The Pennine Acute Hospitals NHS
NHS Trust

The Pennine Acute Hospital NHS Trust

Annual Report

2017-2018

Saving *lives*, Improving *lives*

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Performance Report

Performance Overview

The purpose of this Performance Overview is to provide a brief introduction to The Pennine Acute Hospitals NHS Trust. This includes a glimpse back at our history, an outline of the purpose and activities of the organisation including a brief description of the business model and organisational structure. In addition, the Chief Executive and Chairman's perspective of performance during the year is provided, including the key issues and risks to the delivery of our principal objectives.

Introduction to The Pennine Acute Hospitals NHS Trust

The Pennine Acute Hospitals NHS Trust (Pennine) is one of the biggest in the North West region, and has some of the largest services by volume in the whole of England.

Pennine operates from four main sites in North Manchester, Bury, Oldham and Rochdale, together with the Floyd Unit at Birch Hill Hospital. Our team of over 9,000 staff provide a wide range of acute, specialist and community services to 820,000 people across the north east of Greater Manchester in Bury, Prestwich, North Manchester, Middleton, Heywood, Oldham and Rochdale and parts of East Lancashire. From April 2015 Pennine took over responsibility for managing adult social care services in the north of the city, and as of October 2016 we took responsibility for a range of community and integrated services in Heywood, Middleton and Rochdale.

The health of the population we serve is by many measures some of the worst in England. Our communities are geographically and culturally diverse in their makeup, but remain largely characterised by their industrial past. They range from high density inner city areas with significantly higher than average deprivation and social exclusion to pockets of affluence in country villages. This has contributed to significant health inequalities among the residents with more densely populated areas, in particular, having poorer access to healthcare.

We work with our local Clinical Commissioning Groups (CCGs) in Manchester, Bury, Oldham and Heywood, Middleton and Rochdale and also East Lancashire to plan, develop and commission healthcare services for local people. We also work closely with our local authority partners to develop ever more integrated services across our communities.

Pennine's Values are a focus for how our staff and volunteers work with each other and care for patients.

Quality Driven

- To provide excellent quality, safe, evidence-based patient care that exceeds national standards.
- To push the boundaries of care delivery and efficiency by adopting best practice and building on our clinical and technical knowledge.
- To individually be the best we can in our actions and interactions.
- To work as one team with both our colleagues and partners to deliver the best care both in and out of hospital.

Responsible

- To be honest, open and transparent in all our commitments, actions and results.
- To be personally accountable for the things we do, our services and the Trust's reputation.
- To be alert to the potential for errors and always strive to correct things that go wrong.
- To acknowledge and celebrate success.
- To be resourceful and open to new, innovative, evidence-based ideas.

Compassionate

- To treat you with empathy, professionalism and a positive, friendly attitude.
- To act with integrity and respect at all times.

- To listen to you, understand your perspective, value differences and be approachable, sensitive and considerate.
- To organise our services around the individual needs of our patients and their carers, creating the best patient experience possible.

During 2016/17 Pennine worked increasingly closely with and under the strategic leadership of Salford Royal NHS Foundation Trust (Salford Royal) who were asked by NHS Improvement (NHSI) to provide support to the Trust following the CQC Inspection in February 2016. This arrangement was formalised under a management agreement in April 2017, and paved the way for the establishment of the Northern Care Alliance NHS Group ('Group' in this context does not mean a 'Group' as defined for accounting purposes; financial statements continue to be prepared for the statutory bodies).

From the 1st April 2017, the Northern Care Alliance NHS Group (NCA) was launched, bringing together over 17,000 staff, 2000 beds and serving a population of over 1 million. Whilst Pennine and Salford Royal remain statutory bodies, the respective Trust Boards delegated the exercise of their functions to a Group Committees in Common (Group CiC), effectively managing both Trusts. Four 'Care Organisations' have been established within the NCA; Oldham, Bury & Rochdale and North Manchester (incorporating the main sites from which Pennine operates), alongside Salford, with responsibility for providing high quality and reliable care to the local communities they serve. Each Care Organisation and hospital site has its own Director Leadership Team led by a Chief Officer and consisting of a Medical Director, Director of Nursing, and Finance Director. Together they are accountable to the Group CiC for the day to day running of the hospital services and, as applicable, primary, community, mental health and social care services of the respective Care Organisation. These new local arrangements place the emphasis for operational management where it matters - in each hospital and locality.

Pennine's Vision and Objectives

Saving Lives, Improving Lives

Our Mission Statement that binds us all together is: "Saving lives, Improving lives".

Saving *lives,*
Improving *lives*

Our Priorities

NHS
Bury & Rochdale Care Organisation
Northern Care Alliance NHS Group

Saving lives, Improving lives

... by delivering highly reliable care and services, at scale, which are trusted, connected and pioneering.

Bury & Rochdale Care Organisation Priorities

1. Pursue Quality Improvement to assure safe, reliable and compassionate care

Priorities
- Reduction in standardised mortality rate within the expected range & <100
- Implement the Quality Improvement requirements to achieve an improved Care Quality Commission (CQC) rating
- Implement the Quality Improvement Strategy focusing on reducing avoidable harms and improving care for our sickest patients at risk of deterioration
- Embed shared learning through patient safety collaboratives as part of our Quality Improvement Strategy, including 'End PJParalysis' project
- Increase number of wards that are compliant and 'green' against our Nursing Assessment Score (NAAS)

Targets/Measures
- Standardised Mortality Rates (SMRs) on trajectory to be better than expected
- Achieve improved CQC Rating
- 50% reduction in cardiac arrests outside of CCUs (deteriorating patients)
- Reduction in avoidable harms; pressure ulcers, falls and hospital acquired infections
- Increase in wards compliant and green on NAAS

2. Deliver mandatory standards

Priorities
- Improve our A&E 4 hour access performance in line with our urgent care improvement plan, ensuring no patients have to wait over 12 hours and at least 90% are seen within 4 hours
- Improve our responsiveness of cancer treatment for our patients ensuring that 85% of patients receive first treatment in 62 days

Targets/Measures
- Meet key local and national standards

3. Support our staff to deliver high performance and improvement

Priorities
- Improve staff engagement scores through the Pioneers Programme, director 'work-withs', 1000 voices sessions; increase number of staff who would recommend as a place to work and be treated
- Implement the staff 'contribution framework' with effective staff appraisals

Targets/Measures
- Improved NHS Staff Survey staff engagement scores
- Staff Appraisals
- Strategic talent management plan in place

4. Improve care and services through integration and collaboration

Priorities
- Support the development of our integrated Local Care Organisation to enable further integration of hospital services, primary care, community and social care services
- Support development of a Clinical Services Strategy to create a 'shared hospital service' for Oldham, Bury and Rochdale, assuring services are safe, reliable and sustainable

Targets/Measures
- Agree LCO development plan
- Agree site service portfolios
- Clinical Services Strategy for Oldham, Bury and Rochdale to be completed by January 2018

5. Deliver financial plan to assure sustainability

Priorities
- Deliver financial plans supported by a systematic quality improvement approach to increase efficiency and productivity
- Reduce workforce vacancies and staff turnover by effective recruitment and retention programmes
- Reduce reliance on agency and temporary staff by recruiting to medical and nursing posts

Targets/Measures
- Meet financial plan
- Cost improvement/ reduction plan (CIP)
- Reduce spend on agency and temporary staff
- Recruit to posts; fill vacancies

6. Implement enabling strategies

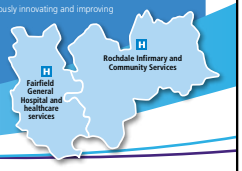
Priorities
- Implement the Digital improvement plan

Targets/Measures
- Achieve IM&T standards for mandated returns
- Meet Information Governance standards
- Deliver document management and control centre v1 milestones

Our Alliance Priorities:

1. Pursue Quality Improvement to assure safe, reliable and compassionate care
2. Deliver mandatory standards
3. Support our staff to deliver high performance and improvement
4. Improve care and services through integration and collaboration
5. Deliver financial plan to assure sustainability
6. Implement enabling strategies

Our **services** will be:
- **Evidence-based** and of the **highest quality**;
- **Highly reliable:** high quality whatever the day of the week or hour of the day;
- **At scale:** creating benefits for people through standardisation of best practice;
- **Trusted:** providing safe, effective and compassionate services;
- **Connected:** seamlessly delivering what matters most to people and communities;
- **Pioneering:** continuously innovating and improving services.



Our Priorities

NHS
North Manchester Care Organisation
Northern Care Alliance NHS Group

Saving lives, Improving lives

... by delivering highly reliable care and services, at scale, which are trusted, connected and pioneering.

North Manchester Care Organisation Priorities

1. Pursue Quality Improvement to assure safe, reliable and compassionate care

Priorities
- Reduction in standardised mortality rate within the expected range & <100
- Implement the Quality Improvement requirements to achieve an improved Care Quality Commission (CQC) rating
- Implement the Quality Improvement Strategy focusing on reducing avoidable harms and improving care for our sickest patients at risk of deterioration
- Embed shared learning through patient safety collaboratives as part of our Quality Improvement Strategy, including 'End PJParalysis' project
- Increase number of wards that are compliant and 'green' against our Nursing Assessment Score (NAAS)

Targets/Measures
- Standardised Mortality Rates (SMRs) on trajectory to be better than expected
- Achieve improved CQC Rating
- 50% reduction in cardiac arrests outside of CCUs (deteriorating patients)
- Reduction in avoidable harms; pressure ulcers, falls and hospital acquired infections
- Increase in wards compliant and green on NAAS

2. Deliver mandatory standards

Priorities
- Improve our A&E 4 hour access performance in line with our urgent care improvement plan, ensuring no patients have to wait over 12 hours and at least 90% are seen within 4 hours
- Improve our responsiveness of cancer treatment for our patients ensuring that 85% of patients receive first treatment in 62 days

Targets/Measures
- Meet key local and national standards

3. Support our staff to deliver high performance and improvement

Priorities
- Improve staff engagement scores through the Pioneers Programme, director 'work-withs', 1000 voices sessions; increase number of staff who would recommend as a place to work and be treated
- Implement the staff 'contribution framework' with effective staff appraisals

Targets/Measures
- Improved NHS Staff Survey staff engagement scores
- Staff Appraisals
- Strategic talent management plan in place

4. Improve care and services through integration and collaboration

Priorities
- Support the development of our integrated Local Care Organisation to enable further integration of hospital services, primary care, community and social care services
- Support development of a Clinical Services Strategy to create a 'shared hospital service' for Oldham, Bury and Rochdale, assuring services are safe, reliable and sustainable
- Work with staff and partners to agree and develop a new service strategy for the future of NMGH as part of the Single Hospital Service arrangements for the City of Manchester
- Develop a distinctive academic presence on the NMGH site

Targets/Measures
- Agree LCO development plan
- Agree site service portfolios
- Clinical Services Strategy for Oldham, Bury and Rochdale to be completed by January 2018
- Agree strategy for NMGH including future governance

5. Deliver financial plan to assure sustainability

Priorities
- Deliver financial plans supported by a systematic quality improvement approach to increase efficiency and productivity
- Reduce workforce vacancies and staff turnover by effective recruitment and retention programmes
- Reduce reliance on agency and temporary staff by recruiting to medical and nursing posts

Targets/Measures
- Meet financial plan
- Cost improvement/ reduction plan (CIP)
- Reduce spend on agency and temporary staff
- Recruit to posts; fill vacancies

6. Implement enabling strategies

Priorities
- Implement the Digital improvement plan
- Open new £5 million purpose-built Intermediate Care Facility on the North Manchester General Hospital site
- Invest £5 million in capital monies on the NMGH site in estates work and infrastructure

Targets/Measures
- Achieve IM&T standards for mandated returns
- Meet Information Governance standards
- Deliver document management and control centre v1 milestones
- Progress and deliver capital investment plan

Our Alliance Priorities:

1. Pursue Quality Improvement to assure safe, reliable and compassionate care
2. Deliver mandatory standards
3. Support our staff to deliver high performance and improvement
4. Improve care and services through integration and collaboration
5. Deliver financial plan to assure sustainability
6. Implement enabling strategies

Our **services** will be:
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- **At scale:** creating benefits for people through standardisation of best practice;
- **Trusted:** providing safe, effective and compassionate services;
- **Connected:** seamlessly delivering what matters most to people and communities;
- **Pioneering:** continuously innovating and improving services.

