suits the Trust's needs. The Trust may select a new supplier or continue the relationship with PAM.

Employees are able to access a range of support for their physical and mental health and wellbeing via the e-HR portal which has been in place for almost a year to enable staff to access information and resources 24/7.

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

The Trust has a Counter Fraud and Corruption Policy in place and as part of this an annual work plan is agreed by the Director or Finance. This covers areas such as creating an antifraud culture, deterring fraud and preventing fraud. The Trust engages the services of a Local Counter Fraud Specialist who attends the Audit Committee to provide updates on the progress of the annual work plan.

5.5 A statement describing the better payment practice code, or any other policy adopted on payment of suppliers, and performance achieved together with disclosure on any interest paid under Late Payment of Commercial Debts (interest) Act 1998

The Better Payment Practice Code (BBPC) requires the Trust to pay all valid non-NHS invoice by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with a supplier.

As a result of the general economic crisis, and at the request of the Prime Minister and Monitor, the Trust now endeavours to pay all smaller non-public sector suppliers within 10 days in order to ease their cash flows.

Legislation is in force which requires Trusts to pay interest to small companies if payment is not made within 30 days (Late Payment of Commercial Debts (interest) Act 1996).

Details of compliance with the above are detailed in note 7 to the accounts.

5.6 Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year

The Trust did not undertake any formal public consultations during 13/14 and there are none planned for the coming year. However, the Trust will continue to engage all of its stakeholders in the development of services and its plans. Section 1.3 provides further information on the nature of such engagement work in year.

5.7 Consultation with local groups and organisations, including the Overview and Scrutiny Committees of local authorities covering the membership areas

The Trust has developed constructive, mature relationships with the three Healthwatch organisations that cover the county through regular communications and positive engagement. Members of the Trust Board have met with Healthwatch Chairs and Chief Executives and dialogue is maintained through Trust representation on operational Healthwatch groups and by providing presentations on aspects of the Trust's work.

The Trust has presented to formal meetings of Overview and Scrutiny Committees when appropriate and has placed increasing emphasis on managing positive informal relationships with OSCs through regular meetings with local authority scrutiny officers and by discussing issues at informal meetings of senior OSC members. Led by the

Trust's Chief Executive, dialogue with local authority colleagues and other partners in the health and social care economy is further maintained through membership of Health and Wellbeing Boards and other groups.

Where appropriate, the Trust has engaged and held conversations with local groups in partnership with other stakeholders including Clinical Commissioning Groups and third sector infrastructure and front line organisations. Such events are both resource efficient and effective in promoting dialogue across organisations as well as between members of the public and organisations.

The Trust is committed to the standards outlined in the GP Charter and recognises that understanding feedback from GPs about their perception of Trust's services is important. Feedback is gained through an annual GP Survey, GP events and visits to practices by Trust staff.

5.8 Any other patient and public involvement activities

Four service user and carer representatives have been recruited by the Trust to play a strategic role in the development of the Trust's Quality Strategy. Two service user and carer representatives sit on the Executive Quality Committee, and two others attend the Service User Experience Group. Their role is to ensure the views and opinions of service users and carers are sought and considered.

The Trust continues to support the use of service user and carer stories and this year has been working with the NHS Leadership Academy. The Trust hosted an event where patients and staff were offered the opportunity to find out about how their experiences of healthcare could help shape the development of future NHS leaders. Several people expressed an interest in sharing their stories on the Professional Leadership Programmes and are progressing this with the NHS Leadership Academy.

The Trust has also been using a series of DVDs from patients and carers as part of its staff induction programme.

A series of events were held throughout the year to listen to the views of patients and carers about the development of the Trust's Dementia Strategy and the management of long term conditions. The Experience and Involvement team have been supporting how feedback from these events is being used to improve the quality of future services.

The Experience and Involvement team has also played a major role in the development of a Trust-wide patient experience questionnaire which has been designed to evaluate the quality of all our services. This has involved providing feedback to NHS England regarding the development of the Friends and Family Test Guidance in Community and Mental Health Settings.

This year many service users and carers have contributed to the Voicenews newsletter and some have gone on to take up volunteering opportunities across the Trust. They have also played a significant role in successfully launching the PLACE

(Patient Led Assessments of the Care Environment) for mental health inpatient wards.

PLACE assessments were carried out between April and June 2013 at the Trust's mental health inpatient wards. This programme allows service users, carers and Healthwatch representatives to conduct checks and evaluations on the care environment.

The Adult Mental Health Network has been working with the Network's Experts by Experience - a group open to service users and carers who wish to become involved in improving the Network's services. The Experts worked closely with operational service managers to co-produce Excellence in Customer Care: Service User and Carers, which is a guide for staff. Compassionate Care is at the heart of the guide, and it provided the basis for staff development sessions co-delivered by the Experts by Experience that have been attended by all operational services staff . The Excellence in Customer Care project was the first to be awarded the Experts by Experience Quality Mark for Service user and/or Carer Involvement.

The EYE-ACT project is a service user leadership project led by specialist rehabilitation services. They formed a film crew and have visited all the Network's supported accommodation services to interview service users, staff and managers for a DVD that welcomes new service users when they first come into specialist rehabilitation services.

The community CAMHS team and Clinical Psychology are part of the Children & Young People's Improving Access to Psychological Therapies (CYP-IAPT). There is a focus on participation not only with young people but also parents and carers and the team are working closely with N-Compass to develop and support this process. There will be a number of groups across the localities were young people and their families are helping shape the future of mental health services and ensure they have a 'voice' in service delivery.

5.9 The number of, and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year

Costs of ill health retirements are borne by the NHS Pensions Agency. Details of numbers and estimates of associated liabilities are supplied by the NHS Pension Agency and detailed in note 6.4 to the accounts.

5.10 Management costs calculated in accordance with the Department of Health's definitions

Best practice requires the Trust to report expenditure on management and administration costs as defined in the Department of Health document 'NHS Management Costs 2002/03'.

Under the agreed definition the Trust's management costs were 9.68% of Trust income (2011/12 9.19%). The increase is largely resultant from additional corporate costs following the transfer of community services transaction in 2011/12.

5.11 Detailed disclosures in relation to 'other income' where 'other income' in the notes to the accounts is significant

The Trust does not consider 'other income' figure in the annual accounts significant enough to disclose detail on.

5.12 Sickness absence data

The Trust's average sickness rate for 2013/14 was 5.4%. Over recent years sickness absence at Lancashire Care has fallen considerably from 6.64% in 2009/10, and Trust managers are continuing to proactively manage and monitor attendance to reduce the number of days lost due to sickness. Our robust policy and procedure continues to aid attendance management and new and existing managers have access to training modules to support them through the process, which is well attended. People Asset Management (PAM), the Occupational Health provider have become more actively involved and attend management meetings across the organisation to discuss absence cases with a view to getting staff back to work. The Workforce team and PAM meet on a monthly basis to review high sickness areas to ensure these are being managed effectively and that PAM are aware of each case. In addition to these interventions, enhanced reporting mechanisms, continue to support the Trust to work towards its target rate.

5.13 A statement that the NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance

The Trust remains compliant with cost allocations and charging requirements laid down by HM Treasury and the Office of Public Sector Information Guidance.

5.14 Details of Serious Untoward Incidents involving data loss or confidentiality breach (required as part of NHS Information Governance rules)

There have been four serious non-clinical information governance incidents during the reporting period which have qualified for automatic reporting to the Information Commissioner's Office (ICO) and the Department of Health. These incidents relate to either a loss of data or a serious breach of confidentiality. Internal investigations have been completed by the Trust for two of the incidents with a further two investigations currently being conducted. Action plans are in place for the two completed investigations and progress will be monitored by the Serious Incident Review Group. To date the ICO have acknowledged all these incidents but regulatory action has not been suggested.

5.15 Income disclosures required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

The Trust can confirm that the income it receives for the provision of goods and services for the purposes of the health service in England exceeds its income from the provision of goods and services for any other purposes.

Income from activities accounts for over 90% of the Trust's income. The remainder is all classed as operating income, split approximately evenly between income received

for the purposes of education, training, research and development and income received for non-patient care services. This other operating income compliments the trust overarching objective to provide goods and services for the purposes of the health service in England.

6. Statement of directors' responsibility in preparing the financial statements

Each of the people 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.

This confirmation is given and should be interpreted in accordance with the UK Corporate Governance Code 2012, para. C.1.1.

For and on behalf of the Board

Derek Brown
Chair
28 May 2014

Professor Heather Tierney-Moore
Chief Executive
28 May 2014

7. Statement of Accounting Officer's Responsibilities

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

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

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

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

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

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

Professor Heather Tierney-Moore
Chief Executive
28 May 2014

8. Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Lancashire 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 Lancashire Care NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a Risk Management Strategy that sets out the role and responsibilities of the Chief Executive, Executive Directors and managerial roles key to the co-ordination of risk management throughout the Trust. The Strategy clearly states that all staff have a responsibility for risk management.

The Trust has a governance structure in place that supports the process of risk escalation. The Executive Risk Management Committee was established in April 2013 to provide assurance to the Board of Directors, via the Executive Management Team, that the Risk Management Strategy is being effectively embedded throughout the Trust. A Non-Executive Director attends the Committee to provide oversight on behalf of the Board of Directors and to act as a critical friend in the discharge of the Committees responsibilities. Over the last 12 months the Committee has received assurance from each of its Networks on the local governance arrangements and processes in place in relation to the identification and management of risks. This has allowed for cross-network learning and sharing of best practices. The Committee has also reviewed the escalation of risks to the Executive Risk Register at each of its meetings. At its most recent meeting the Executive Risk Management Committee reviewed its terms of reference to ensure effective and efficient discharge of its duties. In recognition of the value of continuous improvement the Committee will be changing its focus to encompass a wider remit including assessing and reviewing the composition and ongoing development of the format of the Board Assurance Framework and Executive Risk Register. This will ensure that it provides a robust tool through which the Board of Directors can monitor management of the organisation's key strategic risks, ensuring that effective control and assurance mechanisms are in place and that timely action is being taken to address gaps in control and assurance.

The Executive Risk Management Committee will also challenge risk assessments, evaluate the impact of risk aggregation and where necessary moderate risk scores. In addition the Committee will review risk proximity and the assignment of risk appetite targets per risk for Board approval. An increase in Non-Executive Director attendance at the Committee will support this re-focus.

The Audit Committee has oversight of the system of risk management and assurance and has a cycle of business that requires attendance by members of the senior management team to provide assurance in relation to the development of local systems of control.

Staff are trained to manage risk in a way that is appropriate to their authority and duties. This is supported by the Risk department structure which allocates a Risk Advisor to each Network. A Risk Management e-learning module will be developed with the intention that in due course it will become mandatory for all employees of the Trust to complete. Good practice is promoted through the organisation and the current policy and procedural framework supporting risk management is assessed at level one by the NHS Litigation Authority. The process and governance arrangements supporting the development and ratification of policies is currently under review and recommendations and potential improvements will be reported back to the Executive Management Team. A Total Management System approach is being developed and provides an element of support to staff around risk management including key tools, documentation and contacts.

The risk and control framework

The Trust's Risk Management Strategy has been agreed and operational risk management processes are embedded throughout the organisation. The level and nature of operational risk information that should be subject to Board scrutiny has been determined by the Board of Directors within its Risk Appetite Statement and the Board receives regular updates on the status of those risks. The strategy contains an escalation process for the rapid identification and reporting to the Board of emerging risks or concerns around risk mitigation.

The Board Assurance Framework provides an effective focus on strategic and reputational risk rather than operational issues, and highlights any gaps in controls and assurances. It provides the Board of Directors with confidence that systems and processes in place are operating in a way that is safe and effective. It is a dynamic tool which is regularly reviewed throughout the year and supports me when completing this statement at the end of each financial year.

During the reporting period the Board of Directors invited its senior management team to attend an informal session to undertake an in depth review of its Risk Appetite Statement and subsequently a refreshed version was approved at the formal Board of Directors meeting held on 09 January 2014. The review informed a restructure of the statement which is now categorised by three key areas:

- Quality
- Reputation
- Sustainability

The Executive Quality Committee provides assurance that the Quality Strategy is being deployed throughout the organisation and that the key actions are being progressed. A Quality Analysis Group has been established which advises the Executive Quality Committee of themes in relation to good quality care or signals areas where improvements are needed. The Quality Analysis Group brings together sources of data and intelligence to present a comprehensive picture of quality. Members have the appropriate knowledge and skills to challenge the data and ensure that outcomes for patients are understood. The findings are used to inform the focus of quality improvements feeding back to the Executive Quality Committee.

The Board of Directors receives monthly quality and performance reports via the Chief Executive's Assurance Report and the development of a Board Balance Scorecard is nearing completion which will provide Board members with a measured and comprehensive view of compliance against key targets across operational performance, progression of strategic goals and stewardship standards. The Board of Directors reviews and monitors the assurance received to ensure we maintain our CQC registration as part of the Board Assurance Framework. The Board of Directors has introduced a standard 'Quality Improvement' agenda item and welcomes clinical staff to share their experiences of notable improvements being made across the organisation but also areas that require additional support to make necessary improvements and ensure the highest possible standard of care is provided.

Data security is a risk held on the Health Informatics high level risk register. This risk does not sit on the Executive Risk Register but should the risk rating increase this would be escalated and discussed at the Executive Risk Management Committee. The risk is managed robustly with a range of controls in place with the focus of the technological controls being around prevention and detection. In addition Health Informatics employs skilled staff with specialist data security knowledge who work with key partners to ensure that the most appropriate systems and software is utilised. Independent assurance is also sought via Network penetration tests, operational strategic reviews, internal and external audits.

An array of information security work has been undertaken during 2013/14 including:

- Roll out of Windows 7
- Creation of the Virtual Data centre resulting in increased resilience to the Trust network
- Increased Firewall Resilience
- Use of PinSafe to replace VPN tokens for remote and agile working
- Information Governance Training
- Incident reviews and Emergency Desktop exercises.

The risks to compliance with the conditions of the Monitor Licence are monitored through the Board Assurance Framework which includes compliance with condition 4 – foundation trust governance.

During the reporting period, the Board of Directors undertook an in depth review of the hosting and governance arrangements for the North West Coast Academic Health Science

Network and in considering those arrangements approved the request to host the Network. Bespoke governance arrangements were approved to ensure appropriate monitoring and risk control by the host organisation. The Board of Directors will receive regular updates on the Networks performance against the delivery of their business plan which was approved at the Lancashire Care NHS Foundation Trust Board meeting in May. More information can be found on page 9 of the Annual Report.

The Trust has six Executive sub-committees (Risk, Quality, Workforce, Property, Health Informatics and Finance and Performance) and to promote transparency, a Non-Executive Director also attends each of the Executive sub-committees aligned to their area of expertise. The Board of Directors receives updates on key issues discussed at all the Executive Committees via the Chief Executives Briefing. Board members receive the Board pack one week prior to the meeting.

The Enterprise Assurance Management approach to risk has been embedded throughout the organisation and is tested though Audit Committee via internal audits. Incident reporting is openly encouraged in Lancashire Care NHS Foundation Trust though both the Counter Fraud systems and the internal whistleblowing process. Clinical serious incident reports are reviewed on a weekly basis by the Director of Nursing and Medical Director and areas of significant concern would be reported to the Board of Directors.

The Corporate Governance Statement has been developed by reviewing the risks detailed on the Board Assurance Framework and the Executive Risk Register. The process of identifying risk is an integral part of the annual planning cycle of business and is including in objective setting throughout the organisation. Performance review procedures take specific note of risk to achievement of objectives. There is a robust risk identification, management and escalation system covering both operational and strategic objectives embedding in the organisation which is subject to internal audit and scrutiny by the Audit Committee. Risks are validated through the Trust's governance system at operational Executive level and by the Board of Directors.

Control measures are in place to ensure that patients, public and staff with physical and sensory impairments are able to access buildings on all Trust sites. All new estates schemes, as well as refurbishments or ad hoc improvements, are assessed to ensure that they meet the requirements of the Disability Discrimination Act. Issues identified through patient feedback, contacts are used to inform priorities for estates improvements.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

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 the organisation is compliant with all obligations under equality, diversity and human rights legislation. The Trust has a comprehensive policy setting the standards of policy requirements, this includes the completion of an equality impact assessment.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust has effective systems and processes to support a robust system of integrated governance. This is underpinned by a clear structure and focused reporting arrangements. During the reporting period, the governance arrangements in relation to the executive sub-committees were reviewed and proposed recommendations included the introduction of a 'discharge of duties' report that will outline the work undertaken by each sub-committee in line with their approved terms of reference to ensure consistency with discharged authority. The review also considered the flow of information through the governance structure from ward to board. Areas for improvement were identified and have been addressed.

A Board level Balanced Scorecard has been developed as part of the Chief Executives Briefing which is reported to the Board on a monthly basis. The scorecard provides progress reporting against key indicators which are measured under six domains – Quality, Engagement, Research and Innovation, Service Delivery, People and Finance and Business Health in addition to aspects of stewardship and progress against key programmes of work. The Board level Balanced Scorecard is underpinned by comprehensive reporting system. The Executive Management Team review performance data on a weekly basis and the format of that data is currently under development in line with the Board level Balanced Scorecard.