Our Priorities

NHS
Oldham Care Organisation
Northern Care Alliance NHS Group

Saving lives, Improving lives

... by delivering highly reliable care and services, at scale, which are trusted, connected and pioneering.

Oldham Care Organisation Priorities

1. Pursue Quality Improvement to assure safe, reliable and compassionate care

Priorities
- Reduction in standardised mortality rate within the expected range & <100
- Implement the Quality Improvement requirements to achieve an improved Care Quality Commission (CQC) rating
- Implement the Quality Improvement Strategy focusing on reducing avoidable harms and improving care for our sickest patients at risk of deterioration
- Embed shared learning through patient safety collaboratives as part of our Quality Improvement Strategy, including 'End PJParalysis' project
- Increase number of wards that are compliant and 'green' against our Nursing Assessment Score (NAAS)

Targets/Measures
- Standardised Mortality Rates (SMRs) on trajectory to be better than expected
- Achieve improved CQC Rating
- 50% reduction in cardiac arrests outside of CCUs (deteriorating patients)
- Reduction in avoidable harms; pressure ulcers, falls and hospital acquired infections
- Increase in wards compliant and green on NAAS

2. Deliver mandatory standards

Priorities
- Improve our A&E 4 hour access performance in line with our urgent care improvement plan, ensuring no patients have to wait over 12 hours and at least 90% are seen within 4 hours
- Improve our responsiveness of cancer treatment for our patients ensuring that 85% of patients receive first treatment in 62 days

Targets/Measures
- Meet key local and national standards

3. Support our staff to deliver high performance and improvement

Priorities
- Improve staff engagement scores through the Pioneers Programme, director 'work-withs', 1000 voices sessions; increase number of staff who would recommend as a place to work and be treated
- Implement the staff 'contribution framework' with effective staff appraisals

Targets/Measures
- Improved NHS Staff Survey staff engagement scores
- Staff Appraisals
- Strategic talent management plan in place

4. Improve care and services through integration and collaboration

Priorities
- Support the development of our integrated Local Care Organisation to enable further integration of hospital services, primary care, community and social care services
- Support development of a Clinical Services Strategy to create a 'shared hospital service' for Oldham, Bury and Rochdale, assuring services are safe, reliable and sustainable
- Work with partners across Greater Manchester to reconfigure specialist services in line with the Healthier Together strategy which brings more high acuity services to The Royal Oldham Hospital

Targets/Measures
- Agree LCO development plan
- Agree site service portfolios
- Clinical Services Strategy for Oldham, Bury and Rochdale to be completed by January 2018
- Successful business case for investment and delivery of The Royal Oldham Healthier Together development
- Progress capital investment plans to support and deliver the Healthier Together programme

5. Deliver financial plan to assure sustainability

Priorities
- Deliver financial plans supported by a systematic quality improvement approach to increase efficiency and productivity
- Reduce workforce vacancies and staff turnover by effective recruitment and retention programmes
- Reduce reliance on agency and temporary staff by recruiting to medical and nursing posts

Targets/Measures
- Meet financial plan
- Cost improvement/ reduction plan (CIP)
- Reduce spend on agency and temporary staff
- Recruit to posts; fill vacancies

6. Implement enabling strategies

Priorities
- Implement the Digital improvement plan
- Open second CT scanner in Autumn 2017
- Invest £5 million in The Royal Oldham site in preparation for a significant build in future years

Targets/Measures
- Achieve IM&T standards for mandated returns
- Meet Information Governance standards
- Deliver document management and control centre v1 milestones

Our Alliance Priorities:

1. Pursue Quality Improvement to assure safe, reliable and compassionate care
2. Deliver mandatory standards
3. Support our staff to deliver high performance and improvement
4. Improve care and services through integration and collaboration
5. Deliver financial plan to assure sustainability
6. Implement enabling strategies

Our services will be:

- **Evidence-based** and of the **highest quality**;
- **Highly reliable:** high quality whatever the day of the week or hour of the day;
- **At scale:** creating benefits for people through standardisation of best practice;
- **Trusted:** providing safe, effective and compassionate services;
- **Connected:** seamlessly delivering what matters most to people and communities;
- **Pioneering:** continuously innovating and improving services.

Performance Overview from the Chairman and Chief Executive

We are delighted to introduce this year's annual report which highlights some of the main developments to our services and the improvements that have been made over the past year across The Pennine Acute Hospitals NHS Trust (Pennine).

The annual Quality Report, included within the Annual Report, highlights how we have performed against a number of key national and locally determined clinical standards and our key quality improvement priorities.

We would also like to use this opportunity to update you on the progress we are making in creating the Northern Care Alliance NHS Group (NCA), bringing together the services provided by Pennine and Salford Royal NHS Foundation Trust (Salford Royal).

Benefit of scale, delivered locally

The NCA serves a population of over 1 million people under a new alliance arrangement of hospitals and associated community healthcare services. With an operating budget of £1.3 billion, the NCA provides the benefits of scale but delivers this locally through Care Organisations in Oldham, Bury & Rochdale, North Manchester and Salford.

Whilst our Care Organisations provide hospital care, they play a much broader role in each locality and are supporting the establishment of new integrated models of care. Each Care Organisation is working closely with local Councils to develop integrated Local Care Organisations (LCOs) to join together health and social care services and shift more care into the community, building on the success of integration in Salford.

Over the past year, Pennine successfully transitioned to a "joint" research office with Salford Royal, resulting in significantly quicker study set-up times, more high quality research being undertaken and substantially more patients participating in research studies than in any other previous year.

Care Quality Commission – Improvements made

It has been a difficult and challenging 18 months and this has meant a lot of hard work, dedication and willingness by our staff to drive and implement our improvement plan across our services.

Since Pennine's last Care Quality Commission (CQC) inspection in 2016, the Trust has benefitted from joint working and support from the leadership at Salford Royal. On 1 March 2018, the CQC published its latest report and findings following its unannounced inspection of services carried out in October and November 2017. The CQC found that significant improvements had been made across every hospital run by the Trust, as part of the NCA, with 70% of the aspects of the services inspected now rated as either 'Good' or 'Outstanding'. This is a phenomenal achievement.

The CQC can give one of four ratings to NHS Trusts and services: 'Outstanding', 'Good', 'Requires Improvement', or 'Inadequate'. The overall rating of the Trust has improved from Inadequate to Requires Improvement. The CQC has rated safety, effectiveness and responsiveness as Requires Improvement. Caring and Well-Led are rated as Good. There are now no longer any services across the Trust's hospitals that are rated Inadequate.

The CQC's findings are an absolute testament to the hard work and unwavering commitment shown by our clinical and non-clinical staff across our services to make the changes and improvements that were needed, whilst at the same time dealing with the constant day to day pressures and demand on our services. We know that we still have more to do on our journey of improvement, particularly across a

number of areas and services that require more focus, more support and more investment. But this CQC report will help further energise and drive our staff to work with colleagues across the NCA to make the further improvements and positive changes needed so that we can achieve our aim to be an outstanding rated organisation. Further information regarding the outcome of the CQC Inspection can be found in the Performance Analysis section on page 13.

Listening to our staff

The results of the 2017 national NHS Staff Survey carried out between September and December 2017 show that our Care Organisations in Oldham, Bury & Rochdale and North Manchester (Pennine) are improving in many key areas.

When considered alongside Pennine's positive CQC result, our staff can be proud that all their hard work is now starting to pay off. Some of the positive key findings of the survey include:

- The percentage of staff who would recommend their organisation to friends and family as a place to work has significantly increased from 48% to 52% in 2017
- The Trust has also seen an increase in staff recommending and being happy with the standard of care being provided to their friend or relative – up from 52% to 56% in 2017.

When compared with other trusts nationally, it is also encouraging to know that the percentage of staff feeling unwell due to work related stress has reduced and now compares favourably as does the number of staff experiencing physical violence from patients, relatives or the public in last 12 months.

We recognise the continued focus and commitment needed to engage with all of our staff across our Care Organisations. This remains vitally important in our work to address issues of recruitment and retention, appraisals, and health and well-being of staff.

Recognising our staff

One of the highlights of the year is the Pennine Annual Staff Awards which recognise and celebrate the outstanding contributions of staff. The 8th annual awards held in November 2017 consisted of 14 award categories which recognised the very best of patient care, dedication and innovation across our hospitals and services.

The special 'Unsung Hero' Award was presented to a group of police officers and specialist nurses who provided support to the victims and bereaved families following the Manchester Arena terror attack on 22 May. This year the 'Patients' Choice' Award, sponsored by Mitie Total Security Management, which was voted for by the general public and Trust members, was won by Dawn Littler, Labour Ward Midwife/Bereavement Nurse at North Manchester General Hospital.

Other winners on the night included the staff on Ward F5 at North Manchester General Hospital who won the 'Chief Executive's Achievement Award,' based on their achievement in meeting the highest of standards under the Trust's Nursing Assessment and Accreditation Scheme (NAAS).

Demand & Operational pressures

Over the last year, we, like the rest of the NHS, have experienced severe pressure and demand on our services. Patient attendances, particularly frail elderly and those with high acute medical conditions, to our Emergency Departments, hospital occupancy rates, and delays in ambulance handovers have all been higher than previous years. In our community services, more patients are being supported at home and we continue to work with our partners to make transfers to care homes and other care settings as rapid as possible.

This year's seasonal flu and winter period and the extra demand this placed on our services was also significant. Infection control and prevention remained a key priority for our staff across all of our hospitals and community healthcare services provided by our other Care Organisations.

Amidst continuing challenges, we come across many wonderful examples of compassionate and personal care from our staff day in day out, and never more so than in the response witnessed to the horrific terror attack that Manchester suffered in May 2017. As NHS staff we plan extensively for major incidents such as this. However, no planning could have prepared those involved for the type and severity of the incident. That being said, it was evident that our plans, and our involvement as part of Greater Manchester's response alongside other emergency services, went very well. In total, across our services within the NCA, we treated some 45 patients, many of whom were in a critical condition. We met with a number of teams and individuals and heard first hand of how well staff responded to victims and their families being brought to our hospitals at Oldham, North Manchester and Fairfield. We would like to take the opportunity again to thank our staff who responded so professionally to that incident and to offer our thoughts to family and friends of the 22 people who sadly lost their lives.

Financial challenges

Pennine's financial position for 2017/18 was an operating deficit of £32.4m, reflecting the current national picture across the NHS; a combination of significant pressures on urgent care services in addition to financial pressures arising from the use of temporary staff due to difficulties recruiting frontline staff. The development of our Clinical Services Strategy will describe how Pennine can move from a position of stabilising services to one of transforming services and becoming clinically and financially sustainable in the longer term.

Significant Risks

The Board Assurance Framework (BAF) is a tool for the Group Committees in Common (Group CiC) to assure itself (gain confidence, based on evidence) about successful delivery of Pennine's principal objectives. The risks identified in the BAF are based on a collective assessment by the Directors of the environment in which Pennine operates. It is also informed by high-scoring risks identified locally through the day to day operation of the Care Organisations in Oldham, Bury & Rochdale and North Manchester, which may impact on the achievement of Pennine's principal objectives.