Each of the Trust's four Networks and each corporate department or team develops an annual business plan which are approved by the Executive Management Team and used in the production of the Operational Plan. Quarterly assurance reviews are scheduled throughout the year to allow the Executive Management Team to monitor performance and assess the assurances provided in particular to ensure identified risks have effective controls in place to mitigate them.

During the year the Trust has acknowledged a focus on Value for Money and as such has developed a Value for Money Annual Report which will co-ordinate a formal reporting line through the Trust's governance structure and include continued monitoring of Value for Money through the Programme Management Office as part of project benefit realisation.

The Board of Directors is satisfied that all Executive and Non-Executive Directors have the appropriate qualifications, experience and skills to discharge their functions effectively including setting strategy, monitoring and managing performance and risks and ensuring management capacity and capability. Gaps in capability have been identified during the year and these have been addressed. This is supported through robust recruitment and appraisal

processes. An external independent Board evaluation is currently underway that will provide feedback and recommendations on the current composition of the Board of Directors in line with Monitor's requirements for a regular review of Board Governance.

Annual Quality Report

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

The Trust has effective systems, processes and mechanisms in place to produce the Quality Account and to ensure that it is a general and balanced view and that appropriate controls are in place to ensure the accuracy of the data. The executive lead is the Director of Nursing and operationally the process is managed by the Associate Director of Quality and Experience. The content of the report reflects the Trust's overall Quality Strategy and the priorities included in this document.

The development of the report includes input from service users and carers, staff, senior managers, senior clinicians, the Council of Governors (through the Standards and Assurance committee) the executive directors and non-executive directors. A project plan is in place which ensures that all key stakeholders have input into the report and are able to comment on the content and the overall format of the report. The Account is considered by the Executive Quality Committee, reviewed by the Audit Committee and approved by the Board of Directors.

In developing the report consideration has been given to the comments made by the Trusts External Auditors on previous reports and this supports the Trust's approach to the overall production of the Account and the validation of the data which is included in it. The External Auditors have undertaken a review of the content of the Quality Reports and completed testing on targets.

Finally commissioners, overview and scrutiny committees and local Healthwatch are asked to comment on the report and senior members of the Trust attend relevant forums to present and discuss this report when this is required.

During the final quarter of the year an issue emerged relating to the reporting of two performance targets to the Board of Directors. Following immediate investigations to understand the full extent of the matter, swift action was taken to address the issues including commissioning an external independent review by KPMG to advise on remedial action required and to provide further assurance through additional testing. Additional resource was added to the Trust's Performance team to ensure immediate steps were taken to respond to the Trust's requirements.

An improvement plan relating to the specific data quality issues and the wider data and performance management culture was approved by the Executive Management Team on 13 May 2014 and continues to be monitored through the Trust's governance arrangements.

Work is still ongoing to ensure the Trust continues to capture the lessons learnt from this incident. The impact on the quality of care received by our patients has been a fundamental part of our investigations and I can confirm that patient care was not affected.

Across 2013/14 the Care Quality Commission (CQC) visited Lancashire Care Foundation Trust to assess compliance with the Essential Standards of Quality and Safety. Three moderate concerns and one minor concern were identified which have led to action plans being developed and submitted to the CQC. The progress of these action plans is monitored on an on-going basis through network governance meetings. In demonstration of Lancashire Care NHS Foundation Trust's commitment to the delivery of high quality care significant investment has been made to support the progression of quality improvement plans and the Quality and Governance Directorate are working in partnership with the clinical teams and their leaders.

The challenges relate to:

- Ensuring that the skill mix and staffing levels are appropriate
- Strengthening the leadership arrangements in the service
- Implementation of an improvement plan in line with the Trust's Quality Strategy
- Strengthening governance arrangements to monitor quality standards and ensure that standards are met

Review of effectiveness

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

This statement provides assurances that the Trust has complied with its responsibilities for the development and maintenance of the system of internal control. This statement sets out some examples of the work undertaken to inform this process. These include:

- The crucial role of the Board of Directors in developing the Risk Appetite Statement and reviewing the Board Assurance Framework on an annual basis
- The ability to respond to threats to compliance of recent control issues around contracts for novel business
- Development of a risk management e-training framework
- Re-focus of the Executive Risk Management Committee including the increase of Non-Executive Director membership to provide a wider view of risk controls and assurances

- Quarterly reports to the Audit Committee by internal, external and clinical audit functions and the robust scrutiny of this work that is applied by the Committee to all these functions. There is a clear process in place to address recommendations arising from the internal audits and this ensures that all actions have been closed off appropriately. This is overseen by the Company Secretary. A similar process is in place to support the clinical audit function and this is overseen by the Medical Director.

As part of the review of the system of internal control, I commissioned an additional review in response to concerns triggered by a waivers report presented to the Audit Committee. Alongside this the Chair of Audit Committee commissioned a connected review. The first review examined a waiver (and subsequent order and spend) for refurbishment of a Trust property by a partner organisation. It concluded that, although approved in the normal manner, the transaction carried commitments and implications for the Trust regarding a proposed lease agreement and possible provision of working capital support which were not documented at the time or approved by the Board of Directors.

The second review examined similar style transactions related to either the individuals involved or the process areas affected. It concluded that, whilst there were issues around the application of specific areas in procurement and purchasing controls, that these did not represent the whole population of Trust spend and there was no evidence that they were systemic. The review of similar-style transactions raised issues with the clarity and completeness of business cases to support proposed waivers of procurement activity.

Management took immediate and robust action by agreeing an action plan, which included measures to address the controls affected and longer-term enhancements to the Trust's Reservation of Powers and Delegated Authority arrangements. I am also taking the opportunity to learn from these events by undertaking a management review of the lessons learnt in order to share the learning more widely in the organisation.

The Trust received a Head of Internal Opinion providing substantial assurance.

The Trust has continued to perform well against the Monitor Compliance Framework throughout 2013/14. However the Trust reported a breach of the Delayed Transfers of Care key indicator for Quarter 3. The figures highlighted some issues to be addressed in ensuring that discharges are managed as efficiently as possible. Discharges frequently involve multiple agencies, and can be very complex in our service users' cases and the Trust is taking strong action to turn our performance around. A number of workstreams have been initiated, centred on better coordination of agencies, and better recording of data. It is anticipated that performance on this metric will improve in Quarter 1 2014/15. All other Monitor targets were achieved in year. Whilst remaining compliant, following further testing a data extraction issue relating to the definition used for the target for 7 day follow up of patients on CPA emerged. This resulted in minor adjustments being made to the final figures for the year which caused them to be slightly out of line with those previously reported to the Board of Directors.

Conclusion

During the year the Trust identified an isolated area where certain controls were not applied and where governance and monitoring could be strengthened. This included the development and approval of non-core business propositions, oversight and management of partnerships and confirmation of approval to spend. The Trust also identified and addressed data quality issues relating to specific Monitor targets. No other significant internal control issues have been identified.

Professor Heather Tierney-Moore
Chief Executive
Lancashire Care NHS Foundation Trust
28 May 2014

FOREWORD TO THE ACCOUNTS

LANCASHIRE CARE NHS FOUNDATION TRUST

These accounts for the year ended 31 March 2014 have been prepared by the Lancashire Care NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Lancashire Care NHS Foundation Trust received its authorisation as an NHS Foundation Trust on 1 December 2007 in line with Section 35 of the National Health Service Act 2003.

Its registered headquarters address is:

Lancashire Care NHS Foundation Trust
Sceptre Way
Walton Summit
Bamber Bridge
Preston
PR5 6AW
Tel: 01772 695 300
E-mail: lct.enquiries@lancashirecare.nhs.uk
Web: www.lancashirecare.nhs.uk

Signed …… Dated …28/05/2014……

Professor Heather Tierney-Moore
Chief Executive

Signed …… Dated …28/05/2014……

Derek Brown
Chair

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2014

	NOTE	Year to 31 March 2014 £000	Year to 31 March 2014 £000	Year to 31 March 2013 £000	Year to 31 March 2013 £000
Income from continuing activities	3	**303,846**		304,133	
Other operating income	4	**21,570**		17,606	
Operating expenses from continuing operations	5	**(316,718)**		(314,233)	
OPERATING SURPLUS/(DEFICIT)			**8,698**		7,506
Finance Costs					
Finance income	9	**135**		118	
Finance expense - financial liabilities	10	**(848)**		(422)	
Finance expense - unwinding of discount on provisions	22	**(33)**		(43)	
Public Dividend Capital dividends payable		**(3,171)**		(3,229)	
Net finance costs			**(3,917)**		(3,576)
Share of Profit/(Loss) of Associates/Joint ventures accounted for using the equity method			**(123)**		(105)
Corporation tax expense			**0**		0
Surplus/(deficit) from operations			**4,658**		3,825
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR			**4,658**		3,825
Other comprehensive income:					
Gain/(loss) from transfer by absorption from demising bodies			**7,117**		0
Impairments			**0**		(4)
Revaluations			**0**		4,138
Other reserve movements			**0**		1
FOR THE FINANCIAL YEAR			**11,775**		7,960

The notes on pages 112 to 137 form part of these accounts.

Note, the trust has not consolidated the accounts of its charity with its own accounts as they are not considered material.

STATEMENT OF FINANCIAL POSITION (SOFP) AS AT 31 MARCH 2014

	NOTE	31 March 2014 £000	31 March 2013 £000
NON-CURRENT ASSETS:			
Intangible assets	11	**1,898**	385
Property, plant and equipment	12	**156,386**	130,467
Investments in associates (and joined controlled operations)	15	**18**	116
Other Financial assets	30.1	**695**	575
Total non-current assets		**158,997**	131,543
CURRENT ASSETS:			
Inventories	16	**279**	249
Trade and other receivables	17	**13,416**	10,932
Cash and cash equivalents	19	**35,834**	33,285
Total current assets		**49,529**	44,466
CURRENT LIABILITIES:			
Trade and other payables	20	**(33,643)**	(28,472)
Borrowings	21	**(477)**	(301)
Other financial liabilities		**(122)**	0
Provisions	22	**(3,254)**	(2,135)
Other Liabilities - Deferred Income	24	**(4,594)**	(4,973)
Total current liabilities		**(42,090)**	(35,881)
NON-CURRENT LIABILITIES:			
Borrowings	21	**(25,309)**	(11,487)
Provisions	22	**(1,710)**	(1,760)
Total non-current liabilities		**(27,019)**	(13,247)
TOTAL ASSETS EMPLOYED		**139,417**	126,881
TAXPAYERS' EQUITY			
Minority interest		**0**	0
Public dividend capital		**101,650**	100,889
Revaluation reserve		**21,409**	19,741
Available for sale assets reserve		**0**	0
Other reserves		**0**	0
Merger reserve		**0**	0
Income and expenditure reserve		**16,358**	6,251
Charitable fund reserve		**0**	0
TOTAL TAXPAYERS' EQUITY		**139,417**	126,881

The financial statements on pages 108 to 111 and pages 112 to 137 were approved by the Board on 28 May 2014 and signed on its behalf by Professor Heather Tierney-Moore, Chief Executive:

Signed: ……(Chief Executive) Date: …28/05/2014……

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2014

	Total	NHS Charitable funds reserve ****	Minority Interest	Public Dividend Capital	Revaluation Reserve **	Income and Expenditure Reserve *
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2013	**126,881**	0	0	100,889	19,741	6,251
Surplus/(deficit) for the year	**4,658**	0	0	0	0	4,658
Transfers by modified absorption	**7,117**	0	0	0	0	7,117
Transfers by modified absorption; transfers between reserves	**0**	0	0	0	2,264	(2,264)
Asset disposals	**0**	0	0	0	(231)	231
Public Dividend Capital received	**761**	0	0	761	0	0
Transfer of excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	**0**	0	0	0	(365)	365
Taxpayers' equity at Year Ended 31 March 2014	**139,417**	**0**	**0**	**101,650**	**21,409**	**16,358**

" The I&E reserve is the cumulative surplus/deficit made by the trust since its inception. It is held in perpetuity and cannot be released to the SOCI.

** The revaluation reserve reflects movements in the value of assets as set out in the accounting policy. The revaluation reserve balance relating to each asset is released to the I&E reserve on disposal of that asset. It should be noted that none of the reveluation reserve balance relates to intangible assets as these are carried fair value in the accounts and there has been no change to their value in the financial year.

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2014

	NOTE	Year to 31 March 2014 £000	Year to 31 March 2013 £000
Cash flows from operating activities			
Total operating surplus/(deficit) from continuing operations		**8,698**	7,506
Depreciation and amortisation	5.1	**5,412**	4,868
Impairments	13	**0**	2,707
Reversals of impairments		**0**	0
Gain/(Loss) on disposal		**(14)**	(2)
Amortisation of PFI credit		**0**	0
(Increase)/Decrease in Trade and Other Receivables		**(2,455)**	2,186
(Increase)/Decrease in Other Assets		**(120)**	(220)
(Increase)/Decrease in Inventories		**(30)**	(42)
Increase/(Decrease) in Trade and Other Payables		**3,397**	(67)
Increase/(Decrease) in Other Liabilities		**(379)**	316
Increase/(Decrease) in Provisions		**1,045**	664
Tax (paid) / received		**(104)**	(95)
Movements in operating cash flow of discontinued operations	*16*	**0**	0
Movements in operating cash flow in respect of Transforming Commu	*17.1*	**0**	0
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		**0**	0
Other movements in operating cash flows		**4**	(1)
Net cash generated from operations		**15,454**	17,820
Cash flows from investing activities			
Interest received	9	**135**	118
Purchase of financial assets		**0**	0
Sales of financial assets		**0**	0
Purchase of intangible assets		**(1,602)**	(285)
Sales of intangible assets		**0**	0
Purchase of Property, Plant and Equipment		**(22,887)**	(17,538)
Sales of Property, Plant and Equipment		**674**	267
Cash flows attributable to investing activities of discontinued operation	*12.1*	**0**	0
Cash from acquisitions of business units and subsidiaries		**(25)**	(128)
Cash from (disposals) of business units and subsidiaries	*11.1*	**0**	0
Net cash used in investing activities		**(23,705)**	(17,566)
Cash flows from financing activities			
Public dividend capital received		**761**	**624**
Public dividend capital repaid		**0**	**0**
Loans received from the Foundation trust Financing Facility		**14,291**	**8,800**
Loans received from the Department of Health		**0**	**0**
Other loans received		**0**	**0**
Loans repaid to the Foundation trust Financing Facility		**(176)**	**0**
Loans repaid to the Department of Health		**0**	**0**
Other loans repaid		**0**	**0**
Capital element of finance lease rental payments		**0**	**0**
Other capital receipts		**0**	**0**
Capital element of Private Finance Initiative Obligations		**(117)**	**(114)**
Interest element of Foundation Trust Financing Facility		**(296)**	**(4)**
Interest element of finance lease		**0**	**0**
Interest element of Private Finance Initiative obligations	10	**(430)**	**(418)**
PDC Dividend paid		**(3,200)**	**(3,142)**
Cash flows attributable to financing activities of discontinued operations		**0**	**0**
Cash flows from (used in) other financing activities	22	**(33)**	**(42)**
Net cash used in financing activities		**10,800**	5,704
Increase/(decrease) in cash and cash equivalents		**2,549**	5,958
Cash and cash equivalents prior year	19	**33,285**	27,327
Cash and cash equivalents	19	**35,834**	33,285

NOTES TO THE ACCOUNTS

1 ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *2013/14 NHS Foundation Trust Annual Reporting Manual* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual* to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

The accounts have been prepared under the historic cost convention modified to account for the revaluation of property, plant, equipment and intangible assets.

1.1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.2 Expenditure on goods and services

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

1.3 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. As a consequence it is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. Employers pension cost contributions are charged to operating expenses as and when they become due. The NHS Pension Scheme (England and Wales) Resource Account is published annually and can be found on the Business Service Authority - Pensions Division website at www.nhspa.gov.uk.
Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.4 Intangible fixed 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. Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful economic lives.

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. They are capitalised when they are capable of being used in a trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000. Subsequently intangible assets are measured using the valuation model. Where there is no value in use as there is no active market the asset is valued at historic cost as a proxy for depreciated replacement cost. These measures are a proxy for fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. The carrying value the asset is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'

Amortisation

Intangible assets are amortised over their expected useful economic lives on a straight line basis in a manner consistent with the consumption of economic or service delivery benefits.

1.5 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; and
- the cost of the item can be measured reliably.

Further, property, plant and equipment assets are capitalised if they:

- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value. The costs arising from financing the construction of the asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

All land and buildings are revalued using professional valuations in accordance with IFRS every five years. The last one being carried out as at 31 March 2010 with the next one being due 31 March 2015. A three yearly interim valuation is also carried out and was last carried out as at 31 March 2013.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use.

As part of their valuation of our buildings the valuers assign useful economic lives to individual properties. Non property assets are valued using the following asset lives:

	Years
Medical equipment and engineering plant and equipment	5 to 15
Furniture	5 to 10
Mainframe information technology installations	5 to 8
Soft furnishings	7
Office and information technology equipment	5
Set-up costs in new buildings	10
Vehicles	7

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its useful economic life then the expenditure is charged to operating expenses.

Depreciation

Items of Property, Plant and Equipment are depreciated on a straight-line basis over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust, respectively. Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS foundation trust's professional valuers. Leaseholds are depreciated over the primary lease term. Equipment is depreciated on current cost evenly over the estimated life.

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Carrying values are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met

- the asset is available for immediate sale in its present condition subject only to terms which are usual and
- the sale must be highly probable i.e

1. management are committed to a plan to sell the asset;
2. an active programme has begun to find a buyer and complete the sale;
3. the asset is being actively marketed at a reasonable price;
4. the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
5. the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession i.e.where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement, as interpreted in HM Treasury's FReM, are accounted for as 'on-SOFP' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17. The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.
An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.
Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.7 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.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. Cost is calculated as weighted average cost.

1.9 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.10 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the SOFP date on the basis of the best estimate of the expenditure 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.

As at 31 March 2014 these are:

Short term: -1.90%
Medium term: -0.65%
Long term: 2.20%

Further information can be found at http://www.dfpni.gov.uk/index/finance/afmd/afmd-finance/afmd-financial_reporting/pes__2013__07.pdf

1.11 Contingencies

Contingent liabilities are not recognised as liabilities, but are disclosed in note 26 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

1.12 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 22.

1.13 Non-clinical risk pooling

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

1.14 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury *Financial Reporting Manual*.

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

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note, from 2013/14, the adjustment to net relevant assets calculation in respect of the GBS must be calculated on the basis of average daily cleared balances. In practice therefore, GBS values will not be deducted from 1 April 2013 and 31 March 2014 net relevant assets calculations as spot values at those dates. Rather, average net relevant assets including GBS for the year should be calculated, and then the average daily cleared GBS balances deducted from that figure to arrive at the relevant net assets calculation for the calculation of the dividend. National Loans Fund deposits are considered to be analogous to GBS balances for the calculation of relevant net assets and should also be calculated on an average daily basis.

Note, for 2013/14 organisations receiveing asset transfers from the disestablishing PCTs were also allowed relief from PDC dividend charge. This relief is only allowed for the 2013/14 year and the transferring asets will become subject to PDC dividend charge from 2014/15 onwards.

1.17 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.18 Financial instruments and financial liabilities

Recognition

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described earlier. All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

The trust will commonly have the following financial assets and liabilities.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure', Loans and receivables or 'Available-for-sale financial assets'. Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the SOFP date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the SOFP date, which are classified as long-term liabilities.
Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts where material are determined using discounted cash flow.

Impairment of financial assets

At the SOFP date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate.
The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision. The carrying amount of individual debts is written down directly where it is certain that the debt cannot be recovered. Where there is a level of uncertainty as to the recoverablility of individual debts, an appropriate provsion is made.

1.19 Accounting standards issued but not yet required to be adopted

The Trust has considered the below new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

	Financial Year for which the change first applies and is expected to be adopted by the trust
IFRS 9 Financial Instruments	Uncertain
IFRS 10 Consolidated Financial Statements	2014/15
IFRS 11 Joint Arrangements	2014/15
IFRS 12 Disclosure of Interests in Other Entities	2014/15
IFRS 13 Fair Value Measurement	2014/15
IAS 27 Separate Financial Statements	2014/15
IAS 28 Associates and joint ventures.	2014/15
IAS 32 Financial Instruments: Presentation – amendment	2014/15

1.20 Critical management judgements made when preparing these accounts

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

- Leases

The trust followed IFRS guidance to decide on the most appropriate method of disclosing its leases. It decided that all current leases fall to be treated as operating leases.

- PFI asset recognition.

The trust followed IFRS guidance to assess how to disclose its PFI assets. It decided that on-SOFP disclosure was the most appropriate method of disclosure and are presented as such in these accounts.

- Accruals

As with previous years the trust prepares these accounts using the accruals accounting concept.

- Provisions

The trust has provided for expected liabilities in line with accounting guidance. Details of the provisions can be found in note 22 of these accounts.

- Impairments

Carrying values of assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

- Asset valuations

The trust follows NHS guidance in the valuation strategy of its estate. As such, with an interim valuation of estate having been carried out as at 31 March 2013 the next valuation will be as at 31 March 2015.

1.21 Accounting for Joint Ventures

The trust has also entered into an equally owned Joint Venture Partnership with Ryhurst Ltd. The venture, Red Rose Corporate Services LLP, has been established to support the development of state-of-the-art facilities to deliver modern mental health services in the future, and capitalise on the combined skills & capabilities of the parties to exploit estates and other commercial opportunities.

A review of RRCS's management arrangements and ownership structure has concluded that this venture is accounted for under equity accounting guidance within these financial statements.

Further details surrounding the joint venture can be found in note 28 to these accounts.

1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

2 Operating segments

The trust's Chief Operating Decision Maker as defined by IFRS 8 Operating Segments is the board. It has determined that the trust operates only one material business segment, that being the provision of healthcare services. The operating results of this segment are regularly reviewed by the board.

Note 3 to the accounts analyses income from healthcare activities by type and also by source with the majority of our income coming from CCG and NHS England commisioners (previously PCTs).

Note 4 to the accounts analyses other operating income the trust received during the year. This is largely in relation to non-patient care services to other bodies, medical education and training monies and healthcare research and development funding.

During the year the trust took the oppportunity to host the North West Coast Academic Health Science Network. This organisation represents the NHS in South Cumbria, Lancashire, Cheshire and Merseyside in working together to improve patient care. Its vision being: Improving population health by reducing variation and equalising access to excellent care. Promoting a vibrant economy through investment, innovation and sustainability of employment.

The trust has determined that the AHSN will be managed and reported on in an identical manner to the trusts other clinical networks. This coupled with the acknowledgement that the AHSN's business is one of healthcare has led the trust to confirm that this arrangement has no impact on the trusts reporting of operating segments, with the trust continuing to operate a single material business segment, that being the provision of healthcare services.

3. Income from activities

3.1 Income from Activities by type

	Year to 31 March 2014 £000	Year to 31 March 2013 £000
Income from Mental Health and Community activities	**303,846**	302,068
Other clinical income	**0**	2,065
	303,846	304,133

3.2 Private Patient Income

As in 2012/13 the trust did not generate any private patient income in the year ending 31 March 2014.

3.3 Income from Activities by source

	Year to 31 March 2014 £000	Year to 31 March 2013 £000
NHS Trusts	**216**	531
Department of Health	**72**	970
CCG's and NHS England	**282,795**	0
Other WGA Bodies	0	48
Local Authorities	**20,763**	176
Primary Care Trusts	**0**	302,408
	303,846	304,133

3.4 Income from Commissioner Requested Services and non-Commissioner Requested Services

	Year to 31 March 2014 £000	Year to 31 March 2013 £000
Commissioner Requested Services	**303,846**	302,068
Non-Commissioner Requested Services	**0**	2,065
	303,846	304,133

3.5 Income from continuing operations

	Year to 31 March 2014 £000	Year to 31 March 2013 £000
Continuing Operations	**325,416**	321,668
Discontinued Operations	**0**	0
	325,416	321,668

4. Other Operating Income

	Year to 31 March 2014 £000	` £000
Research and development	**1,486**	1,376
Education, training	**9,167**	7,780
Non-patient care services to other bodies	**10,641**	8,338
Other income	**197**	52
Profit on disposal of land and buildings	**14**	2
Rental revenue from operating leases	**65**	58
	21,570	17,606

5. Operating Expenses

5.1 Operating expenses comprise:

	Year to 31 March 2014 £000	Year to 31 March 2013 £000
Services from Foundation Trusts	**7,280**	8,448
Services from NHS Trusts	**2,537**	3,513
Services from PCTs	**0**	7,954
Services from CCG's and NHS England	**63**	0
Services from other NHS bodies	**96**	7
Purchase of healthcare from non NHS bodies	**4,265**	4,592
Executive directors' costs	**1,019**	911
Non-executive directors costs	**139**	149
Employee costs (excluding executive directors' costs)	**241,994**	237,675
Supplies and services - clinical (excluding drug costs)	**5,927**	5,490
Supplies and services - general	**1,144**	1,258
Establishment	**8,311**	7,465
Transport	**914**	942
Premises	**15,412**	8,978
Increase/(Decrease) in bad debt provision	**444**	91
Drug Costs	**7,050**	7,561
Operating lease rental	**3,513**	3,208
Depreciation and amortisation	**5,412**	4,868
Impairments of assets	**0**	2,707
Audit services - statutory audit	**90**	72
Other auditor's remuneration	**18**	25
Clinical negligence	**466**	531
Consultancy	**4,478**	1,856
Training	**1,809**	1,821
Redundancy Payments	**1,291**	1,840
Retirements	**(38)**	233
Insurance	**716**	705
Other	**2,368**	1,333
	316,718	314,233

5.2 Other auditor's remuneration

	Year to 31 March 2014 £000	Year to 31 March 2013 £000
Other auditor's remuneration comprises:		
- Other non audit services	**18**	25
	18	25

5.3 Auditor liability limitation agreements

Our auditors accept liability to pay damages for losses arising as a direct result of breach of contract or negligence on their part in respect of services provided in connection with or arising out of their letter of engagement (or any variation or addition thereto) but the liability of our auditors, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1 million in the aggregate in respect of all such services.

5.4 Operating leases

As Lessee

Payments recognised as an expense	**Year to 31 March 2014 £000**	Year to 31 March 2013 £000
Minimum lease payments	**3,513**	3,208
Sub-lease payments received	**(65)**	(58)
	3,448	3,150

Total future minimum lease payments

	£000	£000
Payable:		
Not later than one year	**3,512**	3,208
Between one and five years	**5,338**	7,635
After five years	**2,370**	2,310
	11,220	13,153

The trust has 34 operating lease arrangements in place. All of which are arrangements for accommodation. These arrangements do not have an option to purchase or to transfer title to the trust at the end of the lease term, nor are any of them for the majority of the asset life. None of the leases on an individual basis are deemed to be significant, however, 8 of the properties when aggregated account for £3.0m of the minimum lease payments.

The lease terms expire as follows:	Years	Number of Leases
	0 - 1	1
	1 - 5	22
	Over 5	11

As Lessor

Rental revenue	**Year to 31 March 2014 £000**	Year to 31 March 2013 £000
Contingent rent	65	58
Other		
Sub-lease receipts	**65**	**58**

Total future minimum lease receipts

	£000	**£000**
Receivable:		
Not later than one year	**65**	58
Between one and five years	**260**	232
After five years	**316**	340
	641	630

6. Employee costs and numbers

6.1 Employee costs

	Year to 31 March 2014			Year to 31 March 2013
	Total	**Permanently Employed**	**Other**	
	£000	**£000**	**£000**	£000
Salaries and wages	**196,061**	196,061	0	193,901
Social Security Costs	**13,441**	13,441	0	13,277
Employer contributions to NHS Pension Scheme	**23,753**	23,753	0	23,636
Agency/contract staff	**9,758**	0	9,758	7,772
	243,013	233,255	9,758	238,586

6.2 Average number of persons employed

	Year to 31 March 2014			Year to 31 March 2013
	Total	**Permanently Employed**	**Other**	
	Number	**Number**	**Number**	Number
Medical and dental	**327**	327	0	282
Ambulance staff	**0**	0	0	0
Administration and estates	**1,239**	1,239	0	1,224
Healthcare assistants and other support staff	**832**	832	0	876
Nursing, midwifery and health visiting staff	**2,220**	2,220	0	2,341
Nursing, midwifery and health visiting learners	**10**	10	0	11
Scientific, therapeutic and technical staff	**1,021**	1,021	0	991
Social care staff	**0**	0	0	0
Bank and agency staff	**716**	0	716	529
Other	**53**	53	0	56
Total	**6,418**	5,702	716	6,312

6.3 Retirement benefits

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

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

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions
The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

6.4 Workforce Pensions Reform

In line with government driven Workforce Pensions Reform the trust has established its own auto enrollment pension scheme for staff who do not qualify for the normal NHS pension scheme. This was done following option appraisal wiith the result that the trust opted to use the National Employment Savings Trust (NEST) scheme.

6.5 Retirements due to ill-health

During the period to 31 March 2014 there were 6 early retirements from the NHS Trust on the grounds of ill-health (7 in 2012/13 totalling £282k). The estimated additional pension liabilities of these ill-health retirements will be £497k. The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

6.6 Staff Exit Packages

Year to 31 March 2014

Exit package cost band	Number of Compulsory Redundancies	Cost of Compulsory Redundancies £000	Number of other agreed departures	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000
<£10,000	4	22	0	0	4	22
£10,00 - £25,000	20	389	2	36	22	425
£25001 - £50,000	19	588	0	0	19	588
£50,001 – £100,000	2	174	2	128	4	302
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
£200,001 - £350,000	0	0	0	0	0	0
Total	45	1,173	4	164	49	1,337

Year to 31 March 2013

Exit package cost band	Number of Compulsory Redundancies	Cost of Compulsory Redundancies £000	Number of other agreed departures	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000
<£10,000	18	63	6	41	24	104
£10,00 - £25,000	9	141	11	204	20	345
£25001 - £50,000	7	251	14	455	21	706
£50,001 – £100,000	2	109	3	181	5	290
£100,001 - £150,000	2	209	0	0	2	209
£150,001 - £200,000	1	181	0	0	1	181
£200,001 - £350,000	0	0	0	0	0	0
Total	39	954	34	881	73	1,835

The details for compulsory redundancies are for those members of staff who have been compensated due to their positions being lost as a result of departmental reorganisation or clincial service transformation.

6.7 Other exit packages

Year to 31 March 2014

	Number of agreed payments	Value of agreements
		£000
Voluntary redundancy	0	0
MARS contractual costs	1	60
Early retirement in the efficiency of the service	0	0
Contractual payments in lieu of notice	0	0
Exit payments following employment tribunal or court order	3	104
Non contractual payments requiring HM Treasury approval*	0	0
Total	4	164
*Of which where the payment was more than 12 months annual salary	0	0

Year to 31 March 2013

	Number of agreed payments	Value of agreements
		£000
Voluntary redundancy	0	0
MARS contractual costs	73	881
Early retirement in the efficiency of the service	0	0
Contractual payments in lieu of notice	0	0
Exit payments following employment tribunal or court order	0	0
Non contractual payments requiring HM Treasury approval*	0	0
Total	73	881
*Of which where the payment was more than 12 months annual salary	0	0

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance

	Year to 31 March 2014		Year to 31 March 2013	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**62,772**	**90,732**	55,798	63,749
Total Non NHS trade invoices paid within 30 day target	**60,567**	**88,337**	54,018	60,282
Percentage of Non-NHS trade invoices paid within 30 day target	**96%**	**97%**	97%	95%
Total NHS trade invoices paid in the year	**2,279**	**22,859**	2,385	23,331
Total NHS trade invoices paid within 30 day target	**2,190**	**22,597**	2,287	23,102
Percentage of NHS trade invoices paid within 30 day target	**96%**	**99%**	96%	99%

The Better Payment Practice Code represents best practice and requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

As a result of the general economic crisis, and at the request of the Prime Minister and Monitor, the trust now endeavours to pay all smaller non public sector suppliers within 10 days in order to ease their cash flows.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

	Year to 31 March 2014	Year to 31 March 2013
	£000	£000
Amounts included within Finance Expenses (Note 10) arising from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0

8. Other gains and losses

	Year to 31 March 2014	Year to 31 March 2013
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	14	2
	14	2

9. Finance income

	Year to 31 March 2014	Year to 31 March 2013
	£000	£000
Interest from bank accounts	**135**	118
	135	118

10. Finance expense - financial liabilities

	Year to 31 March 2014	Year to 31 March 2013
	£000	£000
Interest on obligations under finance leases and on-SOFP PFI	**430**	418
Interest on loan	**418**	4
	848	422

11. Intangible Assets

11.1 Intangible assets at the SOFP date comprise the following elements:

	Software licences	Total
	£000	£000
Gross cost at 1 April 2013	1,364	1,364
Additions - purchased	1,672	1,672
Gross cost at 31 March 2014	**3,036**	**3,036**
Amortisation at 1 April 2013	979	979
Provided during the year	159	159
Amortisation at 31 March 2014	**1,138**	**1,138**
Net book value at 31 March 2014	**1,898**	**1,898**
- Purchased at 31 March 2014	1,898	1,898
- Total at 31 March 2014	**1,898**	**1,898**

12. Property, plant and equipment

12.1 Property, plant and equipment at the SOFP date comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	19,776	114,325	0	10,090	715	40	12,241	813	**158,000**
Transfer by modified absorption	300	6,572	0	0	113	0	15	141	**7,141**
Additions - purchased	0	2,811	0	20,076	(1)	0	1,805	0	**24,691**
Disposals	(165)	(495)	0	0	0	0	0	0	**(660)**
Cost or Valuation at 31 March 2014	**19,911**	**123,213**	**0**	**30,166**	**827**	**40**	**14,061**	**954**	**189,172**
Depreciation at 1 April 2013	0	18,643	0	0	645	40	7,664	541	**27,533**
Provided during the year	0	3,696	0	0	95	0	1,353	109	**5,253**
Depreciation at 31 March 2014	**0**	**22,339**	**0**	**0**	**740**	**40**	**9,017**	**650**	**32,786**
Net book value at at 31 March 2014	19,911	100,874	0	30,166	87	0	5,044	304	**156,386**
Purchased at 31 March 2014	19,911	100,874	0	30,166	87	0	5,044	304	**156,386**
Total at 31 March 2014	**19,911**	**100,874**	**0**	**30,166**	**87**	**0**	**5,044**	**304**	**156,386**
Asset financing at 31 March 2014									
Owned	19,911	98,514	0	30,166	87	0	5,044	304	154,026
On-SOFP PFI contract	0	2,360	0	0	0	0	0	0	2,360
Net book value at 31 March 2014	**19,911**	**100,874**	**0**	**30,166**	**87**	**0**	**5,044**	**304**	**156,386**

There were no donated assets during the period.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

The trust uses the Modern Equivalent Asset basis for valuing its property assets.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

Following the disestablishment of PCTs on 31 March 2013 the trust inherited several financial assets, as disclosed above and below. These were transacted under modified absorption accounting method as per guidance.