The key risks to which Pennine was exposed to in 2017/18 reflected largely those faced in 2016/17 and were in relation to the following areas:

- Management of the transition from the Pennine Acute Hospitals Trust to a new model of Care Organisations
- Maintaining financial balance whilst delivering agreed cost savings
- Achieving operational performance targets in the face of increasing demand
- Maintaining adequate clinical staffing levels
- Managing the rising cost of agency staff

- Maintaining safe, high quality services in the face of increased demand
- Growing and maintaining a compliant estate
- Maintaining external accreditations for diagnostic services due to a lack of environmental and resource capacity
- Stabilising and investment in IM&T infrastructure

The BAF was maintained by the Group CiC and Care Organisation leaders throughout 2017/18, enabling the identification, analysis and management of risk to the delivery of principal objectives in-year. Controls and assurances were assessed and action plans were developed and implemented appropriately. This has provided clear sight of significant risks and ensured action was prioritised appropriately.

Going Concern Assessment

Where a Trust is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties should be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved.

Should a Trust have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether) it should raise the issue with its sponsor division or relevant national body as soon as possible i.e. NHS Improvement.

Pennine is receiving management support from Salford Royal and financial support from commissioners. Furthermore, Pennine has been drawing down cash support in the form of revenue support loans since January 2018 and has an open resolution in place, approved by the Group CiC, for external revenue loans to continue into 2018/19. Better Care at Lower Cost plans over and above the national tariff requirement are being prepared to improve the financial position of the Pennine. Therefore, at this time there is no reason to suggest that the Trust is not a going concern. This will be kept under review as part of discussions and negotiations.

The Future

We feel we have made a positive difference for patients and for staff during the past year and we will continue to work closely with our partners, to deliver better services that are safe, reliable and high quality.

With our local commissioners we are identifying options for high quality, sustainable service portfolios for each hospital site. We are designing a single 'shared hospital service' across Bury, Rochdale and Oldham – associated with Salford Royal and/or where appropriate, with other partner organisations.

We are also working with our partners in the City of Manchester to develop a positive, strong and vibrant future for the North Manchester General Hospital site as part of the Manchester Single Hospital Service. We will continue to work with our partners in supporting all of the strategies of the GM Health & Social Care Partnership and the priorities of the elected Mayor for Greater Manchester.

These are exciting times: a new name for our alliance, a new sense of purpose, and new investment alongside a commitment to continue to work closely with our staff, our communities and our partners to improve services for patients and staff.

Finally, we are pleased to confirm that the Board of Directors has reviewed this 2017/18 Annual Report and Quality Report and confirm that it is an accurate and fair reflection of our performance. We hope that this Report provides you with a clear picture of how important quality improvement, safety and service user and carer experience are to us at Pennine and across the NCA.

On behalf of the Board, we want to thank all staff for their continued contribution to our mission of 'Saving lives, Improving lives'.

James Potter
Chairman
Date: 25 May 2018

Sir David Dalton
Chief Executive
Date: 25 May 2018

Performance Analysis

To ensure the Northern Care Alliance NHS Group (NCA) delivers its mission to "Save Lives, Improve Lives by delivering highly reliable services at scale, which are trusted, connected and pioneering" and fulfils its statutory duties, the Group CiC identified principal priorities and objectives for the year for Pennine, with high level Key Performance Indicators (KPIs) to provide assurance that national, regional and local performance standards are being attained and strategic and transformation programmes are being delivered and coordinated at all levels.

These principal priorities, objectives and associated KPIs are consolidated within the annual operational plans of the NCA and each of its Care Organisations. These plans are rigorously monitored via the assurance framework to ensure delivery. Risks associated with the delivery of the principal priorities and objectives are reflected within the Board Assurance Framework, mapping the foremost sources of assurance, controls and actions that give confidence to Group CiC about the achievement of principal priorities and objectives through the active management of risk.

An integrated reporting approach is used by the Group CiC to ensure that the impact on all areas of the NCA and its Care Organisations is understood, including patient, clinical, staffing, financial and regulatory perspectives. A 'High Level Performance Dashboard' of the most important metrics and risks, including historical trend analysis and external benchmarks where available, is reviewed on a monthly basis by the Group CiC. The dashboard is supported by a suite of granular reports, including the Chief Executive's Report, Better Care at Lower Cost Programme, Finance and Activity and Strategic Programmes. A quarterly Quality Improvement Dashboard and six-monthly Learning from Deaths and Learning from Experience Report (including incident management, complaints and patient and service user experience) are also reviewed.

The performance of Care Organisations is reviewed through the Group Single Oversight Framework, identifying where Care Organisations will benefit from improvement support and intervention across five areas:

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

The Group Single Oversight Framework, again utilises an integrated reporting approach, including the High Level Performance Dashboard, Care Organisation Board Assurance Framework and Statement of Assurance, Annual Plan Review, Well Led Review and CQC improvement Plans. Each Care Organisation has its own robust governance and assurance framework, ensuring effective oversight from Board to Ward, reflecting the aforementioned five themes, and allowing focus in all areas of the Care Organisation.

This section of the Performance Report provides a detailed analysis of Pennine's performance in relation to each strategic priority and objective, conveying achievements, challenges and any actions taken to address these.

THEME 1

Pursue Quality Improvement to assure safe, reliable and compassionate care

Key Priorities and Objectives

1. **Implement the Quality Improvement requirements to achieve an improved CQC rating**

CQC Inspection

A report published on 1 March 2018 by the Care Quality Commission (CQC) found that significant improvements had been made across every hospital run by Pennine since its last inspection in 2016, with 70% of the services inspected now rated as either 'Good' or 'Outstanding', highlighting the benefit from joint working and support from the leadership at Salford Royal.

In August 2016, Pennine was given an overall 'Inadequate' rating. The rating has since improved to 'Requires Improvement'. The full ratings by the CQC are highlighted below:

	March 2016	October 2017
Safe	Inadequate	Requires Improvement
Effective	Requires Improvement	Requires Improvement
Caring	Good	Good
Responsive	Requires Improvement	Requires Improvement
Well Led	Inadequate	Good
Overall	Inadequate	Requires Improvement

There are now no longer any services across Pennine's hospitals that are rated Inadequate. The areas which have shown most improvement are those which were once most fragile: maternity services at North Manchester General and The Royal Oldham Hospital are now rated as Good; and children's services which were Inadequate are now rated as Requires Improvement at both North Manchester and Oldham. Urgent and Emergency care at both Royal Oldham and North

Manchester General Hospital has also improved to Good. Fairfield General Hospital in Bury has been rated Good overall. Its urgent and emergency care has also improved to Good. The medical service at Fairfield, including older people's care, has improved by two ratings to Outstanding. This rates medical services at Fairfield to be one of the best alongside our Salford Care Organisation in Greater Manchester and amongst the best in the country. At Royal Oldham, surgical services are rated Good for Caring, Responsive and Well-led. Critical care services has also improved. The CQC also found ten areas of notable outstanding practice. This includes the implementation of the NCA's Nursing and Accreditation Assessment System across all sites.

The summary ratings by site were as follows:

Key to tables

Ratings	Not Rated	Inadequate	Requires Improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

Ratings for North Manchester General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑↑ Feb 2018	Good ↑ Feb 2018	Good →← Feb 2018	Requires Improvement ↑ Feb 2018	Good ↑↑ Feb 2018	Good ↑↑ Feb 2018
Medical care (including older people's care)	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018
Surgery	Requires Improvement →← Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good ↑ Feb 2018	Requires Improvement →← Feb 2018
Critical care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016
Maternity	Requires Improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑↑ Feb 2018	Requires Improvement ↑ Feb 2018
End of life care	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Good ↑↑ Feb 2018	Requires Improvement ↑ Feb 2018

Ratings for The Royal Oldham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Requires Improvement →← Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↓ Feb 2018	Requires Improvement →← Feb 2018
Surgery	Requires Improvement →← Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018
Critical care	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018
Maternity	Requires Improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good ↑ Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018
End of life care	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Outpatient and Diagnostic imaging	Requires Improvement Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018

Ratings for Fairfield General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Good ↑ Feb 2018	Good ↑ Feb 2018	Outstanding ↑ Feb 2018	Outstanding ↑↑ Feb 2018	Good → ← Feb 2018	Outstanding ↑↑ Feb 2018
Surgery	Good ↑ Feb 2018	Good ↑ Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018
Critical care	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
End of life care	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires Improvement → ← Feb 2018	Good ↑ Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018

Rochdale Infirmary and Community Services

The CQC did not inspect Rochdale Infirmary or Community Services which were rated as Good overall at the last inspection in 2016.

Notwithstanding the phenomenal achievement, testament to the hard work and commitment of staff, we know that we still have more to do on our journey of improvement, particularly across a number of areas and services that require more focus, more support and more investment. In order to support the development of comprehensive action plan at 'Group' and Care Organisation level, the required 'must-do' and 'should-do' actions have been themed into the following headings:

- Infrastructure
- Workforce
- Risk and Safety
- Training
- Documentation and Standards
- Medicines Management

The action plan will be shared with the CQC in April 2018 and action plans will be monitored via the Care Organisation and Group Risk and Assurance Committee, with risks reported within the Care Organisation Board Assurance Frameworks.

Key Priorities and Objectives

- **Reduction in standardised mortality rate within the expected range**
- **Implement the Quality Improvement Strategy focusing on reducing avoidable harms and improving care for sickest patients at risk of deterioration**
- **Embed shared learning through patient safety collaboratives as part of our Quality Improvement Strategy, including 'End PJ Paralysis' project**
- **Increase number of wards that are compliant and 'green' against Nursing Assessment and Accreditation Standards (NAAS)**

In 2017/18 Pennine completed year one of its Quality Improvement Strategy, starting the journey to transform Pennine into a successful learning organisation for years to come. The principal objective for 2017/18 was no avoidable deaths and to reduce patient harm by:

- Improvement of reliability in recognising deterioration in our patients
- 95% of our patients to receive harm free care

Each of these aims was achieved, with the deteriorating patient collaborative and other projects surrounding them that supported the delivery of our Quality Improvement Strategy. Our projects to reduce harm and mortality, improve patient experience and make the care that we give to our patients reliable and grounded in the foundations of evidence based care are more fully detailed in the Quality Report.

Key achievements against our aims during 2017/18 were as follows:

- 100% of Pennine inpatient wards and departments using the National NEWS chart with e-observation system rolled out fully across Fairfield General with all wards across all sites to be rolled out by December 2018.
- Hospital Standardised Mortality Ratio (HSMR) for


Caution
#EndPJparalysis
I support the #EndPJparalysis
70 day challenge
Name:
Signature:
PJ
ROSE

Pennine has reduced and is now statistically better than expected. (November 2016 to November 2017 most recent data available).

- 98.6% of patients in inpatient areas received harm free care as measured by the safety thermometer. (December 2016 – December 2017).
- 100% of wards were engaged in our End PJ Paralysis initiative.

All inpatient wards/departments have had a NAAS assessment with 49 of 52 areas having a subsequent reassessment completed. There are currently 38% of our wards achieving a green status compared to the baseline position of 24%.

Further information can be found in the Quality Report on page 33.

Concerns, Complaints and Compliments

The Patient Responsiveness Team at Pennine and Salford Royal came together under one management structure during 2017/18, and significant improvements have been implemented. The service is more responsive to the needs of patients, relatives and carers, discussing concerns either face to face or by phone on the day of contact, thus enabling early identification of the real issues for investigation. Robust investigation processes are embedded within the Care Organisations with identified senior leads overseeing timely turnaround.

Wherever possible a meeting is arranged to meet with complainants to feedback the outcome of investigations with the relevant clinical staff attending to provide explanations and support. Feedback from complainants regarding this improved approach has been very positive. A suite of weekly reporting for each Care Organisation is in place, with each having an assigned Complaints Case Handler. This has facilitated more timely resolution of complaints.