A summary of the transactions is:

	East Lancs PCT	Central Lancs PCT	Total
Assets	**£'000**	**£'000**	**£'000**
Land, build & equipment	6,938	203	7,141
Reserves & Provisions			
Revaluation reserve	2,244	20	2,264
Provisions	0	24	24
I&E reserve	4,694	159	4,853
Total reserves recognised	**6,938**	**203**	**7,141**

13. Impairments

Impairments in the year arose from:	Tangible		Intangible	
	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000	**Year Ended 31 March 2014 £000**	Year Ended 31 March 2013 £000
Other *	0	2,711	0	0
Total	**0**	2,711	**0**	0

* The prior year impairment related to a valuation of the trusts land and buildings as at the 31 March 2013 that resulted in a reduction in surplus of £2.5m. The balance related to the demolishing of a building no longer fit for purpose.

14. Capital commitments

Commitments under capital expenditure contracts at the SOFP date were:

	31 March 2014 £000	31 March 2013 £000
Property, plant and equipment	**26,145**	45,017
Total	**26,145**	45,017

15. Investments

	31 March 2014 £000	31 March 2013 £000
Cost or valuation		
Investments in associates	**18**	116
Total cost or valuation	**18**	116

This represents the trusts investment in a joint venture registered as Red Rose Corporate Services (RRCS). It was established as a Limited Liability Partnership (LLP) between Lancashire Care NHS Foundation Trust (LCFT) and Ryhurst Ltd. See note 28 for further details.

16. Inventories

	31 March 2014 £000	31 March 2013 £000
Consumables	**21**	20
Energy	**4**	6
Other	**254**	223
TOTAL	**279**	249

17. Trade and other receivables

17.1 Trade and other receivables

	31 March 2014 £000	31 March 2013 £000
NHS receivables	**8,778**	5,597
Other receivables with related parties	**3,103**	1,775
Provision for impairment of receivables	**(839)**	(431)
Prepayments and accrued income	**1,472**	1,677
Other receivables	**902**	2,314
Reclassified as held for sale	**0**	0
Trade and other receivables falling due within one year	**13,416**	10,932
Trade and receivables falling due after more than one year	**0**	0
TOTAL	**13,416**	10,932

17.2 Provision for impairment of receivables

	31 March 2014 £000	31 March 2013 £000
Balance at beginning of the year	**431**	348
Amount reversed during the year	**0**	0
Amount recovered during the year	**(36)**	(8)
Arising allowance recognised in income statement	**444**	91
Balance at 31 March 2014	**839**	431

The provision consists of overpayments of salary to current and former staff alongside items identified by review of outstanding debt, including items of a unique nature or that are greater then 12 months old.

17.3 Ageing of Impaired Receivables

	31 March 2014 £000	31 March 2013 £000
By up to three months	**0**	0
By three to six months	**0**	0
By more than six months	**839**	431
TOTAL	**839**	431

17.4 Receivables past their due date but not impaired

	31 March 2014 £000	31 March 2013 £000
By up to three months	**1,282**	659
By three to six months	**376**	351
By more than six months	**701**	301
TOTAL	**2,359**	1,311

LCFT does not provide for NHS receivables past their due date but only provides for non-NHS receiveables past their due date where it is thought appropriate. This is due to the reasoning that NHS receivables will eventually be settled at some point in the future. All receivables past their due date but not impaired are NHS.

18. Non-current assets held for sale and assets in disposal groups classified as held for sale

	31 March 2014 £000	31 March 2013 £000
Property, plant and equipment	**0**	0
Intangible assets	**0**	0
Investments	**0**	0
TOTAL	**0**	0

19. Cash and cash equivalents

	31 March 2014 £000	31 March 2013 £000
Balance at beginning of the year	**33,285**	27,327
Net change in the year	**2,549**	5,958
Balance at 31 March	**35,834**	33,285
Made up of:		
Cash at commercial banks and in hand	**84**	278
Cash with the Government Banking Service	**35,750**	33,007
	35,834	33,285

20. Trade and other payables

	31 March 2014 £000	31 March 2013 £000
NHS payables	**7,131**	6,467
Amounts due to other related parties	**7**	13
Other trade creditors	**4,191**	4,883
Capital creditors	**3,684**	1,810
Social Security costs	**2,201**	2,188
Other taxes payable	**2,077**	2,150
Other payables	**3,549**	3,345
Accruals	**10,803**	7,616
Trade and other payables falling due within one year	**33,640**	28,472
Trade and other payables falling due after more than one year	**0**	0
TOTAL	**33,640**	28,472

Other creditors include;

- £3,128k outstanding superannuation contributions at 31 March 2014 (£3,036k 31 March 2013).
- £45k outstanding pensions contributions at 31 March 2013 (£38k 31 March 2013).

21. Borrowings

	31 March 2014 £000	31 March 2013 £000
Loans from Independent Trust Financing Facility	**352**	176
Obligations under PFI contracts	**125**	125
Borrowings falling due within one year	**477**	301
Loans from Independent Trust Financing Facility	**22,563**	8,624
Obligations under Private Finance Initiative contracts	**2,746**	2,863
Borrowings falling due after more than one year	**25,309**	11,487
TOTAL	**25,786**	11,788

Expected timing of cashflows:

	31 March 2014 £000	31 March 2013 £000
Within one year	**477**	301
Between one and five years	**1,908**	1,204
After five years	**23,401**	10,283
TOTAL	**25,786**	11,788

The Independent Trust Financing Facility loan is to fund the development of the trusts new in-patient hospital, The Harbour. This represents drawings to 31 March 2014 against a total agreed loan of £60m that will be accessed by the trust over the project life.

22. Provisions

	31 March 2014 £000	31 March 2013 £000
Pensions relating to other staff	**189**	189
Other legal claims	**263**	169
Redundancy ***	**1,069**	1,553
VAT	**1,486**	0
Other ***	**247**	224
Provisions falling due within one year	**3,254**	2,135
Pensions relating to other staff	**1,710**	1,760
Provisions falling after more than one year	**1,710**	1,760
TOTAL	**4,964**	3,895

	Pensions £000	Legal £000	VAT £000	Other £000	**Total £000**
At 1 April 2012	1,926	352	0	954	**3,232**
Change in discount rate	(28)	0	0	0	**(28)**
Arising during the period	171	135	0	1,618	**1,924**
Utilised during the period	(142)	(106)	0	(581)	**(829)**
Reversed unused	(21)	(212)	0	(214)	**(447)**
Unwinding of discount	43	0	0	0	**43**
1 April 2013	1,949	169	0	1,777	**3,895**
Transfer by modified absorption	0	0		24	**24**
Change in the discount rate	97	0	0	0	**97**
Arising during the year	120	227	1,486	884	**2,717**
Utilised during the year	(142)	(77)	0	(1,331)	**(1,550)**
Reversed unused	(158)	(56)	0	(38)	**(252)**
Unwinding of discount	33	0	0	0	**33**
At 31 March 2014	**1,899**	**263**	**1,486**	**1,316**	**4,964**

Expected timing of cashflows:

	£000	£000	£000	£000	**£000**
Within one year	189	263	1,486	1,316	**3,254**
Between one and five years	756	0	0	0	**756**
After five years	954	0	0	0	**954**
	1,899	**263**	**1,486**	**1,316**	**4,964**

The pensions provisions are ongoing provisions which are regularly reviewed and revalued.

***Other provisions consists of: £1,069k redundancy provision, £185k Carbon Reduction Commitment tax and £62k dilapidation costs.

£5,507k is included in the provisions of the NHS Litigation Authority at 31 March 2014 (2012/13 £5,178k) in respect of clinical negligence liabilities of the Trust.

23. Tax payable

	31 March 2014 £000	31 March 2013 £000
PAYE	**2,077**	2,150
NI Contributions	**2,201**	2,188
Tax payable falling due within one year	**4,278**	4,338
Tax payable	**0**	0
Tax payable falling due after more than one year	**0**	0
TOTAL	**4,278**	4,338

24. Other liabilities

	31 March 2014 £000	31 March 2013 £000
Other Deferred income	**4,594**	4,973
Other liabilities falling due within one year	**4,594**	4,973
Other liabilities falling due after more than one year	**0**	0
TOTAL	**4,594**	4,973

25. Private Finance Initiative (PFI) Transactions

25.1 Obligations in respect of on-SOFP PFI schemes

	31 March 2014	31 March 2013
	£000	£000
Gross PFI liabilities:		
due in less than one year	**470**	470
later than one year and less than five years	**1,880**	1,880
later than 5 years	**2,303**	2,773
Finance charges allocated to future periods	**(1,782)**	(2,135)
Net PFI obligation	**2,871**	2,988
Not later than one year	**125**	125
Later than one year and less than five years	**648**	648
Later than 5 years	**2,098**	2,215

25.2 Commitments in respect of the "Service"element of on-SOFP PFI schemes

	31 March 2014	31 March 2013
	£000	£000
Within one year	**1,522**	1,141
2nd to 5th years inclusive	**6,088**	4,562
Later than 5 years	**3,652**	6,690
	11,262	12,393

25.3 Imputed finance lease obligations in respect of on-SOFP PFI schemes

	31 March 2014	31 March 2013
	£000	£000
Rentals due within one year	**470**	470
Rentals due within two to five years	**1,880**	1,880
Rentals due thereafter	**2,303**	2,773
	4,653	5,123
Less: interest element	**(1,782)**	(2,135)
Total	**2,871**	2,988

25.4 Additional Information

On 1 October 2006 the trust inherited a PFI development from Morecambe Bay PCT (MB). MB was in turn successor to the original NHS body that agreed the deal, Bay Community NHS Trust (BC).
The agreement in Feb 1999 between BC and the PFI provider, Flagship Care (Lancaster) Limited was for 25 years with the provider delivering:

- 3 fully serviced Elderly Mentally Ill Continuing Care Units plus attached Day Facilities,
- A single Resource Centre, and
- An office building.

The contract with Flagship Care (Lancaster), later transferred to Equitix Healthcare (Lancaster), expires on 8 February 2024 and there is no provision within the contract to re-price or re-negotiate the prices and dates. There is however the facility for variations to the contract and the NHS Foundation Trust has procedures to manage those variations in line with Standing Financial Instructions. The annual contract payments will be indexed each year using preceeding December RPI figures.

The Trust has the right to use the buildings, however Equitix have the responsibility for maintaining the buildings to an agreed standard. All lifecycle replacement is also the responsibility of Equitix.

A key feature of PFI schemes is that the operator is responsible for ensuring that the property is maintained to an agreed standard for the entire life of the contract. These are known as lifecycle costs. The cost which the operator expects to incur in doing this is reflected in the unitary payment and reflects two elements:

- maintenance (planned and reactive); and
- replacement of components as they wear out during the contract – this is known as capital lifecycle.

Under the terms of the contract at the end of the concession the trust has 3 options: Walk away from the arrangement, renegotiate a new contract, or acquire the residual interest at market value.

The trust initially did not recognise the properties as being on-SOFP, however, with the adoption of IFRS accounting by the NHS in 2009/10 the trust subsequently recognised the properties as being on-SOFP. This resulted in the introduction to the SOFP of a depreciating asset and an interest bearing liability.

The annual contract payments are apportioned, using appropriate estimation techniques, between repayment of the liability, interest costs and service charges. The payments are subject to annual indexation.

26. Contingencies

The trust had £190k (2012/13 £87k) of contingent liabilities, £105k re: legal claims and £85k in relation to the Risk Pooling Schemes for Trust's.

	31 March 2014	31 March 2013
	£000	£000
Contingent liabilities	**(190)**	(87)
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabiliies	**(190)**	(87)

27. Events after the Reporting Period

There are no material events after the reporting period.

28. Joint Venture Arrangement

The trust has entered into a joint venture registered as Red Rose Corporate Services (RRCS). It was established as a Limited Liability Partnership (LLP) between Lancashire Care NHS Foundation Trust (LCFT) and Ryhurst Ltd. The partnership was established with two primary objectives:

- To deliver estate and other commercial activities that enable the Trust to implement its services strategy and satisfy commissioners etc; and

- To capitalise on the combined skills and capabilities of the parties to exploit other estates and commercial opportunities.

The joint venture has one active subsiduary, Red Rose Corporate Services (Estate Management) LLP, that supports the trust in streamlining and identifying savings on the Trust's estate management

Its is anticipated that further subsiduaries may be created when business opportunities arise.

RRCS's mission is that it will work with the health and social care communities to deliver vibrant, efficient and effective services that enhance customer service provision and deliver a sustainable profit.

RRCS is committed to doing alll this whilst:
- acting with integrity in all it does;
- being transparent at all times;
- empathising with everyone it works with; and
- promoting teamwork in all areas.

29. Financial Instruments

The trust does not have any listed capital instruments and is not a financial institution.

Credit Risk

Credit risk is the possibility that other parties might fail to pay amounts due to the Foundation Trust. Credit risk arises from deposits with banks as well as credit exposures to the Foundation Trust's commissioners and other debtors. The bulk of the Trusts commisioners are NHS, which minimises the credit risk from these customers. Non-NHS customers do not represent a large proportion of income and the majority of these relate to bodies which are considered low risk - e.g. universities, local councils, insurance companies, etc...

An analysis of the ageing of debtors and provision for impairment can be found at Note 17 "Debtors".

Surplus operating cash is only invested with the Government Banking System.

Liquidity Risk

The trust's net operating costs are incurred under service agreements with the local primary care trust's, which are financed from resources voted annually by Parliament. The trust largely finances capital expenditure through internally generated funds and from loans that can be taken out up to an agreed borrowing limit. The borrowing is based upon a risk rating determined by Monitor, the Independant Regulator for Foundation Trusts and takes account of the trust's liquidity. The trust is therefore not exposed to significant liquidity risk.

Market Risk

All of the trust's financial liabilities carry nil or fixed rates of interest. In addition the only element of the trust's financial assets that is currently subject to a variable rate is cash held in the trust's main bank account and therefore the trust is not exposed to significant interest-rate risk.

Treasury Management Risk

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's policies agreed by the board of directors. Trust treasury activity is subject to review by the trust's internal auditors.

30.1 Financial assets by category

All assets are denominated in sterling

	31 March 2014	31 March 2013
	Loans and receivables £000	Loans and receivables £000
Investments	**18**	116
NHS receivables (net of impairment)	**8,778**	5,597
Accrued income	**29**	170
Other receivables	**4,609**	5,165
Other financial assets	**695**	575
Cash at bank and in hand	**35,834**	33,285
Total Financial assets	**49,963**	44,908

30.2 Financial liabilities by category

All liabilities are denominated in sterling

	31 March 2014	31 March 2013
	Other financial liabilities £000	Other financial liabilities £000
Loans	**22,915**	8,800
NHS payables	**7,131**	6,467
Other payables	**26,512**	22,005
Obligations under PFI contracts	**2,871**	2,988
Provisions under contract	**4,964**	3,895
Total Financial Liabilities	**64,393**	44,155

31. Third Party Assets

The Trust held £286k cash at bank and in hand at 31 March 2014 that relates to monies held by the NHS Trust on behalf of patients (£297k at 31 March 2013). This has been excluded from cash at bank and in hand figure reported in the accounts.

32. Prudential borrowing limit

The NHS foundation trust is no longer required to comply and remain within Monitor's prudential borrowing limit.

33. Related Party Transactions

Lancashire Care NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

Mr D Tomlinson, Director of Finance, is a remunerated Non-Executive Director of Niche Healthcare Consulting with whom the trust had financial transactions totalling £26k in 2013/14 (£0 2012/13).

All other directors of the trust have no interest, other than salary payment, with the trust or any of the trusts related parties.

The Trust has had a significant number of material transactions with entities for which the Department of Health is regarded as the parent Department. These entities are:

	2013/14 Debtor £'000	2013/14 Creditor £'000	2013/14 Income £'000	2013/14 Expenditure £'000
NHS Blackburn With Darwen CCG	**255**	**0**	**30,222**	**0**
NHS Blackpool CCG	**117**	**0**	**15,396**	**0**
NHS Chorley And South Ribble CCG	**477**	**0**	**34,547**	**0**
NHS East Lancashire CCG	**911**	**52**	**43,962**	**0**
NHS Fylde & Wyre CCG	**202**	**0**	**15,867**	**0**
NHS Greater Preston CCG	**721**	**0**	**37,990**	**0**
NHS Lancashire North CCG	**272**	**0**	**16,194**	**0**
NHS West Lancashire CCG	**449**	**0**	**11,869**	**0**
NHS England	**3,703**	**46**	**75,207**	**63**
Lancashire Teaching Hospitals NHS FT	**324**	**2,255**	**803**	**5,450**
NHS Property Services	**0**	**1,610**	**50**	**4,270**
Community Health Partnerships	**0**	**1,810**	**2**	**3,457**
Other DoH bodies *	**1,338**	**1,358**	**13,102**	**5,378**
	8,769	**7,131**	**295,211**	**18,618**

* represents immaterial transactions with a number of healthcare commissioners

The Trust has also had a significant number of material transactions with other entities who have commissioned our healthcare services. These entities are:

	2013/14 Debtor £'000	2013/14 Creditor £'000	2013/14 Income £'000	2013/14 Expenditure £'000
UCLAN	**11**	**0**	**32**	**203**
MIND	**0**	**0**	**0**	**69**
Making Space	**0**	**0**	**2**	**0**
Alzheimer's Society	**0**	**0**	**0**	**51**
Lancashire County Council	**2,014**	**5**	**21,590**	**2,318**
Blackpool County Council	**7**	**0**	**1,711**	**36**
Blackburn with Darwen Borough Council	**146**	**0**	**2,686**	**546**
Burnley Borough Council	**0**	**0**	**0**	**96**
Lancaster City Council	**0**	**0**	**0**	**180**
Preston City Council	**0**	**0**	**0**	**301**
South Ribble Borough Council	**0**	**0**	**0**	**193**
Wye Borough Council	**0**	**0**	**0**	**115**
Other local authorities*	**26**	**2**	**45**	**202**
	2,204	**7**	**26,066**	**4,310**

* represents immaterial transactions with a number of local authorities.