Lessons learned are captured from each complaint and shared across Care Organisation assurance committees to inform service change and service developments.

Improvement trajectories have been agreed with Clinical Commissioning Groups (CCGs) which has tracked month on month improvement.

Performance during 2017/18

A monthly improvement trajectory was agreed with commissioners for 2017/18, acknowledging that performance at the end of the year is below the agreed target, month on month progress has been made and there has been significant improvement in response timescales, and more importantly in the quality of responses.

Total number of complaints received during the year = 992

Total number of PALS cases received during the year = 3353

Total number of compliments received = 533

% compliance against performance targets = 51% (average over 10 months)

Response Times

Threshold 90%	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Target	45%	50%	55%	60%	65%	70%	75%	80%	85%	90%	90%	90%
Actual	34%	37%	43%	50%	47%	55%	53%	61%	61%	67%	X	X

THEME 2

Deliver Mandatory Standards

Key Priorities and Objectives

1. **Improve A&E 4 hour access performance in line with urgent care improvements plan, ensuring no patients have to wait over 12 hours and at least 90% are seen within 4 hours**
2. **Improve responsiveness of cancer treatment for patients ensuring that 85% of patients receive first treatment in 62 days**

In September 2017, the Secretary of State and Chief Executive Officers of NHS England and NHS Improvement (NHSI) affirmed that there would be three core priorities for the NHS:

- **Emergency Department 4 Hour Standard:** To achieve either an increase on last year's performance or 90% whichever is the greater, with the ambition to progressively improve to 95%;
- **62 Day Cancer Standard:** 85% of patients to receive first treatment in 62 days;
- **Financial Control Total:** To achieve agreed total. Further information regarding this priority can be found in section: Theme 5 Deliver Financial Plan to Assure Sustainability

A&E 4 hour Access

Like the rest of the country, Greater Manchester continued to experience a significant increase in demand for A&E services during 2017/18. Pennine's A&E services were no different, with significant pressure placed on the department by high levels of attendance throughout the year. In this challenging time, our primary focus has been to provide safe services, whilst working hard to reduce delays in discharge, and work with our partners to ensure all patients and service users are being cared for at the right time and in the right place. Improvement trajectories were set by the Greater Manchester Health and Social Care Partnership and these have been monitored throughout the year. A&E performance at the end of March 2018 fell short of the 95% national standard for all Care Organisations. For 2017/18, Pennine's cumulative performance was 83.56% and performance by Care Organisation for March '18 was as follows:

North Manchester - 71.72% against a trajectory of 80%.

Oldham - 78.35% against a trajectory of 88.45%

Bury & Rochdale - 94.41% against a trajectory of 92%

62 Day Cancer Standard:

There has been significant focus on delivering the 62 day cancer standard. Pennine's overall performance for 2017/18 was 82.1%. against an 85% standard. Most notably the Oldham Care Organisation experienced significant challenges in General Surgery and Gastro-enterology and received support from the National Intensive Support Team with a focus on upper and lower GI pathways. A recovery plan was implemented and a trend of improvement was evident within the Oldham Care Oldham from the end of 2017/18 with compliance with the standard expected to be achieved in 2018/19.

Further information regarding performance against many patient safety and experience indicators during 2017/18 can be found in the Quality Report on page 33.

THEME 3

Support staff to deliver high performance and improvement

Key Priorities and Objectives

1. **Improve staff engagement scores through the Pioneers Programme, director 'work-withs', 1000 voices sessions; increase number of staff who would recommend as a place to work and be treated**
2. **Implement the staff 'contribution framework' with effective staff appraisals**

The percentage of staff who would recommend Pennine to friends and family as a place to work significantly increased from 48% in 2016 to 52% in 2017. The Trust has also seen an increase in staff recommending and being happy with the standard of care being provided to their friend or relative by the Trust from 52% in 2016 to 56% in 2017.

Staff reported a slight deterioration in the quality of appraisals in 2017, this has been an area of focus throughout the year, alongside strengthening clinical and site leadership and increasing frontline staffing numbers. Overall the staff engagement scores have increased from 3.64% in 2016 to 3.71% in 2017 survey.

Staff experience has improved overall in five key areas:

Encouragingly, the staff group engagement score for our adult general nursing workforce and health care assistants/nursing assistants (which make up the largest proportion of the Trust's workforce) has increased significantly from 3.67 to 3.72. This shows that in the face of the huge amount of pressures our nursing workforce are under, more of our frontline clinical staff have more confidence in the future, feel better engaged and can see they are being listened to and supported.

Following the results of the 2015 NHS Staff Survey, a number of actions were implemented such as the Go-Engage Pioneers' Programme, 1000 Voices and open surgeries with directors. These were aimed at further improving staff engagement and we can see from the 2017 NHS Staff Survey that these have had a positive impact on staff, which in turn benefits patients and patient care.

Work will continue on the above and further actions agreed from this year's results throughout 2018.

Further information is included in the Staff Report on page 156.

THEME 4

Improve care and service through integration and collaboration

Key Priorities and Objectives

1. **Support the development of our integrated Local Care Organisations (LCOs) to enable further integration of hospital services, primary care, community and social care services**
2. **Support development of a Clinical Services Strategy to create a 'shared hospital service' for Oldham, Bury & Rochdale, assuring services are safe, reliable and sustainable.**
3. **Work with staff and partners to agree and develop a new service strategy for the future of NMGH as part of the Single Hospital Service arrangements for the City of Manchester**

Support the development of our integrated LCO to enable further integration of hospital services, primary care, community and social care services

Each locality within the Pennine footprint is at a different stage of development and focus. The Greater Manchester Health and Social Care Partnership (GMHSCP) is developing a framework for Local Care Organisations and has completed a stocktake of current position. Opportunities to share and standardise good practice across the NCA localities is underway, with the development of a blueprint.

Manchester Local Care Organisation

The Manchester Local Care Organisation (MLCO) will be launched on 1st April 2018, with much work having taken place during the latter part of 2017/18 with the MLCO and Manchester Foundation Trust (MFT) whom will host the MLCO to ensure the safe transfer of community staff and services from Pennine. It has been agreed that community staff will transfer in July 2018 with the full completion of the transfer by April 2019. MFT will hold the contract for community services from April 2018 and have sub-contracted Pennine for provision of services prior to transfer.

Rochdale Local Care Organisation

A Partnership Agreement has been signed by all partners across the Rochdale LCO which includes the NCA, Pennine Care NHS Foundation Trust, Rochdale Borough Council, Heywood, Middleton and Rochdale (HMR) CCG, Rochdale Health Alliance, GP Care and the Voluntary Sector.

The Bury and Rochdale Care Organisation's Chief Officer has been appointed Chief Officer of the Rochdale LCO and NCA will host the provider arrangements during 2018//19. The Rochdale LCO will focus on prevention, mental health and well-being and further transformation of urgent and pro-active care based on population need.

Bury Local Care Organisation

Bury LCO has not moved initially to consideration of organisation form, but has developed a Mutually Binding Agreement to be signed in April 2018 by the five key provider partners – NCA, Pennine Care NHS Foundation Trust, GP Federation, Bury Metropolitan Borough Council and Bury and Rochdale Doctors on Call. The Bury LCO will be prioritising transformation of urgent care, developing 'home first' and integrated care teams.

Oldham Local Care Organisation

The Oldham Care Alliance Board has been established to oversee implementation of integrated care in Oldham. The Chief Officer for Oldham Care Organisation has been seconded as the Programme Director and an Alliance Agreement and a Memorandum of Understanding have been developed.

Support development of a Clinical Services Strategy to create a 'shared hospital service' for Oldham, Bury & Rochdale, assuring services are safe, reliable and sustainable.

The development of a Clinical Service Strategy to create a 'shared hospital service' has progressed in 2017/18, albeit at a slower pace than originally anticipated, as management arrangements with Salford Royal were established. In May 2017 we agreed the approach to the development of the Clinical Service Strategy with

our commissioners in Bury, Heywood, Middleton & Rochdale, Oldham and Manchester. To date we have:

- Identified key services to prioritise
- Put in place a dedicated programme team to manage this process
- Commenced a review of services including critical care and cardiology
- Linked our activity into wider Greater Manchester work to 'standardise acute and specialist services'

We aim for the Clinical Service Strategy to be finalised by June 2018. As many of the services being reviewed are also under the remit of the Greater Manchester Theme 3 'Standardising Acute and Specialist Services' programme, this may affect when the Clinical Service Strategy is finalised, consulted upon and implemented.

The diagram below provides a summary of the key services being reviewed:

North East Sector - clinical service strategy development

Context and case for change ⟷ **Strategic drivers and direction**

Strategies being implemented include:
Healthier Together (General Surgery, Acute and Emergency Medicine); Major Trauma

Strategies in development - wave 1:

- Breast surgery
- Cardiology
- Critical care and anaesthesia
- Orthopaedics
- Paediatrics
- Pathology
- Pharmacy
- Radiology - clinical support
- Rehabilitation
- Stroke
- Urology
- Vascular

Wave 2 includes:

- End of life care
- Maternity
- Ophthalmology
- Respiratory
- Sterile services

Local Care Organisation - Bury

Local Care Organisation - Oldham

Local Care Organisation - Rochdale

Core Clinical Services - surgery, medicine, women's and children's

Innovation and improvement opportunities e.g. digital

Enabling strategies e.g. R&D, education, IM&T and estates

Work with staff and partners to agree and develop a new service strategy for the future of North Manchester General Hospital as part of the Single Hospital Service arrangements for the City of Manchester

During 2017 NHS Improvement (NHSI) determined its preferred long term solution for delivering sustainable services currently provided by Pennine:

- Salford Royal to be the preferred acquirer of the Oldham, Rochdale and Bury hospitals, and
- Manchester Foundation Trust (MFT) to be the preferred acquirer of the North Manchester General Hospital (NMGH).

The disaggregation of NMGH from Pennine is supported by an independent review undertaken by Sir Jonathan Michael, articulating that the best way forward for NMGH is for it to be integrated into the MFT Single Hospital Service; this view is supported by the Greater Manchester Health and Social Care Partnership (GMH&SCP) and local commissioners.

For the acquisitions to be completed successfully by Salford Royal and MFT, both organisations will have to deliver coordinated strategic and business cases to NHSI, highlighting demonstrable patient benefits and value for money. This process is known as a "transaction" and is expected to complete in the latter half of 2019/20. Until this time NMGH will remain part of the NCA. Significant work is now being undertaken by Salford Royal, MFT, commissioners, NHSI and the GM H&SCP to establish the most effective and sustainable way forward.

Work with partners across Greater Manchester to reconfigure specialist services in line with the Healthier Together strategy which brings more high acuity services to The Royal Oldham Hospital.

Pennine is currently completing a business case to access funding to undertake the capital programme to bring more high acuity services to The Royal Oldham Hospital in line with the Healthier Together programme. This will see the construction of a 4 story building, with 48 surgical beds, a new critical care unit and the provision of 2 theatres.

THEME 5

Deliver financial plan to assure sustainability

Key Priorities and Objectives

1. **Deliver financial plans supported by a systematic quality improvement approach to increase efficiency and productivity**
2. **Deliver financial plans supported by a systematic quality improvement approach to increase efficiency and productivity**

Summary of Financial Performance

The main headlines of financial performance for Pennine in 2017/18 were:

- The deficit used for measuring NHS performance i.e. excluding impairments and donated assets adjustment is £30.4m which is £19.1m worse than plan.
- The overall income and expenditure position shows a deficit of £31.3m but this is after accounting for a number of non-operational items. These are set out in the table below.
- The financial risk rating (Use of Resources rating - UoR) using NHS Improvement's methodology to assess the level of financial risk based on the position at the end of March 2018 is a 4.

Statement of Comprehensive Income Position

This statement within the annual accounts shows the total value of income and expenditure for the year ended 31 March 2018. The following table summarises the actual income and expenditure performance as at 31 March 2018.

	Actual Results £m
Income	661.9
Expenditure	(659.8)
Earnings before Interest, Tax, Depreciation and Amortization (EBITDA)	**2.1**
Exceptional income / costs and impairments	(0.7)
Depreciation and amortisation	(22.6)
Total interest receivable / (payable)	(2.0)
PDC dividends	(8.1)
Net deficit per annual accounts	**(31.3)**
Normalising adjustments:	0.9
Operating deficit	**(30.4)**

- Income
  Income from patient care activities has increased by £30.7m from 2016/17. This is primarily driven by a growth in demand for urgent and unplanned clinical activity £30.2m.
- Expenditure
  Operating expenses have increased by £45.6m when compared to 2016/17. The increase in operating expenses is largely driven by the growth in demand for urgent and unplanned clinical activity. Pay costs for the Trust have increased by £30.8m from 2016/17. Planned investment has been made in increasing staffing levels in our wards and department. The Trust has however experienced continued financial pressures arising from the use of temporary staff due to the difficulties recruiting frontline clinical staff and in particular medical and nursing staff.

Capital Expenditure 2017/18

In 2017/18 Pennine spent £19.9m in maintaining and improving the physical estate of our hospitals and to develop frontline clinical services. The table below summarises the capital investment during 2017/18.

	Capital Investment £m
Supporting enhanced Clinical Service Delivery	
and hospital infrastructure	£6.2m
Replacing our medical and scientific equipment including anaesthetic equipment, telemetry cardio equipment, MR Scanner and an audiology system	£7.2m
Enhancing our IM&T infrastructure to better support efficient and effective service delivery	£3.6m
Maintaining and upgrading our estate and buildings	£2.9m

Accounting Policies

Pennine reviews its accounting policies on a regular basis following the requirements of the International Reporting Standards and the Department of Health and Social Care Group Accounting Manual. These policies are reviewed and approved by the Audit Committee and reflect changing nature of the guidance and the external environment within which the Trust functions. Pennine's key accounting policies are set out in the annual accounts included in this report. There were a small number of changes made to the accounting policies in 2017/18.

Details of senior employees' remuneration can be found in the Remuneration Report.

Post balance sheet events

There are no significant post balance sheet events.

A look forward

The Trust continues to operate in a very challenging financial environment and is working with its healthcare partners, in particular, the local North East Sector Commissioners and the GM Health and Social Care Partnership to plan for the future. The Trust's financial plan for 2018/19 was submitted to NHS Improvement in April 2018.

The financial plan for 2018/19 is a deficit of £68.9m. The financial plan reflects national planning guidance in addition to:

- Continuing negotiations with NHSI on the proposed control total and therefore no allocation from the Sustainability and Transformation Fund (STF) for 2018/19
- A stretching cost improvement target of £21.1m (3.3% of turnover)
- Further investment to improve quality and address recommendations from the CQC report
- Contracts signed with commissioners

The impact of CCG locality plans regarding anticipated population growth and schemes to treat more patients in the community to address the growing demand on acute hospital services have been reflected within the plan.

Achieving financial efficiency through the Better Care at Lower Cost Programme is increasingly challenging given the increasing demand for our services and the required investment in improving the quality of service delivery. There will be a strong focus in 2018/19 on delivering the planned savings of £21.1m which relate to improving quality and productivity.

Investment will continue in Pennine's asset base with an investment of £20.0m. Investment is planned in replacing essential medical and IT equipment and providing the necessary investment in the maintenance and upkeep of our buildings.

Reduce workforce vacancies and staff turnover by effective recruitment and retention programmes

Reduce reliance on agency and temporary staff by recruiting medical and nursing posts

This year saw a detailed review of our overall approach to recruitment, and as part of our improvement strategy, have moved to 'multi-source' attraction to reach more candidates, with a much stronger digital presence utilising Facebook and Twitter. We are working more closely with a wider range of universities and also aim to convert more of the students who are placed with us into employment. A key part of the NCA recruitment work has focussed on overseas nursing recruitment and commissioning ID Medical to work with us to recruit nurses from India. To assist with our retention of nursing staff we have developed a nurse rotation scheme and also a nurse transfer scheme whereby nurses who were looking for a career move or were unhappy in their area of work could request a transfer to an alternative role. The NCA is engaged in a retention collaborative as part of the work initiated nationally by NHSI.

We have recruited to Trainee Nursing Associate posts and these will supplement the registered nursing workforce.

As set out above we have undertaken a number of initiatives to recruit into posts to reduce agency spend. We have engaged NHS Professionals to operate a medical staff bank for the Trust, implemented from December.. We are also working with NHS Professionals to grow both our medical and non-medical banks and have re-introduced weekly pay for our own staff for any medical locum shifts worked at Pennine. In addition, in terms of agency reduction we have introduced an auto-registration process whereby, unless they opt-out, staff are automatically enrolled onto the bank with NHS Professionals.

THEME 6

Implement Enabling Strategies

Implement the Digital Improvement Plan

The Digital Improvement Plan aims to advance support for clinical care whilst restoring the performance of existing key systems. IM&T infrastructure stability has been challenged by forthcoming organisational changes, the necessary additional workload following the Wannacry virus attack which affected many NHS organisations in May 2017 and ongoing financial and capacity constraints; however progress is being made. Key achievements have included the deployment of the North Manchester Community Electronic Patient Record, E-Observations technology implemented across many wards, a new telephony platform, new hospital to hospital communications networks and a range of complex upgrades such as Pharmacy systems. In parallel with the complex infrastructure and applications activity, increasing external rigour is being applied to the Electronic Patient Record investment case, extending this substantial work into 2018/19. This is the future focus of high quality patient care.

Research and Innovation

Over the past year, Pennine successfully transitioned to a "joint" research office with Salford Royal. The joint research office harmonised and streamlined all research and development processes, resulting in significantly faster study set-up times and more high quality research being undertaken within the organisation. During 2017-18, our patients were recruited to 117 National Institute for Health Research Clinical Research Network (NIHR CRN) clinical research studies. Participation in research also increased substantially with more patients from across Pennine participating in high quality NIHR research studies than in any other previous year. Indeed, more than 5500 patients participated in a NIHR CRN clinical research study, representing an annual increase of 30%. Patients have participated in research across a broad range of clinical specialities and our level of research participation within infectious diseases, diabetes, gastroenterology and paediatrics is amongst the highest in England. The Trust's reputation for attracting high quality industry trials remains strong with over 750 patients recruited to industry-sponsored NIHR CRN studies. This places Pennine in the top 5% of Trusts in England in terms of recruitment to industry studies.

Open second CT scanner in Autumn 2017

From January 2018 patients requiring complex dental imaging as part of their hospital treatment benefitted from a new cone beam CT scanner, which was been installed at The Royal Oldham Hospital. A dental cone beam CT scanner uses x-rays and a computer to produce 3D cross sectional images of the jaws and teeth. It is a compact, faster and safer version of a regular CT scanner and the time needed for scanning is much reduced.

Furthermore, around 6,000 patients a year will benefit from brand new MR (magnetic resonance) scanners installed at North Manchester General Hospital and Rochdale Infirmary in September 2017. The new £600,000 machine replaced the existing scanner which was a decade old and will be used for all inpatients and outpatients who are undergoing treatment at North Manchester General Hospital and will be used for musculoskeletal, neurology and oncology scans as well as angiograms.

Invest £5 million in capital monies on the North Manchester General Hospital site in estates work and infrastructure

Invest £5 million in The Royal Oldham site in preparation for a significant build in future years

Some of the early works involved with this project have involved the demolition of the old laundry building at the North Manchester General Hospital (NMGH) and the creation of a new car park for staff and visitors. Further work on site infrastructure is to be carried out over the next 18-month period, include providing NMGH with a new energy centre with an updated steam infrastructure, heating and hot water systems a new Combined Heat and Power system and LED lighting retrofit to replace older fluorescent lighting installations. The works to be completed at The Royal Oldham Hospital include the installation of a new heating and boiler plant, replacing two emergency generators, steam system rationalisation,

a new Combined Heat and Power system and LED lighting retrofit to replace older fluorescent lighting installations. We also intend to create a new borehole water supply to feed our on-site laundry as well as a number of other smaller projects which will be designed to increase the overall efficiency and use of energy across both sites. A principal contractor was appointed in December 2017, with the last quarter of 2017/18 spent undertaking an Investment Grade Audit.

Open new £5 million purpose-built Intermediate Care Facility on the North Manchester General Hospital site

A brand new purpose-built £5m, 24 bed community Intermediate Care Unit situated in the grounds at North Manchester General Hospital opened in March 2018. The new unit, known as Crumpsall Vale, will support patient flow from the hospital and the community, initially with 16 residential beds and eight nursing beds, increasing to 16 nursing beds and eight residential beds. All rooms have their own bathroom with a shower, a sunken communal garden, a patient gym and a mock apartment to help patients adjust to home life again. A multi-disciplinary team of dedicated professionals including nurses, physiotherapists, occupational therapists, assistant practitioners, GPs, trainee nurse associates and podiatrists provide an enhanced service for community patients who require a period of rehabilitation. The unit will also support patients who do not require, or no longer need, specialist acute hospital care and treatment, but still need support within a community setting. The Crumpsall Vale unit is a joint partnership between Pennine and Manchester Health and Care Commissioning.

Sustainability Report

It is important to realise that the NHS must tackle sustainability in the widest terms possible. That is, the NHS cannot just be economically sustainable without considering social and environment sustainability at the same time. The combinations of these elements are fundamental to a truly future-proof NHS and a cornerstone to providing a high quality, productive and efficient healthcare service.

Climate Change is without doubt the biggest threat facing the planet today. The NHS Carbon Reduction Strategy seeks to ensure that all NHS organizations establish a fully integrated strategy. Its principle is firstly to identify and address all of the Trust's sources of carbon emissions, secondly to embed the principles of sustainability throughout the organisation and its stakeholders.

Pennine Sustainable Development

We have undertaken steps to reduce our impact on the environment using a Sustainable Development Action Plan devised in line with guidance from the NHS Sustainable Development Unit. Initially produced in 2010, the action plan was a statement of our intentions and built upon the Trust's ambition to provide high quality healthcare today and into the future in a way that results in a reduction in our carbon footprint.

As part of the newly formed NCA, we remain fully committed to reducing our impact on the environment and over the next 12 months intend to produce a revised Sustainable Development Management Plan (SDMP)

The SDMP for the NCA will focus on key priority areas such as:

- Energy & Carbon Management
- Procurement
- Low Carbon Travel & Transport
- Water
- Waste
- Designing the built environment
- Governance
- Staff Awareness

Energy and Energy Consumption

Reducing the amount of energy used in our organisation contributes to achieving the NHS Carbon Reduction targets for England. There is also a financial benefit which comes from reducing our energy consumption.

Energy Consumption

Our total energy consumption has fallen during the year from 117,694 to 116,052 MWh. This is due to the energy saving measures put in place by the Trust, although the cold winter this year has had an impact on potential savings.