All income was received as income to commission heathcare services, and all expenditure relates to the associated operating expenses.

All transactions were conducted during the normal course of business in delivering healthcare.

Other related party transactions				
NHS Pension Scheme	0	3,128	0	23,753
National Insurance Fund	0	2,201	0	13,441
Other central government	0	2,077	0	1,719
	0	**7,406**	**0**	**38,913**

The trust has also entered into an loan arrangement with a Social Enterprise organisation that focusses on delivering increased choice and access to detoxification services across Lancashire; contributing to the successful provision of a whole treatment system thereby increasing positive outcomes for service users, carers and families.

The outstanding debtor represents finance the trust has provided to the enterprise for it to support the establishment of it's operations. This debt will be repaid to the trust from future operational surpluses.

	2013/14 Debtor £'000	2013/14 Creditor £'000	2013/14 Income £'000	2013/14 Expenditure £'000
Harvey House, Lancaster*	**899**	**0**	**0**	**120**
	899	**0**	**0**	**120**

*A number of the trusts employees have interests in Harvey House details of which can be found in the trusts Register of Interests.

The trust has also entered into an equally owned Joint Venture Partnership with Ryhurst Ltd, The venture, Red Rose Corporate Services LLP, has been established to support the development of state-of-the-art facilities to deliver modern mental health services in the future, and capitalise on the combined skills & capabilities of the parties to exploit estates and other commercial opportunities.

	2013/14 Debtor £'000	2013/14 Creditor £'000	2013/14 Income £'000	2013/14 Expenditure £'000
Red Rose Corporate Services LLP	**0**	**0**	**0**	**448**
Total	**11,872**	**14,544**	**321,277**	**62,409**

Lancashire Care NHS Trust Charity

The trust is a corporate trustee of the Lancashire Care NHS Foundation Trust Charity and Other Related Charities. The trust has received monies from the charity in respect of its management of the charity to the value of £7k (£7k to 31 March 2013). The charity is registered with the charities commission (Charity Number 1099568) and produces its own annual report and accounts. These documents are available on request from the Finance Department of the Foundation Trust.

34. Losses and Special Payments

There were 35 cases of losses and special payments totalling £22k paid during year to 31 March 2014 (56 totalling £40k for year to 31 March 2013). Special payments are recognised on an accruals basis.

35. Intra-Government and Other Balances

2013/14 Balances

Receivables

		Total	Non-WGA amounts	FTs	NHS Trusts	Department of Health	Public Health England	Health Education England	Special Health Authorities	NDPBs	Local Authorities	Bodies external to government	CCGs and NHS England	Other DH bodies	Other WGA
Current	NHS Receivables	8,778	0	602	273	389	0	24	0	0	0	0	7,472	9	9
Current	Other receivables with related parties	3,103	0	0	0	0	0	0	0	0	2,193	910	0	0	0
Current	Prepayments	1,443	0	0	0	0	0	0	0	0	0	1,443	0	0	0
Current	Accrued income	29	0	0	0	0	0	0	0	0	0	29	0	0	0
Current	Other receivables	63	0	0	0	0	0	0	0	0	0	63	0	0	0
Current	VAT, SS and other taxes receivable, Curren	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Current	NHS Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Other receivables with related parties	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Prepayments	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Accrued income	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Other receivables	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Balance as at 31 March 2014	**13,416**	**0**	**602**	**273**	**389**	**0**	**24**	**0**	**0**	**2,193**	**2,445**	**7,472**	**9**	**9**

Payables

		Total	Non-WGA amounts	FTs	NHS Trusts	Department of Health	Public Health England	Health Education England	Special Health Authorities	NDPBs	Local Authorities	Bodies external to government	CCGs and NHS England	Other DH bodies	Other WGA
Current	NHS payables	7,131	0	2,773	835	0	1	0	4	0	0	0	98	3,420	0
Current	Amounts due to other related parties	7	0	0	0	0	0	0	0	0	7	0	0	0	0
Current	Accruals	10,803	0	0	0	0	0	0	0	0	0	10,803	0	0	0
Current	Other payables	11,421	0	0	0	0	0	0	0	0	0	8,293	0	0	3,128
Current	VAT, SS and other taxes payable, Current	4,278	0	0	0	0	0	0	0	0	0	0	0	0	4,278
Non-Current	NHS payables	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Amounts due to other related parties	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Accruals	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Other payables	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Balance as at 31 March 2014	**33,640**	**0**	**2,773**	**835**	**0**	**1**	**0**	**4**	**0**	**7**	**19,096**	**98**	**3,420**	**7,406**

2012/13 Balances

Receivables

		Total	Non-WGA amounts	FTs	NHS Trusts	Department of Health	SHAs	PCTs	Special Health Authorities	NDPBs and Skipton Fund	Local Government	Central Government
Current	NHS Receivables	5,820	0	664	174	293	86	4,590	0	13	0	0
Current	Other receivables with related parties	1,775	0	0	0	0	0	0	0	0	1,775	0
Current	Prepayments	1,497	1,497	0	0	0	0	0	0	0	0	0
Current	Accrued income	170	170	0	0	0	0	0	0	0	0	0
Current	Other receivables	797	797	0	0	0	0	0	0	0	0	0
Current	VAT, SS and other taxes receivable, Curren	879	0	0	0	0	0	0	0	0	0	879
Non-Current	NHS Receivables	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Other receivables with related parties	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Prepayments	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Accrued income	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Other receivables	0	0	0	0	0	0	0	0	0	0	0
	Balance as at 31 March 2013	**10,938**	**2,464**	**664**	**174**	**293**	**86**	**4,590**	**0**	**13**	**1,775**	**879**

Payables

		Total	Non-WGA amounts	FTs	NHS Trusts	Department of Health	SHAs	PCTs	Special Health Authorities	NDPBs and Skipton Fund	Local Government	Central Government
Current	NHS payables	6,467	0	2,407	785	0	2	3,266	4	3	0	0
Current	Amounts due to other related parties	13	0	0	0	0	0	0	0	0	13	0
Current	Accruals	7,616	7,616	0	0	0	0	0	0	0	0	0
Current	Other payables	2,620	2,620	0	0	0	0	0	0	0	0	0
Current	VAT, SS and other taxes payable, Current	11,712	4,338	0	0	0	0	0	0	0	0	7,374
Non-Current	NHS payables	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Amounts due to other related parties	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Accruals	0	0	0	0	0	0	0	0	0	0	0
Non-Current	Other payables	0	0	0	0	0	0	0	0	0	0	0
	Balance as at 31 March 2013	**28,428**	**14,574**	**2,407**	**785**	**0**	**2**	**3,266**	**4**	**3**	**13**	**7,374**

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LANCASHIRE CARE NHS FOUNDATION TRUST

We have audited the financial statements of Lancashire Care NHS Foundation Trust for the year ended 31 March 2014 on pages 107-138. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2013/14.

This report is made solely to the Council of Governors of Lancashire Care NHS Foundation Trust 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 Council of Governors of the Trust, as a body, 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 Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 97 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2014 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Lancashire Care NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Timothy Cutler for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
St James' Square
Manchester
M2 6DS

28 May 2014

Lancashire Care NHS Foundation Trust

Quality Account 2013/14

Contents

Part 1: Statement on Quality from the Chief Executive of the Organisation

Lancashire Care NHS Foundation Trust is a health and wellbeing organisation providing a holistic service that is able to meet a wide range of health needs, supported by our mission to provide high quality care with wellbeing at its heart.

This Quality Account is our report about the quality of services we deliver. In this report we describe an account of the quality of services we provided for the period April 2013 to March 2014 and in addition to this, we set out our priorities for improving quality over the coming year from April 2014 to March 2015.

We have a duty to publish a Quality Account and we welcome this as a valuable opportunity to help raise awareness of our work. In conjunction with our Annual Report, this Quality Account will give you an overview of what we do and the range of our activities and current performance.

In developing our Quality Account our staff have been able to reflect on and demonstrate their commitment to continuous, evidence-based quality improvement. We want to be open as well, demonstrating real improvements where we can, and being honest about where we need to improve.

Quality is at the heart of everything we do in the organisation and is reflected within our Quality Strategy which ensures year on year quality improvements. There is no doubt that the future priorities are ambitious but they have been selected to have the highest possible impact on quality across Lancashire Care NHS Foundation Trust and reflect key national agendas.

We want our Quality Account to be part of our evolving conversation with the people we serve about what quality means and about how we must work together to deliver quality across the organisation. In offering you an overview of our approach to quality, we invite your scrutiny, debate, reflection and feedback.

The Council of Governors and Lancashire Care NHS Foundation Trust Board have approved this Quality Account which covers the full range of services we provide. To the best of our knowledge the information contained in this account is accurate. I hope that you find this Quality Account to be enlightening and informative.

Professor Heather Tierney-Moore
Chief Executive

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2.1) Priorities for Improvement - Forward Looking 2014/15

This section of the Quality Account is the 'forward looking' section. It describes the improvements related to the quality of services provided which Lancashire Care NHS Foundation Trust plans to take over the next year. This section explains why the Trust priorities have been chosen, how they will be implemented, monitored and reported.

Quality is about giving people treatments that work (effectiveness), making sure that they have a good experience of care (patient experience) and protecting them from harm (safety). Quality is part of our Trust value of excellence.

Three priorities were chosen following consultation with a range of stakeholders including service users, carers, members, staff, network directors, deputy directors of nursing and professional leads. Each priority relates to one of the quality domains of safety (implementation of the Quality Strategy), patient experience (implementation of the Friends and Family Test) and effectiveness (Harm Free Care Programme), reflecting a health and wellbeing organisation. The progress to date is reported in Part 3: Review of Quality Performance 2013/14. The priority areas continue to be a focus for ongoing quality improvements during 2014/15 with additional stretch targets added to ensure further improvements with positive impacts on patient care.

To inform the organisation's focus on quality and continuous improvement an appraisal of the national quality reports[1] published in 2013 was undertaken:

- Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013 (Francis 2).
- Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report Professor Sir Bruce Keogh July 2013 (Keogh Review).
- Promise to learn – a commitment to act. Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England August 2013 (Berwick Report). Common themes have been distilled from the recommendations which are reflected in the table on the next page. The common themes have been translated into a series of expected outcomes reflecting the achievement of goals and evidence of actions are incorporated within the Quality Strategy and throughout our quality priorities. As such separate action plans have not been developed as the principals are reflected throughout our approach to the provision of high quality patient care. In Lancashire Care NHS Foundation Trust both the Quality Strategy and the Appreciative Leadership Programme have given us a strong foundation from which to further build and develop quality services.

[1] http://www.midstaffspublicinquiry.com/report
http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

Francis - themes	Keogh - vision	Berwick - actions
Putting patients first & having common values	Demonstrable progress to reducing avoidable deaths in hospitals	Listen to and involve patients and carers
The importance of fundamental standards	Boards and leadership teams use data and other intelligence confidently and competently to inform quality improvement	Constantly monitor the quality and safety of care
Non-tolerance of non-compliance	Listen to patient and carer feedback & act upon it	Respond directly, openly, faithfully and rapidly to early warning indicators e.g. complaints
Openness, transparency & candour	Patients and clinicians are actively involved in CQC inspections	Embrace complete transparency
Compassionate, caring and committed staff	Organisations will not be isolated	Train and support all staff all the time
Patient centred leadership	Staffing levels and skill mix reflect patient needs	Create networks and learn from each other
Accurate, useful & relevant information	Junior doctors & student clinicians will be listened to	Use evidence based tools to ensure adequate staffing levels
	Happy and engaged staff positively effect patient outcomes	

Expected quality outcomes in Lancashire Care NHS Foundation Trust:

1. Quality of care and patient safety are at the top of our priorities for investment, inquiry, improvement, regular reporting, encouragement and support
2. Patients and carers are present, powerful and involved at all levels from wards and teams to the Board
3. Staff are present in appropriate numbers to provide safe care at all times and are well supported
4. As a learning organisation leaders create and support the capability for learning and change to continually and forever reduce patient harm.
5. Staff are committed to learning about patient safety and quality of care embracing the 'compassion' in care agenda at all levels
6. As a transparent organisation we share non-personal data on quality and safety in a timely and accessible form across the organisation and with both the public and regulators
7. To seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care
8. Staff are supported and the organisation learns from errors and improves practice, and also holds people to account

Across 2013/14 the Care Quality Commission (CQC) visited Lancashire Care NHS Foundation Trust to assess compliance with the Essential Standards of Quality and Safety[2]. Three moderate concerns and one minor concern were identified which have led to action plans being developed and submitted to the CQC. The progress of these action plans is monitored on an on-going basis through network governance meetings. In demonstration of Lancashire Care NHS Foundation Trust's commitment to the delivery of high quality care significant investment has been made to support the progression of quality improvement plans

[2] http://www.cqc.org.uk/organisations-we-regulate/registered-services/guidance-meeting-standards

and the Quality and Governance Directorate are working in partnership with the clinical teams and their leaders.

The challenges relate to:

- Ensuring that the skill mix and staffing levels are appropriate
- Strengthening the leadership arrangements in the service
- Implementation of an improvement plan in line with the Trust's Quality Strategy
- Strengthening governance arrangements to monitor quality standards and ensure that standards are met

In last year's Quality Account we reported the temporary closure of an inpatient ward following the identification of concerns that could impact on the quality of care provided. The Wordsworth Unit reopened in September 2013 and details of this can be found in section 3.

The implementation of the Quality Strategy[3] during 2013/14 has continued to focus on gaining a picture of quality across all clinical teams against the Essential Standards of Quality and Safety. The Quality SEEL is centred on the domains of Safety, Effectiveness, Experience and Leadership (SEEL) and is a self-assessment framework which enables team leaders to review the quality of care provided, at the point of care, and identify and address any issues which may compromise this. This approach of 'self-assessment' is entirely consistent with Lancashire Care NHS Foundation Trust's ambition to both win the hearts and minds of staff and to grow clinical leaders, who can lead their teams to deliver excellence. The assessment involves speaking to staff, patients, service users, carers, families, observing the care setting and reviewing clinical records. In presenting the outcomes in this way, the teams can start to build a picture of quality and have conversations as a team to continually monitor the quality of care provided and strive to constantly develop.

Across 2013/14 work has progressed to develop Team Information Boards to bring together a range of information to support and inform the team conversation about ongoing quality care provision and quality improvements. This includes any risks identified in relation to the Essential Standards of Quality and Safety which are included on team level risk registers with clear action plans which are monitored and reviewed by the clinical team and escalated through network governance processes as appropriate. In addition team level information in relation to incidents, complaints, compliments is available via the Datix system. To support real time availability of data and intelligence to support quality an electronic team information board is being rolled out across the organisation. As a result of the Quality SEEL, the identification of potential risks and ongoing conversations about quality at team level, through the team information boards, facilitates the flow of information from the point of patient care to the Trust Board.

During 2013/14 all clinical teams have completed a second self-assessment using the Quality SEEL and have team information boards and risk registers. The results are reported in section 3. The systems developed support a culture of openness and transparency in relation to areas of good practice and concern to enable Lancashire Care NHS Foundation Trust to continuously learn and improve the services and care we provide. This will be supported in 2014/15 by the development of a Service User Experience and Involvement Strategy. This strategy is being developed in partnership with service users, carers and stakeholders to ensure that experience is at the heart of everything we do in Lancashire Care NHS Foundation Trust.

During the final quarter of the year an issue emerged relating to the reporting of two performance targets to the Board of Directors. Following immediate investigations to understand the full extent of the matter, swift

3 http://www.lancashirecare.nhs.uk/CubeCore/.uploads/Publications/Quality_Account/Quality%20Improvement%20Strategy%20II.pdf

action was taken to address the issues including commissioning an external independent review by external auditors, KPMG, to advise on remedial action required and to provide further assurance through additional testing. Additional resource was added to Lancashire Care NHS Foundation Trust's Performance team to ensure immediate steps were taken to respond to the requirements.

An improvement plan relating to the specific data quality issues and the wider data and performance management culture was approved by the Executive Management Team on 13 May 2014 and continues to be monitored through Lancashire Care NHS Foundation Trust's governance arrangements.