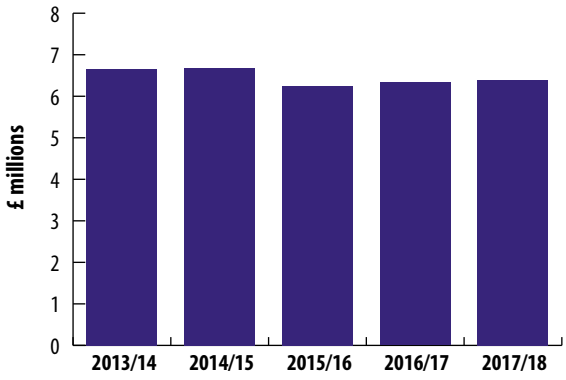
Carbon Emissions

Over the last three years we have significantly reduced our carbon impact by over 250 tonnes. Much of this has been achieved by the installation of the combined heat and power (CHP) unit at Fairfield General Hospital which produces around 12% of the site's total energy demand. However due to some planned significant investment at both North Manchester and The Royal Oldham Hospital sites we intend to reduce our impact even further by installing additional CHP units and an extensive investment around energy demand reduction by replacing the older fluorescent lighting installations with new energy reducing LED lighting technology.

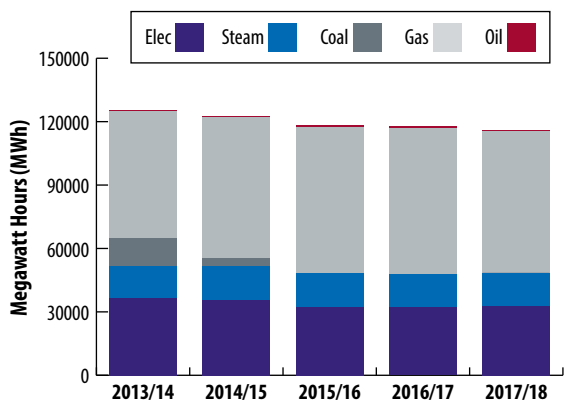
Energy Efficiency Schemes

During 2017/18 our gross expenditure on the CRC Energy Efficiency Scheme was £277,258 for Carbon Emission Allowances. This is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations.

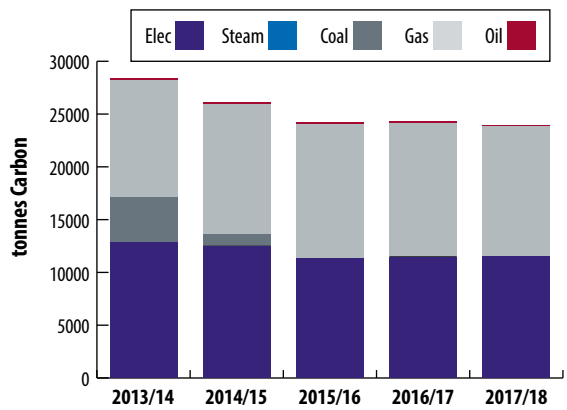
Total energy costs



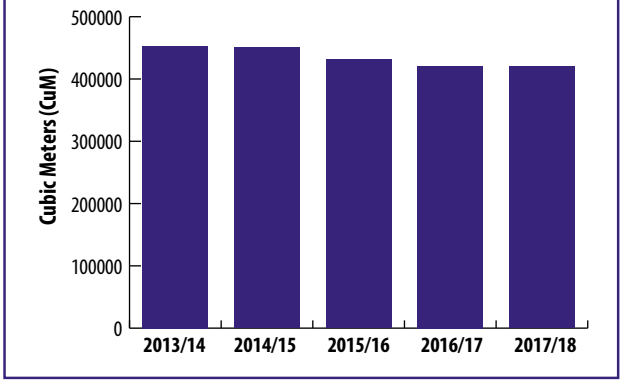
Total energy usage



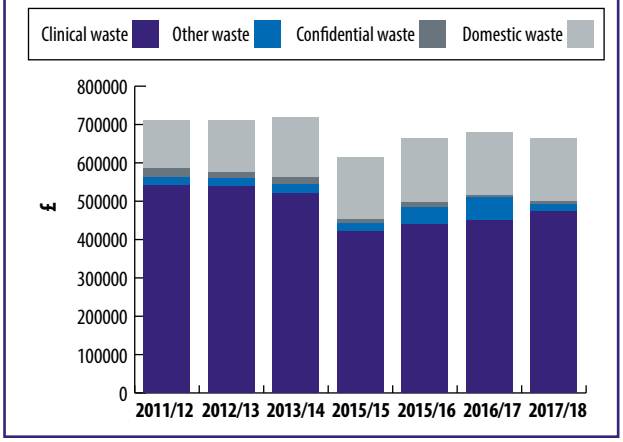
Carbon Emmisions



Water usage



Waste cost by type



Procurement

In addition to our focus on carbon reduction, we are also committed to reducing wider environmental, economic and social impacts associated with the procurement of goods and services. This is set out within our policies on sustainable procurement and we will continue to develop and review a sustainable procurement strategy, in particular recognising the impact of whole life considerations, application of new technologies and engagement with our supply base including Small Medium Enterprises (SMEs)

Low Carbon Travel & Transport

As a member of the Transport for Greater Manchester Travel Choices Business Network, we are committed to encouraging active and sustainable travel across Greater Manchester. We have sought to deliver realistic

active and sustainable travel actions and promotions throughout our hospital sites to facilitate changes to travel patterns and encourage reduced emissions.

During the 2017/2018 year as part of this work we have;

- Achieved a Silver Award from Transport for Greater Manchester (TfGM) for championing sustainable travel in the workplace in 2017 and been re-accredited for this, as the Northern Care Alliance, in 2018.
- Worked with Transport for Greater Manchester (TfGM) in developing a delivery and servicing plan to better manage delivery and servicing journeys at Fairfield General Hospital.
- Continued with the provision of electric vehicle charging points at each of our hospital sites, as part of the Greater Manchester wide charging network.

Water Consumption

Our annual water consumption has remained similar to the previous year.

Waste Recovery & Recycling

In 2017/18 we recovered almost 2785 tonnes of waste (clinical & domestic) across the sites, a small increase on the 2714 tonnes produced on the previous years. Only very small amounts of waste e.g. residue from general skips, goes to landfill.

Designing the Built Environment

We consider the potential need to adapt the organisation's buildings and estates as a result of climate change, but not the potential need to adapt the organisation's activities.

Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

Sustainability issues are included in our analysis of risk facing the Trust. NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations.

We also have a Sustainable Transport Plan. The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. It is therefore important that we consider what steps are appropriate to reduce or change travel patterns.

Energy Performance Contract

The Trust has recently embarked on an Energy Performance Contract in response to a number of key drivers:

- **Delivery of savings:** financial and carbon emissions – energy savings are a top priority for the organisation. The Trust would like to meet its carbon emission obligations of a 34% reduction by 2020/21 (compared to a 2007/08 baseline) if possible, as part of this project.
- **Improving resilience:** ensuring operational continuity and reducing risk associated with ageing infrastructure
- **De-risking future development:** particularly at The Royal Oldham Hospital, where future developments and capacity will need to be considered as part of the project.

This exciting energy project incorporates the deployment of a combination of energy efficiency measures and infrastructure at both the North Manchester General Hospital and The Royal Oldham Hospital sites. The project is estimated to reduce CO2 emissions by approximately 5,750 tonnes CO_2 which equates to approximately a reduction of around 17% against our 2017 baseline.

Looking forward to 2018/19

With the establishment of the NCA, the 2018-19 Operational Plan has been developed from a group-wide perspective, enabling Care Organisations to deliver tailored local plans, whilst working together to achieve the common NCA mission and shared objectives

The Operational Plan also incorporates priorities contained within:

- Five Year Forward View and NHS Mandate
- 'Taking Charge of our Health and Social Care in Greater Manchester'; Greater Manchester's Devolution and Sustainability Transformation Plan (STP)
- Locality Plans (jointly developed by the statutory health and social care partners)
- Organisation-specific plans to address financial and operational pressures

In 2018/19 Pennine forecasts:

- An operating deficit of £59.0m
- A normalised net deficit, after costs of financing and depreciation, of £69.0m
- A deficit excluding depreciation on donated assets of £68.9m

Our key priorities are highlighted below:

Strategic Theme	Strategic Priority/Principal Objective
Pursue Quality Improvement to assure safe, reliable and compassionate care	We will demonstrate continuous improvement towards our goal of being the safest health and social care organisations in England
Improve care and services through integration, collaboration and growth	We will improve patient and care pathways to deliver improved prevention, earlier diagnoses, earlier treatment and earlier discharge across the system (including care at home or in a supportive environment)
	We will offer leadership, scale and technology to improve care and deliver the goals of our Care Organisations and their locality plans
	We will develop Group Shared Services functions to deliver scale, resilience, operational excellence and transformation for our Care Organisations and partners
	We will ensure a safe and sustainable future for the Care Organisations of Salford, Bury, Rochdale and Oldham and collaborate with the City of Manchester and NHS Improvement to secure the transition of North Manchester
	We will grow and strengthen the Northern Care Alliance to ensure a sustainable future for our populations served
Deliver the financial plan to assure sustainability	We will demonstrate continuous improvement in operational and workforce productivity and efficiency We work with partners to ensure financial plans are sustainable and deliver on our annual income and expenditure budgets
Support our staff to deliver high performance and continuous improvement	We will support staff to have rewarding, productive and fulfilling careers, enabling us to recruit and retain talented people.
Deliver Operational Excellence	We will ensure good operational planning and execution to deliver on our urgent care, cancer and elective plans and trajectories, and deploy relevant standard operating models
Develop and implement our Service Development Strategy and the Northern Care Alliance enabling strategies	We will invest and reconfigure our estate and facilities to enable the delivery of an efficient and productive environment which improves patient and care experience
	With our partners we will determine future models of care and a sustainable service configuration to ensure clinical and financial sustainability
	We will reduce variation in care and improve experience and outcomes through the development of our Standard Operating model, our clinical reliability groups and the deployment of our quality and productivity improvement methodology
	Service productivity is improved through digital transformation and the delivery of automation, clinical decision support and patient/user activation products
	Through excellence in change management and delivery of new ways of working we embed the changes resulting from our Northern Care Alliance strategies

Sir David Dalton
Chief Executive
Date: 25 May 2018

Quality Report

Acheivements in quality

In 2017/18 we have achieved:

100% 100% of Pennine inpatient wards and departments using the NEWS observation chart with e-observation system rolled out fully across Fairfield General with all wards across all sites to be rolled out by December 2018.

98.6% 98.6% of patients in inpatient areas received harm free care as measured by the safety thermometer. *(December 2016 – December 2017).*

93.3% Hospital Standardised Mortality Ratio (HSMR) for Pennine has reduced mortality and is now statistically better than expected.

100% 100% of wards were engaged in our End PJ Paralysis initiative.

41% All inpatient wards / departments have had a Nursing Assessment and Accreditation System (NAAS) assessment with 51 of 52 areas having a subsequent reassessment completed. Currently, 41% of our wards have achieved green status compared with a baseline of 24%.

70% 70% of Pennine's rateable services assessed as good or outstanding by the CQC in March 2018

Some 2017/18 achievements

Girlguide Ambassador

Fiona Murphy MBE, Associate Director of Nursing (End of Life, Bereavement, Organ and Tissue Donation) has been made one of Girlguiding North West England's Ambassadors.

Pride in Britain Award

Staff from across the Northern Care Alliance honoured with Pride in Britain Award following the Manchester Arena terror attack response.

Michelle Croston

Michelle Croston, a HIV nurse specialist from North Manchester General Hospital, won the national HIV Nurses' Association (NHIVNA)/ Gilead 'HIV Nursing Award' for 2017.

Pennine Shortlisted

Pennine Acute shortlisted at the National Diversity Award 2017 in the 'Diverse Company' category.

Prof Cuong Dang

Prof Cuong Dang, was awrded the 'Investigator of the Year' title at the Greater Manchester Clinical Research Awards for his significant contribution to research.

End of life care Award

The North Manchester Macmillan Palliative Care Support Service (NMMPCSS) won an International Journal of Palliative Nursing award for end of life care.