Work is still ongoing to ensure Lancashire Care NHS Foundation Trust continues to capture the lessons learnt from this incident and this will be a priority during 2014/15. The impact on the quality of care received by Lancashire Care NHS Foundation Trust patients has been a fundamental part of our investigations. Lancashire Care NHS Foundation Trust confirms that patient care was not affected.

Lancashire Care NHS Foundation Trust has a number of key quality work streams focused on providing quality assurance and evidence of continuous quality improvement. Three of these quality priorities for 2013-15 are detailed below with additional stretch targets (reflected in bold) to ensure further improvements with positive impacts on patient care. Progress against the priorities for 2013 -14 is included in part 3.0.

Priority 1	**Quality Strategy Implementation**
Domain	Effectiveness
Rationale	Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013 (Francis 2). Quality in the new health system – maintaining and improving quality from April 2013. The NHS Outcomes Framework 2013/14.
Target	All teams will have completed the Quality SEEL All teams will have monitored progress against the Quality SEEL All teams will have completed the risk register and managed risks appropriately All teams will have team information boards and use these to drive quality improvements **All teams will have a quality improvement framework**
How progress will be monitored	Monitoring through team level to Network Governance to the Quality Committee
How progress will be reported	Network Governance to the Quality Committee

Priority 2	**All teams will seek the views of service users and carers to inform quality improvements**
Domain	Patient Experience
Rationale	Department of Health - The NHS Friends and Family Test
Target	Taking the learning from the local implementation in line with Lancashire Care NHS Foundation Trust's project plan **implement the NHS Friends and Family Test across the organisation in line with national guidance**
How progress will be monitored	Quality SEEL outcomes, team information boards and friends and family implementation plan
How progress will be reported	Team level progress will be discussed through Team Information Boards and escalated through Network Governance to Quality Committee

Priority 3	**Compliance with Harm Free Care national priority:** **Reduction in the number of pressure ulcers developed in our care** **Reduction in the number of falls** **Reduction in the number of catheter acquired infections** **To participate in a pilot of the Mental Health Harm Free Care Programme**
Domain	Safety
Rationale	Harm Free Care quality initiative. Commissioning for Quality and Innovation (CQUIN). Quality Strategy.
Target	Monthly submissions of the physical health safety thermometer for all applicable services to the Information Centre **To achieve the improvement target in relation to pressure ulcers** **Implementation of Mental Health Harm Free Care Programme in accordance with the Trust project plan**
How progress will be monitored	Monthly reporting to Health and Social Care Information Centre and quarterly submission to Commissioners
How progress will be reported	Harm Free Care sub groups, steering group and Quality Committee

2.2) Statements of Assurance from the Board

This section of the Quality Account is governed by regulations which require the content to include statements in a specified format; this allows the reader to compare statements for different Trusts. These statements serve to offer assurance to the public that Lancashire Care NHS Foundation Trust is performing to essential standards, providing high quality care, measuring clinical processes and involved in initiatives to improve quality.

Review of Services

During 2013/14 Lancashire Care NHS Foundation Trust provided three types of NHS services (mental health & learning disability services, community services and specialist services).

Lancashire Care NHS Foundation Trust has reviewed all the data available to them on the quality of care in these three NHS services via the quality schedule of the NHS standard contract and through the reconciliation of Commissioning for Quality & Innovation scheme (CQUIN).

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

Participation in Clinical Audits

During 2013/14, 5 national clinical audits and 1 national confidential enquiry covered NHS services that Lancashire Care NHS Foundation Trust provides.

During that period Lancashire Care NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

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

- National Audit of Schizophrenia
- National Audit of Learning Disabilities
- National Audit of Rheumatology
- National Audit of Memory Assessment Clinics / Services
- Sentinel Stroke National Audit Programme (SSNP)
- National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH)

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

Name of Audit	Participation	% Cases Submitted
National Audit of Schizophrenia	Yes	100 (100%) audit of practice 200 patient surveys (response to be confirmed by NAS when report circulated)
National Audit of Learning Disabilities	Yes	2 organisational checklist 15 case note audit 45 staff questionnaires 10 Carer/service user (response to be confirmed by NALD when report circulated)
National Audit of Rheumatology	Yes	Trust registered awaiting report
National Audit of Memory Assessment Clinics/Services	Yes	1 (100%)
Sentinel Stroke National Audit Programme (SSNP)	Yes	Part of yearly programme (figures to be confirmed when report circulated)

Name of National Confidential Enquiry	Participation	% Cases Submitted
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes	Suicide 100% Homicide 100%

The reports of the national clinical audits and national confidential enquiries that Lancashire Care NHS Foundation Trust participated in in 2013/14 will be reviewed and acted upon when published.

The reports of 32 internal clinical audits were reviewed by the provider in 2013/14 and the following are a selection of the actions Lancashire Care NHS Foundation Trust intends to take to improve the quality of healthcare provided:

1) **Audit: Quality Standard 6 Diabetes; Adult Community Diabetes Teams**

Audit statement measured: Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes self-management by the person with diabetes.

Example action: The current Proforma will be amended to include acute changes in plasma glucose levels and managing sick days of the service user; the Proforma to be rolled out to the Central Lancashire team.

2) **Audit: Suicide; Adult Community; Older Adult Mental Health**

Audit standard measured:

- A risk assessment must be completed and documented and inform the care planning process. Any new information gained which impacts on the assessment of risk must be identified and documented. This will trigger a review of the care plan
- All service users will be allocated a care coordinator. The care plan will identify the care coordinator and all those involved in supporting the care
- When the service user is discharged from inpatient services, a written discharge plan detailing immediate follow up care will be provided. The plan will have been developed at a formal review by all key practitioners and will include details of crisis and contingency arrangements and the medication prescribed on discharge. This plan must be forwarded to all key practitioners involved in delivery of the care
- All service users discharged from inpatient services will be followed up within 7 days of discharge
- Prior to discharge from the Care Programme Approach (CPA) all service users will have a CPA review

Example action: A communication to remind community teams of policy expectations around risk assessments and identification of additional risks triggering the care plan review has been circulated, including crisis and contingency arrangements.

3) **Audit: Quality Standard 8 Depression; Adult Mental Health Service**

Audit statement measured

- Service Users who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode
- Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the findings to adjust the delivery of interventions
- Improving Access to Psychological Therapies (IAPT). Service Users with persistent sub threshold depressive symptoms or mild depression receive appropriate low-intensity psychosocial interventions

- Service Users with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy
- Service Users with depression who have not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed

Example action: A formal performance improvement group to address the challenges facing this service has been implemented and the challenges have been recorded on an appropriate Risk Register. The performance improvement group is chaired by a senior member of staff (e.g. Clinical Director / Deputy Clinical Director) and reports to the Psychological Therapies Committee on a regular basis.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Lancashire Care NHS Foundation Trust in 2013/14, recruited in that period to participate in research approved by a research ethics committee was 1090.

Goals Agreed with Commissioners
Use of the CQUIN Payment Framework

A proportion of Lancashire Care NHS Foundation Trust income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between Lancashire Care NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The amount of income in 2013/14 conditional upon achieving quality improvement and innovation goals in Lancashire Care NHS Foundation Trust was £6,703,005. In 2012/13 this value was £6,652,578.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at: http://www.england.nhs.uk/nhs-standard-contract. Lancashire Care NHS Foundation Trust has worked closely with commissioners to agree local CQUIN goals as part of each contract. Examples include; care planning, smoking cessation, Making Every Contact Count and carer involvement

Statements from the Care Quality Commission

Lancashire Care NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered'. Lancashire Care NHS Foundation Trust does not have any conditions placed on its registration.

The CQC has not taken enforcement action against Lancashire Care NHS Foundation Trust during 2013/14.

Lancashire Care NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data Quality

Statement on Relevance of Data Quality and Actions to Improve Data Quality

Lancashire Care NHS Foundation Trust has/will be taking the following actions to improve data quality:

- Commissioned an external independent review by external auditors, KPMG, to advise on remedial action required and to provide further assurance through additional testing
- Added additional resource to Lancashire Care NHS Foundation Trust's Performance team to ensure immediate steps were taken to respond to the requirements
- Ensuring implementation of the improvement plan relating to the specific data quality issues and the wider data and performance management which will be monitored through Lancashire Care NHS Foundation Trust's governance arrangements
- Continuing to capture the lessons learnt from this incident, this will be a priority during 2014/15.

NHS Number and General Medical Practice Code Validity

Lancashire Care NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

Record Type	Area	Trust Compliance Up to Feb 2013/14
Patients Valid NHS Number	Admitted Patient Care	99.9%
	Outpatient Care	99.9%
Patients Valid General Practitioner	Admitted Patient Care	99.8%
Registration Code	Outpatient Care	100%
Source: SUS Data Quality Dashboard		*Data is governed by Standard National Definitions*

This data includes all Lancashire Care NHS Foundation Trust inpatient facilities (e.g. mental health wards and Longridge community hospital) and outpatient clinics (e.g. Musculoskeletal and Rheumatology). The reflects the reporting period April 2013 – February 2014 as March data has not been published at the time of completing this report. Lancashire Care NHS Foundation Trust continues to perform well against this metric.

Information Governance Toolkit Attainment Levels

Lancashire Care NHS Foundation Trust Information Governance Assessment Report score overall score for 2013/14 was 95.2% and was graded **Green.**

Clinical Coding Error Rate

Lancashire Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission. Lancashire Care NHS Foundation Trust did participate in the Connecting for Health Clinical Coding Audit in January 2014. This audit looks at the accuracy of diagnosis and procedure coding recording for all inpatient episodes. The results should not be extrapolated further than the actual sample audited.

Coding Field	Information Governance Requirement 514 Level 2 Target 2012-2013	Information Governance Requirement 514 Level 2 Target 2013-2014	Level Achieved 2012-2013	Level Achieved 2013-2014
Primary Diagnosis	>=85%	>=90%	92%	89%
Secondary Diagnosis	>=75%	>=80%	93%	91.82%
Primary Procedure	>=85%	>=90%	100%	None of the records audited had a primary procedure recorded
Secondary Procedure	>=75%	>=80%	87%	None of the records audited had a secondary procedure recorded

Source: SUS Data Quality Dashboard *Data is governed by Standard National Definitions*

The overall accuracy of clinical coding is good with a performance meeting level 2 in Information Governance Toolkit Requirement 514. The accuracy of the clinical coding is shown in the table above. None of the records audited had a primary or secondary procedure recorded. Lancashire Care NHS Foundation Trust information reflects Electroconvulsive therapy (ECT) procedures only, which are limited in number.

Good practice was noted in the process the Trust's clinical coders follow in retrieving the information, which is supported by a robust electronic patient record.

As a result of the findings the assurance level provided in respect of clinical coding and underlying processes was:

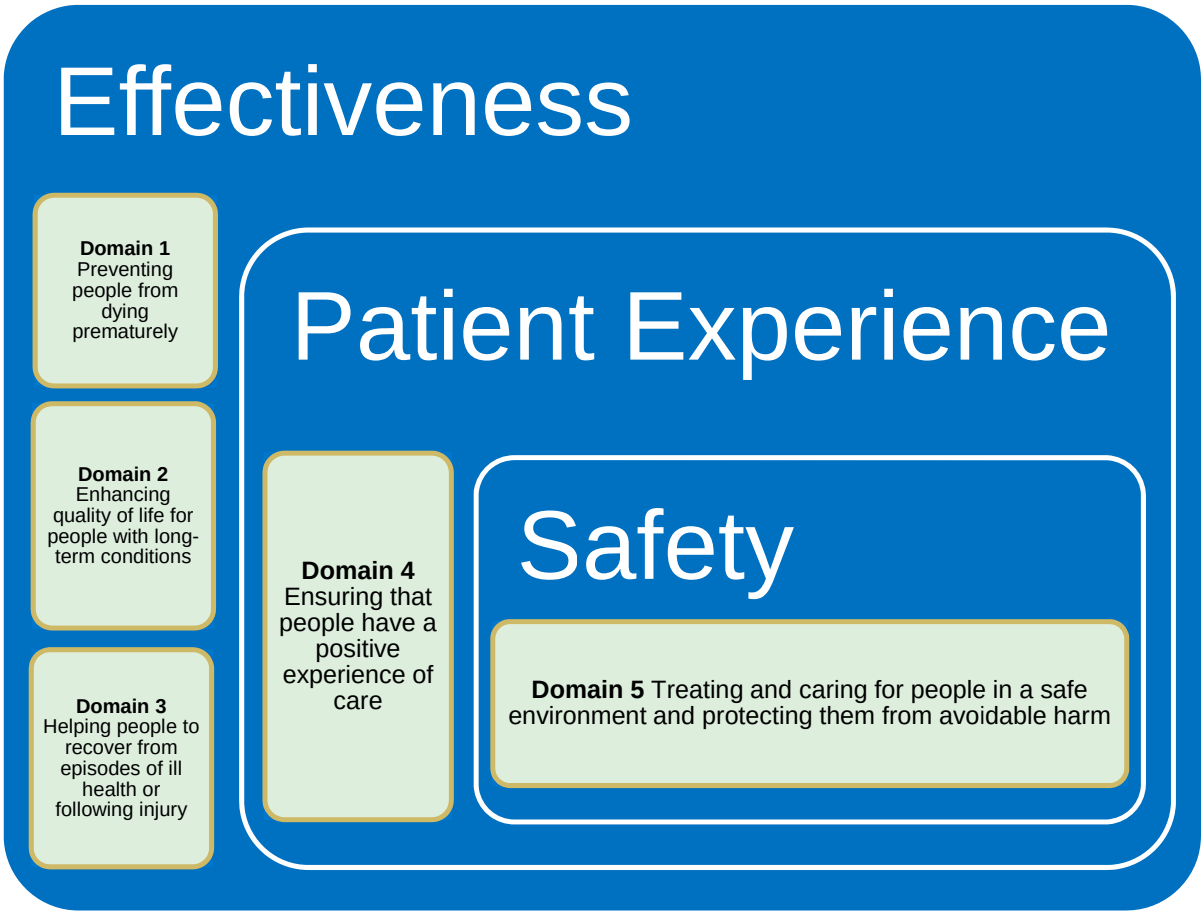
SIGNIFICANT ASSURANCE

2.3) Reporting against core indicators

This section of the document contains the mandatory indicators as set by the Department of Health and Monitor. For Lancashire Care NHS Foundation Trust this includes indicators relevant to all trusts and all trusts providing mental health services. There are no mandatory quality indicators for community services.

The indicators are linked to the five domains of the NHS Outcomes Framework and the quality domains of safety, experience and effectiveness.

NHS Outcomes Framework and Quality Domains



Effectiveness

Domain 1: Preventing people from dying prematurely Domain 2: Enhancing quality of life for people with long-term conditions					
Indicator	Target	2012/13 Outcome	2013/14 Outcome	2013/14 England Average	Targets Achieved
Patients on Care Programme Approach (CPA) who are followed up within seven days of discharge from psychiatric inpatient care	95.0%	96.0%	95.9%	97.3%	✓
Admissions to inpatients services for which the Crisis Resolution Home Treatment acted as a gatekeeper	95.0%	98.0%	97.0%	98.7%	✓
Data source: LCFT Internal Information System (eCPA and NCRS) Data is governed by Monitor definitions					

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

- The data is reported from our local system to the Health and Social Care Information Centre

For patients on Care Programme Approach who are followed up within 7 days of discharge from psychiatric inpatient;

- Lancashire Care NHS Foundation Trust has reported CPA 7 day follow-ups in the same way for a number of years, achieving consistently good performance. However, Lancashire Care NHS Foundation Trust has identified a data extraction issue relating to the definition used for this indicator. Lancashire Care NHS Foundation Trust has reviewed all 2013/14 quarterly submissions and revised the calculation to comply with this. The figures already submitted to Monitor for 2013/14 showed achievement of target for all quarters, this remains unchanged with the implementation of the appropriate definition. The data reported for 2012/13 reflects the former interpretation of the definition.

For admissions to inpatient services for which the Crisis Resolution Home Treatment Team acted as a gatekeeper:

- Lancashire Care NHS Foundation Trust has continued to report all gate kept admission, rather than just the under 65s, and the figures reported to Monitor reflect this. The trust achieved the target for all quarters including the over 65 age range as well as when using the under 65's only.

Lancashire Care NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by:

For patients on Care Programme Approach who are followed up within 7 days of discharge from psychiatric inpatient;

- Ensuring trust-wide sign-off of the definition used
- Regular data quality reviews undertaken to check coding
- Ensuring that this data is available in Lancashire Care NHS Foundation Trust's performance systems and is regularly monitored, both at service and executive level, enabling ownership, self-monitoring and improvement.

- Ensuring all service users about to be discharged have a confirmed follow up appointment with date, time, venue and name of the practitioner who will see them. Appointment cards will standardise this information.
- Ensuring that where a service user is thought to be unlikely to engage, Lancashire Care NHS Foundation Trust will negotiate a telephone follow-up and record this as part of the follow up plan
- Ensuring if a service user is arrested, Lancashire Care NHS Foundation Trust will liaise with the Criminal Justice Liaison service and try to secure information to support follow up. If the service user is in custody Lancashire Care NHS Foundation Trust will request follow up by the Prison Mental Health In-reach Team.
- The adoption of the new construct for all future reporting
- Facilitating a pre discharge meeting with Service Users to secure better engagement and higher potential for attendance at scheduled meetings
- Ensuring robust reporting of whether a service user is on the Care Programme Approach or not
- The inauguration of Operational Performance Group chaired by the Chief Operating Officer overseeing performance of all key metric

For admissions to inpatient services for which the Crisis Resolution Home Treatment Team acted as a gatekeeper:

- Ensuring that future reporting is in line with Monitor guidance and only those service users under 65 will be included in the return

Domain 1: Preventing people from dying prematurely
Domain 2: Enhancing quality of life for people with long-term conditions

Indicator	Target	2013/14 Outcome	2013/14 England Average	Targets Achieved
Patients on Care Programme Approach (CPA) who have a formal follow-up within 12 months.	95.0%	97.2%	79.8%	✓

Data source: LCFT Internal Information System (eCPA and NCRS) Data is governed by Monitor

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

- The data has been taken from internal reporting systems and is regularly reviewed

Lancashire Care NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by:

- Implementation of a new Performance and Information Improvement Plan, which addresses data quality, reporting and systems.
- Continuing to prioritise the collection and quality of this data through the Performance Strategy, monitoring issues at the weekly Senior Operational Performance Group.
- Ensuring consistency in recording of data.
- Ensuring that this data is monitored weekly as part of Lancashire Care NHS Foundation Trust's performance systems.

Domain 2: Enhancing quality of life for people with long-term conditions				
Indicator	Target	2012/13 Outcome	2013/14 Outcome	Targets Achieved
Minimising mental health delayed transfers of care	<=7.5%	4.6%	7.8%	✗
Meeting commitment to serve new psychosis cases by early intervention teams	95%	152%	131%	✓
Data source: LCFT Internal Information System (eCPA and NCRS) Data is governed by standard definitions				

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

- The data has been taken from internal reporting systems
- In relation to minimising mental health delayed transfers of care, through the year, coding of "medically fit" on the case note improved, resulting in increases in reports of delayed discharges, and the threshold was breached in quarter 3
- The target relating to meeting the commitment to serve new psychosis cases by early intervention teams refers to 95% of the commissioned caseload. More than the commissioned caseload were seen by the Early Intervention Team, which resulted in the target being exceeded

Lancashire Care NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by:

In relation to minimising mental health delayed transfers of care by:

- The development of Performance Improvement Strategy for Lancashire Care NHS Foundation Trust which places delivery of Monitor targets as the first priority, establishes a hierarchy of reporting focussing on this for use down from the trust board, to Executive Management Team, to Network performance meetings.
- Enhanced network performance meetings concentrating on the hierarchy described above.
- The Performance Department and Network Directors examining current arrangements and relationships with a view to developing a more effective focus on performance issues
- Weekly phone conference between the Deputy Clinical Director, ward Modern Matrons and performance team to drive discharge process and ensure correct coding of "medically fit" date. Focus includes both current delays, and better/earlier planning for complex delays
- The development of better information on current delays and performance tracking for operational staff within a "Monitor Compliance" report. Internal targets for new delays will be developed and tracked.
- The inauguration of a weekly Operational Performance group with Chief Operating Officer and Network Directors and Director of Performance to ensure high level focus on Delayed Transfers of Care
- Consistent approach for monitoring and addressing delayed transfers of care across all networks.
- Engagement with commissioners to ensure suitable focus on delays as a Lancashire Care NHS Foundation Trust priority, and development of an escalation process to formally highlight delays to responsible commissioners
- Weekly senior operational meeting with senior clinical and operational staff to share good practice on improving performance

- Development of internal standard operating procedure (SOP) which will include a flow diagram for managing discharges, and prioritisation processes.
- Ensuring consistency in recording of data.
- As with all key Monitor indicators, and other indicators for Lancashire Care NHS Foundation Trust, an executive lead will be agreed for the indicator who will be responsible for overseeing the reporting of the indicator and accountable for its delivery

Domain 2: Enhancing quality of life for people with long-term conditions					
Increasing Access to Psychological Therapies (IAPT)					
The % of people who are moving to recovery as a proportion of those who have completed a course of psychological treatment	**Target**	**2012/13 Outcome**	**2013/14 Outcome**	**Variance between 2013/14 and target**	
North Lancashire (5NF)	50%	38%	37%	↓	-13%
East Lancashire (5NH)	50%	44%	42%	↓	-8%
BwD (5CC)	50%	40%	31%	↓	-19%
Central (5NG)	50%	36%	37%	↓	-13%
Data Source: LCFT Information Systems using standard definitions					

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

- The data has been taken from internal reporting systems
- There is no data for Blackpool as primary care mental health services are provided by the Acute Trust

Failure to deliver against the IAPT targets reflects both access to services and data quality issues.

Lancashire Care NHS Foundation Trust intends to take/has taken the following actions to improve this percentage, and so the quality of its services, by:

- The board approving the purchase of IAPTus, which is the national leading system to support IAPT delivery and reporting.
- Data Project Group has been convened that meets weekly to ensure;
    - Data submissions comply with the requirements of the IAPT 1.0 data standard,

    - Data standard 1.5 is delivered from 01/07/14
    - Implement IAPTus. This will be project managed
- Rectifying identified shortfalls in data submissions, future reports will reflect actual performance
- Actioning National IAPT team recommendations over the coming few months. Delivery against actions will be monitored internally and externally
- Convening an internal weekly IAPT Recovery and Performance Meeting chaired by the Deputy Clinical Director with support from the Network Director. This meeting will
    - Monitor and review progress against performance targets
    - Overview delivery of the action plan from Intensive Support Team visit against agreed milestones
    - Overview service recovery
    - Review and approve Performance Reports to ensure accuracy
    - Ensure robustness of current data systems
    - Overview implementation of IAPTus. To include data cleansing and migration.
    - Ensure that the actions do not adversely affect care quality, safety or outcomes
- Convening a two weekly meeting with the Clinical Commissioning Group and Lancashire Care NHS Foundation Trust representatives to monitor and review progress against the action plan.

Patient Experience

The question "% of patients who rate the overall service they received in the last 12 months as excellent, very good or good," has been discontinued in the 2013 survey and as such is no longer comparable to 2013 outcomes. The replacement question is shown in the table below.

Domain 4: Ensuring that people have a positive experience of care					
Indicator	**2012 Outcome**	**2013 Outcome**	**National Average 2013**	**Comparison to National Average**	
Community Mental Health Services: Overall, the rating of your experience was? Outcomes for Ratings 8-10 used. (Scale 0-very poor experience to 10-I have a very good experience)		58.7%	52.8%	5.9%	↑
Inpatient Mental Health Services: % of patients who rate the overall care they received during their recent stay in hospital as excellent, very good or good.	72%	69.4%	69.6%	-0.2%	=
Date Source: National Community Mental Health Survey *Mental Health Inpatient Survey*			*Data is governed by standard definitions*		

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

- This data has been taken from the national survey data
- The Community Mental Health Survey rated Lancashire Care NHS Foundation Trust as "Better than other Trusts" on 5 of the 9 sections. The Trust was rated "The same as other Trusts" for the remaining 4 sections
- Lancashire Care NHS Foundation Trust scores indicated they were better than other Trusts for care plans, care review meetings, crisis care and day to day living.
- Lancashire Care NHS Foundation Trust scores indicated that they were the same as other Trusts for health and social care workers, medications, talking therapies and care co-ordination.
- The overall score for the inpatient survey is similar to the national average
- Individual scores for Lancashire Care NHS Foundation Trust when benchmarked against other Trusts indicate that for 3 items Lancashire Care NHS Foundation Trust was in the top 20% of Trusts (information about ward routine, dietary needs and talking therapies); for 2 items Lancashire Care NHS Foundation Trust was in the bottom 20% of Trusts (shared sleeping areas, delayed discharge).

Lancashire Care NHS Foundation Trust intends to take the following actions to continue the programme of improvement

- Environmental improvements including a new build Mental Health Centre
- Development of a staff competency framework
- Introduction of Infection Control champions
- Development of a service user co-ordinator post

Domain 4: Ensuring that people have a positive experience of care				
Indicator	**2012 Outcome**	**2013 Outcome**	**National Average 2013**	**Comparison to National Average**
% of staff employed by Lancashire Care NHS Foundation Trust, who would recommend Lancashire Care NHS Foundation Trust as a provider of care to their family or friends.	67%	60%	59%	↑ 1%
Date Source: National NHS Staff Survey Co-ordination Centre **http://nhsstaffsurveys.com/cms/index.php?page=staff-survey-2013**				*Data is governed by standard definitions*

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

- The data has been taken from the national staff survey

Lancashire Care NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- Complementing this annual staff survey with the introduction of the staff friends and family test which will provide information on a quarterly basis. This will inform quality improvements.

Domain 2: Enhancing quality of life for people with long-term conditions Domain 4: Ensuring that people have a positive experience of care				
Indicator	**2012 Outcome**	**2013 Outcome**	**2013 National Average**	**2013 Comparison to National Average**
Patient experience of contact with community mental health services staff (Score out of 100)	85.9	80.0	85.8	↓ 5.8
Data Source: Community Mental Health Survey *https://indicators.ic.nhs.uk/webview/ P01413*			*Data is governed by standard definitions*	

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

- The data has been taken from the Health and Social Care Information Centre
- Data is calculated as the average from 4 survey questions, an average weighted score (by age and sex) is calculated for each of the questions:
  Did this person listen carefully to you?
  Did this person take your views into account?
  Did you have trust and confidence in this person?
  Did this person treat you respect and dignity?

Lancashire Care NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- Implementing a new Patient Experience and Involvement Strategy in 2014-15
- Further development of care planning programme
- Developing a staff competency programme

Safety

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm												
	1 April 2012 to 30 September 2012 (NRLS report)				1 October 2012 to 31 march 2013 (NRLS report)				1 April 2013 to 30 September 2013			
Indicator	LCFT	National Average	Comparison to National Average		LCFT	National Average	Comparison to National Average		LCFT	National Average	Comparison to National Average	
Rate of patient safety incidents	38.5 per 1,000 bed days	23.8 per 1,000 bed days	↑	14.7 per 1,000 bed days	39.2 per 1,000 bed days	Not available		Not available	48.45 per 1,000 bed days	26.37 per 1,000 bed days	↑	22.08 per 1,000 bed days
Percentage resulting in severe harm	0.2% (7 cases)	0.8%	↓	0.6%	0.7% (28 cases)	Not available		Not available	0.3% (11 cases)	0.4%	↑	0.1%
Percentage resulting in death	0.1% (3 cases)	0.8%	↓	0.7%	0.3% (11 cases)	Not available		Not available	0.6% (25 cases)	0.9%	↓	0.3%
Data Source: National Reporting and Learning System									*Data is governed by standard definitions*			

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

- The data has been taken from the National Reporting and Learning System (NRLS)
- The latest data available from the NRLS reports is for 1 April 2013 to 30 September 2013
- Data reports are made available six months in arrears
- NRLS[4] encourage high reporting of patient safety incidents. "Scrupulous reporting and analysis of safety related incidents, particularly incidents resulting in no or low harm, provides an opportunity to reduce the risk of future incidents. Research shows that organisations which report more usually have a stronger learning culture where patient safety is a high priority. Through high reporting the whole of the NHS can learn from the experiences of individual organisations"
- The Trust reporting rate is higher than average which represents a maturing safety culture and the Trust remains in the top percentile of reporters (NRLS, 2014) in the current comparable cluster of Trusts. The incident reporting data is reviewed by the Trust alongside a 6 monthly thematic analysis and report of serious incidents
- Due to the judgemental nature of this indicator it is difficult to be certain that all incidents are identified and reported and that all incidents are classified consistently within the organisation and nationally. One individual's view of what constitutes severe harm can differ from another's substantially. As a Trust we work hard to ensure all our staff are aware of and comply with internal policies on incident reporting and standardisation in clinical judgements
- The Trust period to period comparison highlights an increase in the actual number of deaths despite the overall percentage remaining low and comparison with other Trusts in the cluster being comparable – however this variation has been investigated by the Trust and it is considered that differences in data reporting and quality checking of data before submission has resulted in an artificially high figure for the period of April to September 2013 , in addition to a way in which the Trust records community mental health deaths.

[4] NRLS Frequently asked questions (FAQs) about the Data http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/#11

- The Trust has reported a higher number of documentation errors compared with other Trusts in the cluster and this is being reviewed in the serious incident thematic analysis and report. The Trust is also strengthening the specialist involvement of its specialist Information Governance Team in the serious incident governance process
- Further details of patient safety incidents and reporting of serious incidents can be found in the Safety section of this document.

Lancashire Care NHS Foundation Trust has taken the following actions to improve its incident reporting rates and therefore patient safety:

- Continued development of the Datix risk management system including the usage of Dashboard and Hotspot analysis tools and the action planning module
- Provided a programme of training in incident reporting and root cause analysis
- Established a serious incident governance group to provide enhanced quality assurance of post incident reviews
- Delivered a number of Daring to Share and Time to Shine events to promote learning from incidents across the Trust.

Part 3: Review of Quality Performance 2013/14

This section of the document reports on the quality performance across Lancashire Care NHS Foundation Trust in the past year. Quality is reported using a combination of measurable indicators and best practice examples from our services.

Overview of Services Provided

Lancashire Care NHS Foundation Trust provides health and wellbeing services for a population of around 1.4 million people. The Trust covers the whole of the county and employs around 7,000 members of staff across more than 400 sites.

A range of clinical services are delivered through four Networks as in the table below which is not an exhaustive list but gives a flavour of the services provided. A comprehensive list can be found at http://www.lancashirecare.nhs.uk/services

Adult Community	**Specialist Services**	**Adult Mental Health**	**Children and Families**
• Adult Learning Disabilities • Community Matrons • Community Older Adult Mental Health Teams • Dental Services • Dermatology • Diabetes • District Nursing • Health Improvement • Inpatient Dementia beds • Longridge Hospital • Memory Assessment Services • Occupational Therapy • Physiotherapy • Podiatry • Speech and Language Therapy • Stroke and Rehabilitation • Treatment Rooms	• Criminal Justice Mental Health Team • Forensic Community Mental Health Team • Low Secure Inpatient Units • Medium Secure Inpatient Units • Mentally Disordered Offenders • Prison Healthcare • Substance Misuse Services	• Adult Mental Health Inpatient Care • Complex Care and Treatment Teams • Eating Disorder Services • Mental Health Liaison Teams • Mindfulness • Primary Care Mental Health Services • Restart Social Inclusion and Day Services • Specialist Psychological Interventions • Supported accommodation and group homes • Veterans Mental Health	• Alcohol and Drugs, Education • Child and Adolescent Mental Health Services • Children and Family Psychological Services • Contraceptive and Sexual Health Services • Early Intervention Service • Health Improvement Services • Health Visiting and School Nursing • Homeless Team • Safeguarding Vulnerable Adults and Children • Services for Children with Complex and Additional Needs
Corporate Services give support across the networks and includes the following functions: Quality and Governance, Human Resources, Finance, Learning and Organisational Development, Transformation Team, Research and Development, Clinical Audit, Safeguarding and Infection prevention and control.			

In part 3 we will report against the quality priorities for 2013/14. Networks and corporate services have provided case studies which illustrate the high quality services they provide. Team leaders were asked to provide examples of service improvements and innovations building on areas of development identified by the team for example: from patient feedback, clinical audit findings, CQC visits and appreciative leadership action research projects. Many of the case study examples reflect the promotion of both self-care and self-management support**.** Self-care is all about individuals taking responsibility for their own health and wellbeing. This includes: staying fit and healthy, both physically and mentally and taking action to prevent illness and accidents. Self-management support is any activity that enables a person to develop the confidence, knowledge and skills to be able to manage their long term health condition in a collaborative partnership with the healthcare team.

Effectiveness

This section of the document explains the effectiveness of treatment or care provided by services. This is demonstrated using clinical measures or patient/service users' feedback, this may also include people's wellbeing and ability to live independent lives.