Macmillan Professionals Excellence Award

The Macmillan Care Improvement Partnership Team won a national Macmillan Professionals Excellence Awards which celebrates the outstanding contribution Macmillan professionals make to cancer services.

Paediatric clinical team shortlised

The Paediatric clinical team at North Manchester were shortlisted as finalists in the 2017 British Medical Journal (BMJ) Awards in the Prevention category.

Needle-free flu vaccine pilot

A team of clinicians at North Manchester General Hospital were shortlisted for a prestigious national British Medical Journal (BMJ) award for their needle-free flu vaccine pilot.

PEN Patient Experience Awards

Staff representing the Birth Centre at The Royal Oldham Hospital were named as one of five finalists at the PEN Patient Experience Awards.

BMA Association Medal

Professor Andrew Rowland, Consultant in paediatric emergency medicine at North Manchester General Hospital, awarded the Association Medal by the British Medical Association in recognition of his contribution to medicine.

Specialist Primary Stroke Unit

The specialist Primary Stroke Unit at Fairfield General Hospital rated as the best in England out of 228 units nationally, by The Sentinel Stoke National Audit Programme (SSNAP).

'Health and Social Care' Award

In April 2017, a partnership between Pennine Acute Hospitals NHS Trust, Rochdale Borough Council and NHS HMR CCG won the 'Health and Social Care' gong at the Local Government Chronicle Awards for their pioneering Intermediate Tier Service.

Digital Innovation in Healthcare Award

The Pennine L&OD & e-Learning team were named overall winners of the Digital Innovation in Healthcare Award at The Learning Matters Health and Care Awards 2017 for their 'Validating Your Care' system.

Joint emergency vehicle

Rochdale HEATT emergency vehicle scheme, a collaborative health and social care project that helps people avoid urgent care in the Rochdale area, wins NHS North Improvement award.

Meeting with HRH Prince Charles

Louise Hines, Macmillan Community Specialist Nurse was proud to meet HRH Prince Charles at Buckingham Palace, where the Prince met more than 350 nurses from across the country, including first responders to last year's terror attacks and Grenfell Tower fire. He said he was "astounded" by the stories from individuals responding to "harrowing incidents."

Statement on quality from the Chief Executive

Welcome to the Quality Report for Pennine Acute Hospitals NHS Trust for 2017/18.

The last 18 months have been, without doubt, the most challenging period for us all in recent years but I am continuously amazed by the resilience of our staff and their strong desire to achieve high quality care for all our patients and users of our services. This report provides us with an opportunity to highlight some of the main developments to our services and the improvements we have made to care over the past year across Pennine Acute, whilst also reporting on how we have performed against key national and locally-determined clinical standards, waiting times and our key quality improvement priorities.

I would also like to update you on the progress we are making towards the creation of our group of hospitals, community and integrated healthcare services known as the Northern Care Alliance.

The Northern Care Alliance NHS Group (NCA) brings together The Pennine Acute Hospitals NHS Trust and Salford Royal NHS Foundation Trust to create one of the largest NHS healthcare organisations in Greater Manchester and the North West. Together we serve a population of over 1 million people under a new group arrangement of hospitals and associated community healthcare services.

From 1st April 2017, the Board of Directors of both Trusts delegated their functions to a group 'Committees in Common'. While the two Trusts remain two statutory bodies, the Committees in Common (CiC) effectively manage all aspects of service provision on behalf of both Trusts. The NCA aims to standardise services to the evidence of best practice and deliver this reliably across multiple hospitals and community based services.

Saving Lives, Improving Lives

Our 'mission statement' that binds us all together is: 'Saving lives, Improving lives'.

In 2017, Pennine Acute published its' first Quality Improvement strategy which aims to enable us to become the safest organisation in the NHS. This strategy sets out a number of key improvement projects and programmes of work which we have committed to work on in 2018/19. These include: reducing pressure ulcers; improving care of deteriorating patients and ending 'PJ Paralysis'. For example, 100% of inpatient wards/departments across Pennine's four hospital sites are currently engaged in testing changes to end 'PJ Paralysis' by ensuring that we get patients up, dressed and out of bed at the earliest appropriate opportunity. You can read more about the Care Organisation specific improvement work in part 2 of this Quality Account.

Care Quality Commission (CQC) Report

In March 2018, the CQC published its findings and final report following its inspection of our services for Pennine Acute carried out in October/November 2017.

I wanted to take this opportunity to congratulate and thank all of our staff across Pennine Acute for what was an extremely positive report which evidences the fantastic improvements which have been made since the previous visit in February/March 2016. Overall, the rating for Pennine Acute has improved from inadequate to requires improvement.

It is hugely satisfying that the areas which have shown the most improvement are those which were previously rated as most fragile by the CQC: maternity services at both North Manchester General Hospital (NMGH) and the Royal Oldham Hospital (ROH) are now rated as good; and children's services which were previously inadequate are now rated as requires improvement across NMGH and ROH.

Of particular note, are the fantastic improvements made by medical services at Fairfield General Hospital (FGH) which have improved by two ratings from requires improvement to outstanding. This rates the medical services at FGH, alongside Salford Care Organisation, as one of the best in Greater Manchester and amongst the best in the country. Furthermore, FGH is now rated as good overall.

It is remarkable that our acute hospital services across

Oldham, Bury, Rochdale and North Manchester now have 70% of their rateable services, by domain categorisation, assessed as good or outstanding. This is a phenomenal achievement and it confirms independently that we are making positive progress towards delivering the improvements which our staff, our patients and their families deserve.

We know that there are still improvements to be made, with a number of areas and services requiring more focus, support and investment. However, the CQC report has helped to energise and drive staff across Pennine Acute to implement the further improvements which are needed so that we can achieve our aim to become an outstanding rated service.

You can read more about our CQC report and actions to improve further upon the findings in part 2 of this Quality Account.

Demand & Operational pressures

Over the last year, we, like the rest of the NHS, have experienced severe pressure and demand on our services. The number of patient attendances to our Emergency Departments (particularly frail elderly patients and those with complex acute medical conditions), hospital occupancy rates and delays in ambulance handovers have all been higher than previous years.

Our community services are supporting more patients at home and we continue to work with our partners to make transfers to care homes and other care settings as rapid as possible.

Infection control and prevention remains a key priority for our staff here at Pennine Acute and for our colleagues at Salford Royal and we are proud to report that the number of Clostridium Difficile cases in 2017/18 was significantly lower than our trajectory.

Maintaining high standards of care, patient safety, cleanliness and management on our wards and across our services is something we are proud of here at Pennine Acute. Every ward is assessed using the Nursing Assessment and Accreditation System (NAAS) to measure specific aspects of safety, cleanliness, nursing care and multi-disciplinary working. We are pleased to report that 41% of wards across our four hospital sites have a NAAS rating of 'green' and 49% rated as 'amber'.

The views of our patients, service users and staff are very important to us. We continually seek to engage and receive feedback through a number of methods, including surveys and patient and staff stories; all of which provide us with vital information and views on how we can improve further.

Amidst these continuing challenges, I have come across many wonderful examples of compassionate and personal care from our staff day in day out and, never more so than during our response to the horrific terror attack that Manchester suffered in May 2017.

As NHS staff we plan extensively for major incidents such as this. However, no planning could have prepared those involved for the type and severity of this incident which, without doubt, made it so much more distressing and challenging. That being said, it was evident that our plans, and our involvement as part of Greater Manchester's response alongside other emergency services, went very well. In total, across the Northern Care Alliance, we treated some 45 patients, many of whom were in a critical condition.

Finally, I am pleased to confirm that the Board of Directors has reviewed this 2017/18 Quality Account and confirm that it is an accurate and fair reflection of our performance.

I hope that this Quality Account provides you with a clear picture of how important quality improvement, safety and service user and carer experience are to us at Pennine Acute Hospitals NHS Trust and the Northern Care Alliance NHS Group.

On behalf of the Board, I want to thank all staff, in each of our Care Organisations, for their continued contribution to our mission of 'Saving lives, Improving lives'.

Best wishes

Sir David Dalton
Chief Executive

Pennine Acute Hospitals NHS Trust
Northern Care Alliance NHS Group
Comprising the Care Organisations of Salford, Bury & Rochdale, Oldham and North Manchester.

Our Aims

Our aims

Since March 2016, Pennine Acute has been managed by Salford Royal and the two trusts now constitute the Northern Care Alliance (NCA) NHS group. Pennine's hospital sites are three of the four 'care organisations' in the group (Oldham, Bury/Rochdale and North Manchester) and are referred to collectively as the North East Sector (NES) care organisations. The fourth care organisation within the NCA is Salford Royal. The NCA has a single board of directors.

Also in 2016, a new QI strategy was launched for the NES and while this QI strategy addresses the distinct quality challenges of the three Care Organisations that make up the NES, it is important to note that we will be working collectively as a group on quality with each of the Care Organisations (Salford, North Manchester, Oldham, and Bury/Rochdale) working together to create best practice standard operating procedures.

This QI strategy is built on the knowledge that our staff are the best asset we have and we aim to provide the tools and space for learning, collaboration and improvement that will see our staff transform their services to 'good' or 'outstanding'.

No preventable deaths

Estimating preventable deaths is complex. The mortality reviews we carry our make us certain that not all patients receive all ideal aspects of care for their conditions in a timely manner. We use these mortality reviews to find defects in care that we can remedy in pursuit of our aim to have no preventable deaths.

In 2017/18 we improved the position of the NES's risk adjusted mortality from 'worse than expected' to 'as expected.'

Continuously seek out and reduce patient harm

Harm is suboptimal care which reaches the patient either because of something we shouldn't have done, or something we didn't do that we should have done. In 2017/18, 98.6% of our patients received harm free care, as measured by the safety thermometer.

Achieve the highest level of reliability for clinical care

In the NES, we use the principles of reliability science to maintain high performance, and ensure that care is reliably high quality for every patient, every time. In the pages that follow, we detail several projects worked on over the past year in the pursuit of reliable high quality care. Additionally, we have increased the number of wards who are rated as 'green' to 41% on the Nursing Assessment and Accreditation System.

Deliver what matters most: work in partnership with patients, carers and families to meet all their needs and better their lives

The views of our patients and staff are very important to us and we receive feedback through a number of methods, including surveys and patient and staff stories, all of which provide us with vital information on how to improve. In 2017/18, 92% of the NES in-patients surveyed would recommend Pennine Acute as a place to receive care.

Deliver innovative and integrated care close to home which support and improve health, wellbeing and independent living

Caring for patients, their families and carers, is just as important out of hospital as it is when they're staying with us as an inpatient. Our Care Organisations are working closely with community partners such as district nurses, community allied health professions, commissioners and mental health trusts to prevent patients from needing to come into hospital as well as safely transitioning patients home if they have needed to be in hospital.

A review of quality improvement projects 2017/18

Below is a list of quality initiatives in progress and their current status. Several projects are explained in more detail in the following pages.

	Target achieved/ On plan	Close to target	Behind plan
Improving Urgent Care & Patient Flow			≤
Deteriorating Patients	=		
Infection Prevention	=		
Pressure Ulcer Reduction	=		
Nursing Assessment Accreditation Scheme	=		
Help Line	=		
Mortality Reduction	=		
End of Life/Bereavement Care	=		
End PJ Paralysis/Last 1000 Days	=		
Sepsis		≥	
Maternal and Neonatal Health Safety Collaborative	=		

Improving urgent care & patient flow

Fairfield General Hospital was the best performing hospital in Greater Manchester for compliance with the 4 hour A&E target in March 2018.

The North East Sector Care Organisations which make up Pennine Acute are faced with the challenge of managing the increased demand on its' services whilst ensuring a smooth patient journey for all patients .

The three North East Sector Care Organisations have each established work programmes designed to successfully improve patient flow throughout the whole organisation resulting in a reduction in the number of 'stranded' patients and improvements towards reaching the national A&E targets.