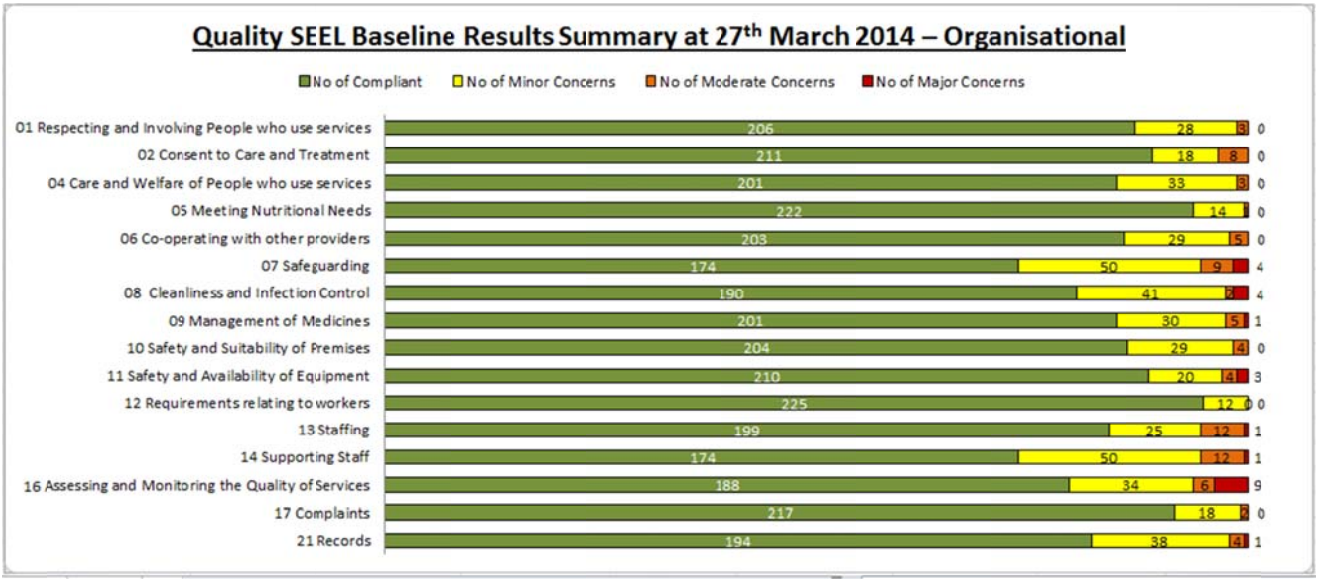
Other quality indicators relating to the domain of effectiveness have been reported in section 2.3 and include:

- Patients on Care Programme Approach (CPA) who are followed up within seven days of discharge from psychiatric inpatient care
- Admissions to inpatient services for which the Crisis Resolution Home Treatment Team acted as a gatekeeper
- Patients on Care Programme Approach (CPA) who have a formal review within 12 months
- Minimising mental health delayed transfers of care
- Meeting commitment to serve new psychosis cases by early intervention teams
- Increasing access to psychological therapies – the percentage of people who are moving to recovery as a proportion of those who have completed a course of psychological treatment

Quality Priority 1 - Quality Strategy Implementation	
Target	**Progress**
• **All teams will have completed the Quality SEEL** • **All teams will have monitored progress against the Quality SEEL** • **All teams will have completed the risk register and managed risks appropriately** • **All teams will have team information boards and use these to drive quality improvements**	 All teams have completed Quality SEEL self-assessments during 2012/13 and 2013/14 with these findings reflected on the Team Information Boards and in team level risk registers.

The information below reflects the new baseline positions resulting from the Quality SEEL self-assessment process completed during the latter part of 2013/14. The system has been further developed to enable changes to the dashboard to be made in year to illustrate the effective management of risks to quality and to reflect any new risks identified in year. As such the information will always reflect the current position which will support and enable teams to use the data to inform conversations about quality and quality improvement.

The self-assessment and associated validation process supports a culture of openness and transparency in that concerns are identified and teams receive the appropriate support to empower them to lead the necessary changes. This information is presented as part of the Lancashire Care NHS Foundation Trust Board report reflecting quality performance and outcomes information known as the Board Balanced Scorecard, supporting ward / team to Board information flows.



Data Source: Quality SEEL dashboard, LCFT

Risk Registers

Training has been delivered as part of the implementation of the Quality SEEL tool to ensure that any areas of risk that were identified by the Quality SEEL assessment would then be captured on a risk register and proactively monitored. Following the initial training that was focused on individual ward and team managers, subsequent training was delivered on a wider scale and was expanded to include service managers, business unit managers and clinical leads. Work is ongoing to ensure all risks identified have information on Controls and Assurances included and that individual action plans are created to enable comprehensive detail of the risks and their mitigation to be recorded. The use of the Datix (the system used to support risk management) dashboard module has enhanced the process in the way that risks align to the CQC Outcomes is easily obtainable and dynamic.

Team Information Boards

Clinical teams across the organisation have Team Information Boards (TIBs) in place to facilitate and enable ongoing conversations about quality. The TIB enables a variety of team specific data and additional information to be viewed in one place, the team can then discuss the findings and implications of this and triangulate the data to support continuous quality review and improvement. An associated learning programme has progressed across 2013/2014 for teams to whom the TIB was a new concept. Teams continue to develop their TIBs both in terms of the content and the way in which they understand and use the information. An overview of this learning programme can be viewed on the next page:

Poster summarising impact of the Team Information Board Learning Sessions

Title: **TIB Session Feedback Summary - Update** Date: 26/11/2013 Version: 1.1 Author: Lean Development Team

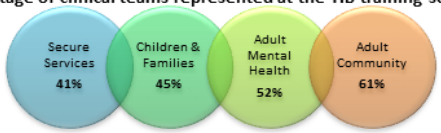
Lancashire Care NHS
NHS Foundation Trust

Background

Team Information Boards (TIB) are physical boards situated throughout the workplace. They bring people together to support key conversations and add value to a team's way of working. They help you visualise how you are performing with real time data, and can help save you time by displaying essential information to assist you and your teams work. TIB Sessions have been developed to provide staff with knowledge, skills and tools to start developing their own boards, this approach has been embedded into the Quality Strategy II.

What we have delivered

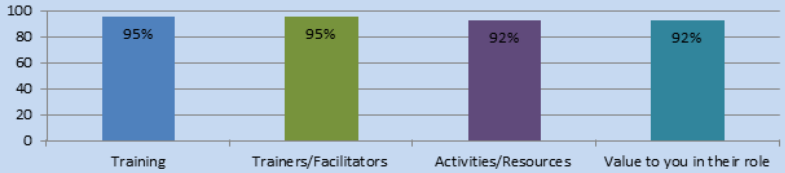
Percentage of clinical teams represented at the TIB training sessions



- 31 half day TIB Sessions between 16th May 2013 to 30th October 2013 (348 Staff attended)
- Follow-up bespoke TIB sessions offered at training (17 delivered)
  - Provide support and guidance to individual clinical teams
  - Facilitate team conversations in creating their vision for their TIB
  - Developing team roles and responsibilities in regards to the board and huddle
  - Provide independent feedback on the continuous improvement of teams TIB and huddle
- Attended 4 Quality Drop in Sessions providing information and guidance on TIBs

Feedback from staff on quality of sessions

What staff attending training scored the key comments (Excellent/Good)



What extent have the materials and learning activities equipped you to take action back in the workplace and with the team?

"The video was a great tool for sharing how others have used the TIB"

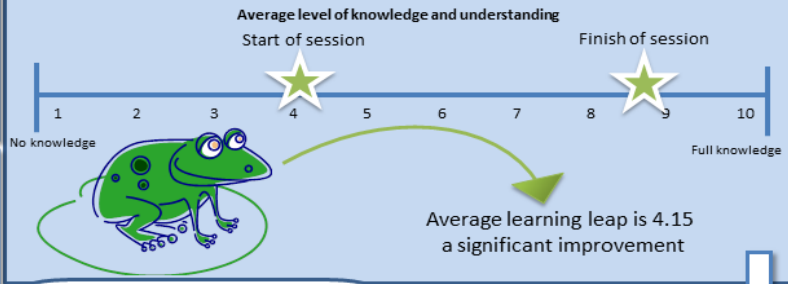
"Loved seeing other examples, especially in the room, only seen pictures previously. Aware now of how varied we can make it."

"Good materials used and familiar styles could be adapted in my workplace to define standards in every area of work"

"Visual TIB very useful, constant reminder during the session, linked the talk to the board"

Self reported increase in learning

Average level of knowledge and understanding



What staff said about the training

The workshop has shifted by thinking about TIBs

"I can see how we can make monitoring performance more inclusive so the team are involved rather than it is done to them"

"Initially I had no idea of how this board will be utilized. I now understand how the board should quickly capture information and assist the team to operate more effectively. I plan to disseminate the information to staff at development day"

"See the value rather than another task to do"

How I promise to proactively apply this new thinking!

"Talk to other members of staff and actively get involved in collating information for the board, pass on the theory behind the ideas"

"To sit down with team and discuss our hopes for the board, plan to allocate responsibilities for team sections once all committed to its development"

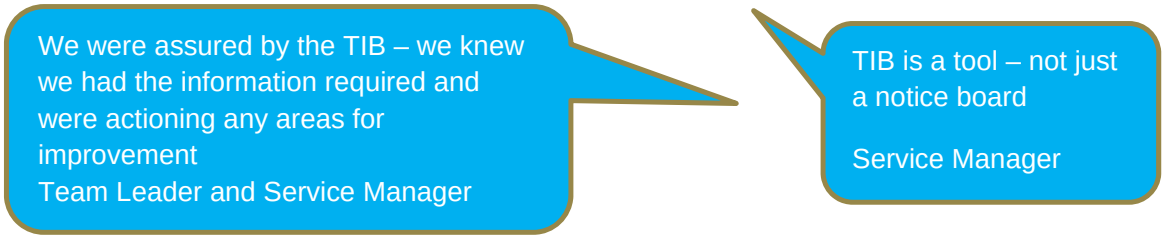
"We are developing our TIB so I promise to talk and involve the team from the start"

Next Steps

- 3 half day TIB training sessions arranged between December and February (capacity 45)
- Training Video highlighting the value of TIBs to be used in TIB sessions, quality drop in sessions and available on lean intranet page
- Attend quality drop in sessions to provide information and guidance on how TIBs provide a good communication tool and value for linking performance, Quality SEEL, risk registers and continuous improvement
- Visit teams to provide independent feedback on the continuous improvement of their TIB and team huddle

Team comments about how the Team Information Board quality information informed CQC visits

- The inspector was impressed by the development of the Team Information Board (TIB) – as information about quality was visible and up-to-date.
- In Lancashire Care NHS Foundation Trust the TIB is the way the quality of care provided is monitored at team level
- The TIB included serious incidents, risks, audit, National Institute for Health and Care Excellence (NICE) Guidelines and Quality Standards , service user feedback, Quality SEEL results and the progress against these – "the so what"
- Network governance arrangements were included on the TIB and the inspector was interested in the sharing of information "ward to board"
- The inspectors were impressed when they witnessed the "huddles" in action and how all staff had a clear understanding about quality
- The inspectors also commented on the value of the huddles to provide informal supervision



Risk Assessment Framework

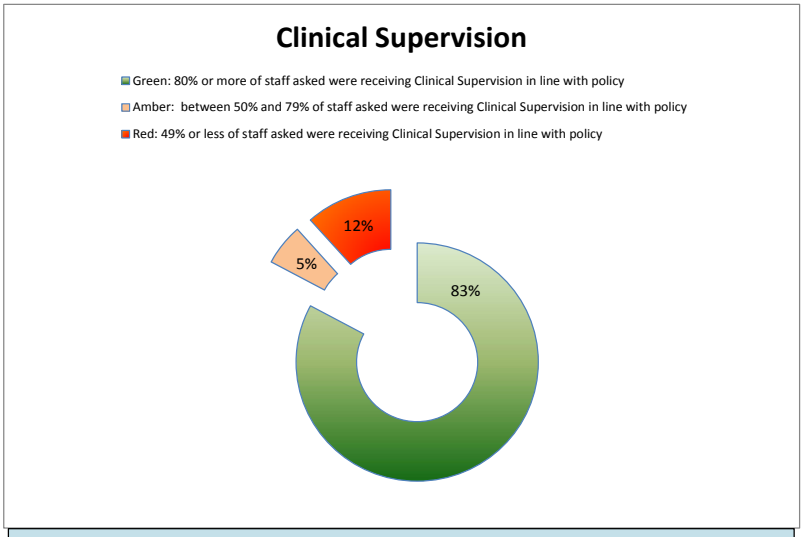
Risk Assessment				
Indicator	Target	2012/13 Outcome	2013/14 Outcome	Targets Achieved
Data completeness: identifiers	97%	99.7%	98.5%	✓
Data completeness: outcome	50%	75.8%	65.6%	✓
Data source: Lancashire Care internal monitor compliance dashboard				

Lancashire Care NHS Foundation Trust continues to perform well against these indicators and will continue to undertake regular data quality reviews.

Clinical Supervision

Clinical supervision is an activity which allows clinical staff to meet with a skilled supervisor in order to reflect upon their practice. The purpose of these meetings is to improve practice by identifying solutions to problems and increase understanding of professional problems. There are various approaches to clinical supervision for example: one-to-one supervision, group supervision or peer group supervision (Royal College of Nursing, 2004).

The Quality SEEL self-assessment process includes specific questions relating to clinical supervision opportunities. The findings are reflected below:



Data Source: Quality SEEL dashboard, LCFT

Clinical teams will use their team level information to inform quality improvement plans. Lancashire Care NHS Foundation Trust is committed to supporting staff to understand their roles, responsibilities and key objectives, enabling them to undertake their job as effectively as possible. The supervision of staff is one of the ways that this can be achieved and continues to be a priority for Lancashire Care NHS Foundation Trust.

Research and Development

Lancashire Care NHS Foundation Trust is dedicated to improving the health of its service users, carers and stakeholders by providing its staff with the most current research findings in the country and by actively taking part and leading in high quality research.

Lancashire Care NHS Foundation Trust is a member of the North West Coast Academic Health Science Network (NWC AHSN) which covers Merseyside, South Cumbria, and most of Cheshire and Lancashire.

Academic Health Science Networks are NHS led Networks, and are intended to include all of the Clinical Commissioning Groups, providers of primary, community, secondary and tertiary NHS services, universities, industrial and other organisations and partners.

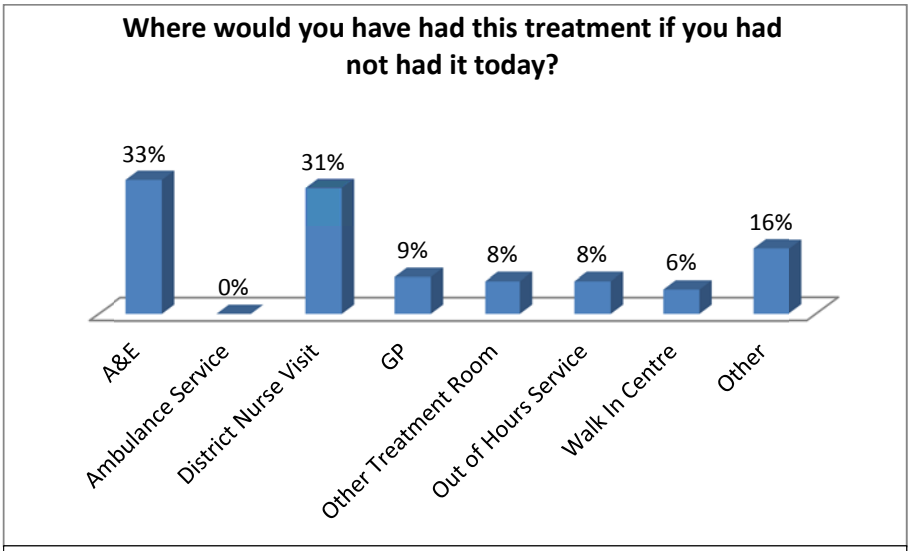
To access further information on the North West Academic Health Science Network go to: http://www.nwcahsn.nhs.uk/index.php

Treatment Room Service: 7 Day working

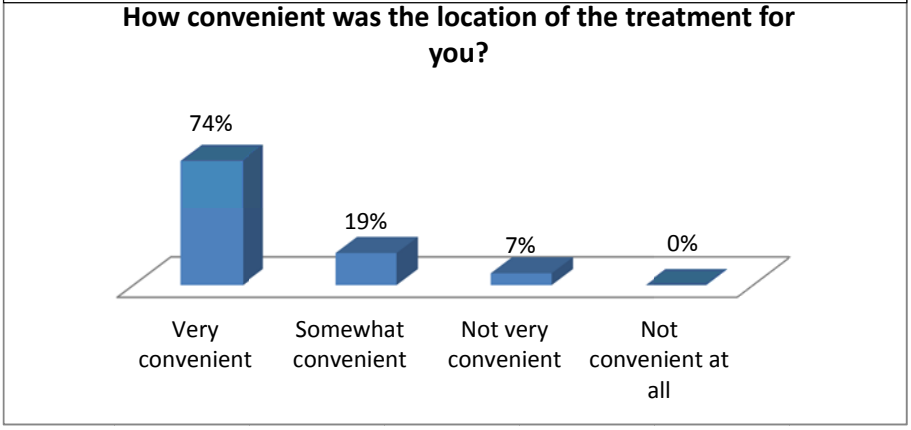
The Treatment Room Service in Blackburn with Darwen covers 6 health centre sites. The Treatment Room provides a variety of clinical interventions. The service currently consists of two teams, one with a focus on acute treatments; these include ear care minor injuries and phlebotomy. The second team's primary focus is on the care of wounds and leg ulcer management. The service is commissioned Monday to Friday and over the weekend period any service users who require care and treatment would be seen by a district nurse or secondary care.

Lancashire Care NHS Foundation Trust was commissioned to provide weekend treatment rooms across the winter months in response to predicted increased seasonal demands. Running from 1st December 2013 until 31st March 2014 across Preston, Chorley and South Ribble and Blackburn with Darwen localities; including minor injury services in Blackburn with Darwen. The aim of the initiative was to:

- Provide care closer to home in a community setting
- Free up capacity within A&E, medical out of hours services and District Nursing services
- Support early hospital discharge



N.B: Some respondents ticked more than 1 box



Independent Auditor's Report to the Council of Governors of Lancashire Care NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Lancashire Care NHS Foundation Trust to perform an independent assurance engagement in respect of Lancashire Care NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital;
- Admissions to inpatient services had access to crisis resolution home treatment teams.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources - specified in the *Detailed Guidance for External Assurance on Quality Reports; and*
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;

- The 2013 national patient survey;
- The 2013 national staff survey;
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Lancashire Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting Lancashire Care NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Lancashire Care NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Lancashire Care NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*

KPMG LLP

Chartered Accountants

St James Square

Manchester

M2 6DS

28 May 2014