The Improving Patient Flow programmes of work consist of multiple workstreams which focus on: Urgent Care, timely discharge and 'fundamental standards' for effective patient flow processes. Each Care Organisation has established similar workstreams which are monitored and directed by the Care Organisation's Improving Patient Flow/Urgent Care Improvement Board.

What: To successfully improve patient flow throughout the whole organisation resulting in improvements towards reducing the number of 'stranded' patients and reaching the national A&E targets

		Fairfield & Rochdale	North Manchester	Royal Oldham
How much:	A&E 4 hour target	92%	90%	90%
	'Stranded' patients	10% reduction	50% reduction	10% reduction
By when:	A&E 4 hour target	March 2018		
	'Stranded' patients	June-18	April-18	Mar-18
Outcome:	A&E 4 hour target*	91.93%	75.23%	82.40%
	'Stranded' patients	No reduction as of March 2018		

* A&E data is year-end 2017/18 percentage for each Care Organisation

Urgent Care

The aim of 95% of patients being seen within four hours of arriving at Accident and Emergency departments is one of NHS England's most widely discussed and reported aims. Demand on urgent care services such as A&Es has always been high, and is increasing, which has resulted in the four hour target being consistently missed by NHS trusts across the United Kingdom.

The North East Sector Care Organisations each established urgent Care workstreams in late 2017, looking at how to work most effectively to manage high demand on urgent care services whilst ensuring that all patients are seen, assessed and treated in a timely and appropriately manner every time.

Each care organisation has developed a driver diagram looking at specific improvement projects relating to urgent care at their organisation:

Driver Diagram - Urgent Care

AIM: To achieve trajectory so that by March 2018, we achieve 90% of 4th target

Secondary Drivers	LEAD	Driver Measures
Pathology system overload - IM&T solutions	Medium Priority	
Radiology escalation process	Medium Priority	
Fit to sit in A&E and A&E ward i.e bed replaced with 10 chairs	Medium Priority	
Review of ED documentation • Nursing documentation • Medical documentation (Med priority)		• Increase in commencement of intentional rounding • Increased completion of SBAR • Time to triage
Same Day Care		• x% increase in Emergency care Take (Amb/Walk-in)
Speciality Pathways		• No of response times recorded (% compliance) • For those recorded how many responded within the hour • x% increase in 4 hour performance • No 12 hour breaches (DTA)
A&E board rounds - 2 hourly MDT board round	Medium priority	
Rapid Assessment Process		• Time from ED arrival to blood tests being ordered • Time from ED arrival to imaging being ordered
7am (8am) consultants in AMU		• No patients discharged before 12 noon • Discharge lounge data
Surgical stream / Ambulatory care pathway / Trauma / Pre-op workstream		
Frailty Model		• LOS for frail patients - TBC • Discharges before 12pm for frail patients • Re-admissions within 30 days • Inpatients falls in frail patients • Reduction in routine investigations • (These measures will be collectable with a frailty marker on the EPR system) • All patients identified as frail has an MDT led Comprehensive Geriatric Assessment

Improvements achieved

- The Care Quality Commission (CQC) reported substantial improvements in urgent and emergency services across the North East Sector Care Organisations in their most recent inspection report (March 2018):
  - Fairfield General Hospital urgent and emergency services rated 'Good' against all five CQC domains and overall.
  - North Manchester General Hospital urgent and emergency services rated 'Good' in five out of six CQC domains and overall.
  - The Royal Oldham Hospital urgent and emergency services rated 'Good' in five out of six CQC domains and overall
- Each Care Organisation has established a workstream group made up of both clinical and non-clinical 'experts' and senior leaders who meet weekly to drive improvement and monitor progress against their aims.
- A dedicated GP streaming service is now available in all three A&Es; this service appropriately 'pulls' patients out of the A&E department before they reach triage to assess and treat them in a more

suitable care setting in order to reduce both demand on A&E resources and delays in the patient pathway.

- All three A&E departments are engaged in implementing the 'fit to sit' model which encourages clinicians to move those patients who are well enough to sit, out of A&E trolleys and beds into chairs whilst they await assessment and treatment. This initiative aligns to the #EndPJParalysis campaign which aims to help patients get up out of bed and home sooner.
- The urgent care workstreams have adapted and implemented the ED Patient Safety Checklist designed by University Hospitals Bristol NHS Foundation Trust which outlines clinical tasks, assessments, patient personal needs requirements etc. to ensure that these are undertaken in a timely way to improve patient satisfaction and reduce risks.

Further improvements identified

- Introduce Rapid Assessment and Treatment model (RAT) which relocates triage to the front door for ambulance arrivals to speed up the process of patients being seen by a senior clinician.
- Continued investment in infrastructure and workforce to create an 'emergency village' on the North Manchester and Fairfield hospital sites.

Inpatient Flow and Stranded Patients

Once a patient is admitted to hospital, it is often the case that they remain here for longer than is necessary. This delay is not beneficial for either the patient or the organisation. A well patient may deteriorate again while waiting to be discharged, while at the same time an acutely unwell patient in Medical Assessment Unit (MAU) may be waiting to be admitted onto a ward.

A 'stranded patient' is defined as a patient who has had a length of stay in hospital of seven days or more. Each North East Sector Care Organisation has therefore established workstreams which aim to get patients out of hospital and back into their community as soon as they are well enough.

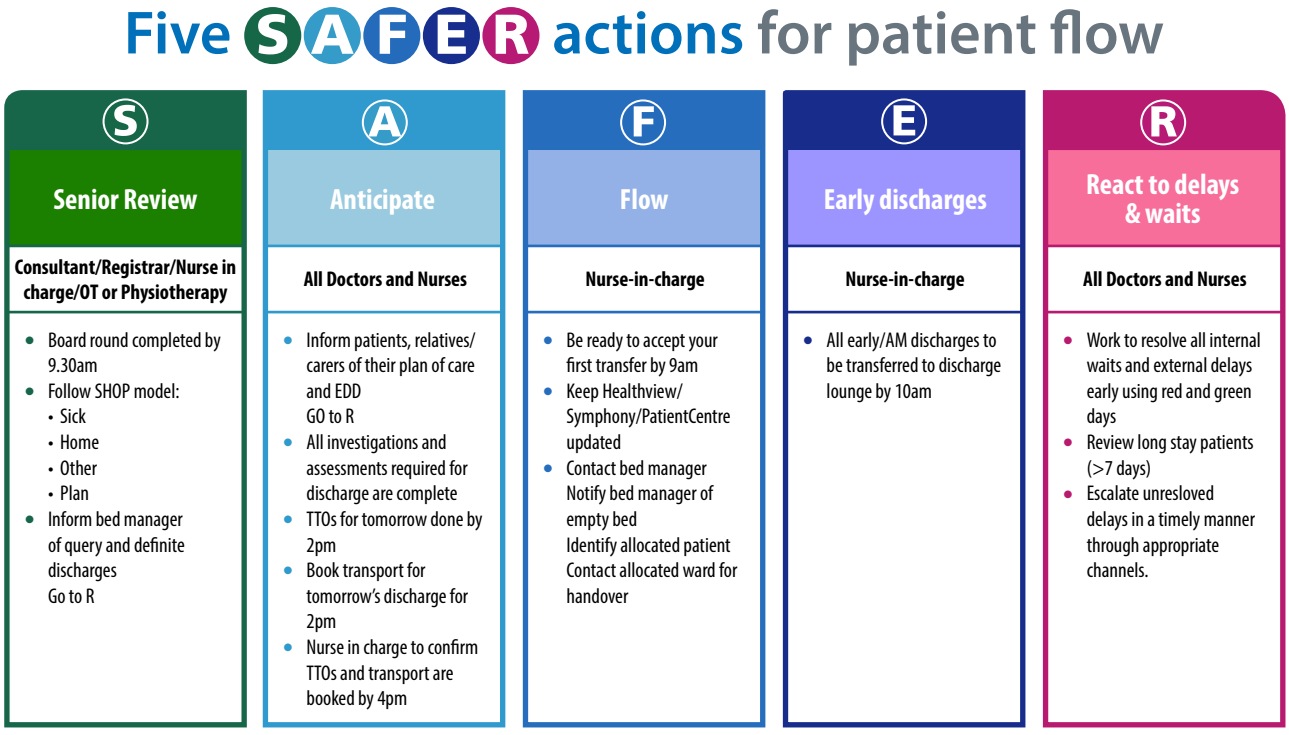
Improvements achieved

- Oldham Care Organisation have established a weekly multidisciplinary and multi-agency 'Length of Stay MDT Summit' attended by acute, community and social care staff to review all patients with an extended length of stay or delayed discharge, and to progress plans and overcome barriers to discharge.
- Process mapping exercises have been undertaken with a range of clinical and non-clinical teams across each Care Organisation to understand the hospital system including barriers to effective patient flow in order to identify opportunities for improvement.
- The roll-out of the SAFER patient flow bundle has commenced in selected ward areas to improve discharge processes through improved multi-disciplinary communication and planning.
- Senior Managers on Call (SMOCs) are given additional support through briefing sessions and action learning forums to provide all leaders (clinical and non-clinical) with the right skills and knowledge to manage patient flow across our hospital sites out of hours and over weekends.

Further improvements identified

- Improve utilisation of the Discharge Lounge in line with the '10by10' initiative which facilitates the earlier transfer of patients awaiting discharge out of hospital beds into the Discharge Lounge before 10am, in turn supporting improved flow for patients awaiting admission in urgent and emergency care services.
- Continue the roll-out and reliable implementation of SAFER patient flow bundle (see poster below) with a focus on embedding effective board round processes for inpatient wards.
- Improve reliability of ward rounds through continued testing on selected pilot wards of 'Ward Round Proforma' to ensure all patients receive a daily senior review with key areas of patient care and discharge planning discussed each time.
- Spread 'Length of Stay MDT Summit' processes across all North East Sector Care Organisations, ensuring standardisation where appropriate.
- Work collaboratively with community teams to utilise effective 'Discharge to assess' models which supports wards to discharge patients to be assessed in the community wherever it is safe to do so.

The image below is taken from a poster designed by staff to outline the five elements of the SAFER patient flow bundle:



Deteriorating patient breakthrough series collaborative

23% reduction in the mean cardiac arrest rate as measured now, compared to the baseline period

We have achieved a statistically significant reduction in the cardiac arrest rate (per 1000 admissions) across our Deteriorating Patient Collaborative innovation wards.

What:	Reduce the cardiac arrest rate (per 1000 admissions) on collaborative wards
Target:	50% reduction
By when:	December 2018
Outcome:	During Phase 1 of the collaborative (since November 2016) we have achieved a 7% reduction in cardiac arrest rate
Progress:	

This statistically significant reduction is also replicated on the collaborative wards at Fairfield General Hospital (Bury/Rochdale Care Organisation) and Royal Oldham Hospital (Oldham Care Organisation).

We have been working with a selection of innovation wards from across the trust since November 2016 to design, test and reliably implement the improvement ideas of staff with the aim of improving the care of deteriorating patients.

Improvements achieved

A change package has been developed which details the 6 key improvements which can reduce cardiac arrests when applied reliably to patient care. The changes are:

1. Highlighting sick patients
2. Timely observations and appropriate escalation
3. Allocation of cardiac arrest roles
4. Manual observations
5. 'Stop the Clock'
6. The Weekend Plan

All collaborative wards are asked to implement each of the six key changes outlined within the change package by December 2018. Lessons learnt regarding the spread and sustainability of the Deteriorating Patient change package will be used to inform the subsequent trust-wide roll out of successful interventions.

At a Celebration Event in December 2017, Sir David Dalton celebrated the improvements teams had made to date and welcomed a second cohort of wards to the collaborative.

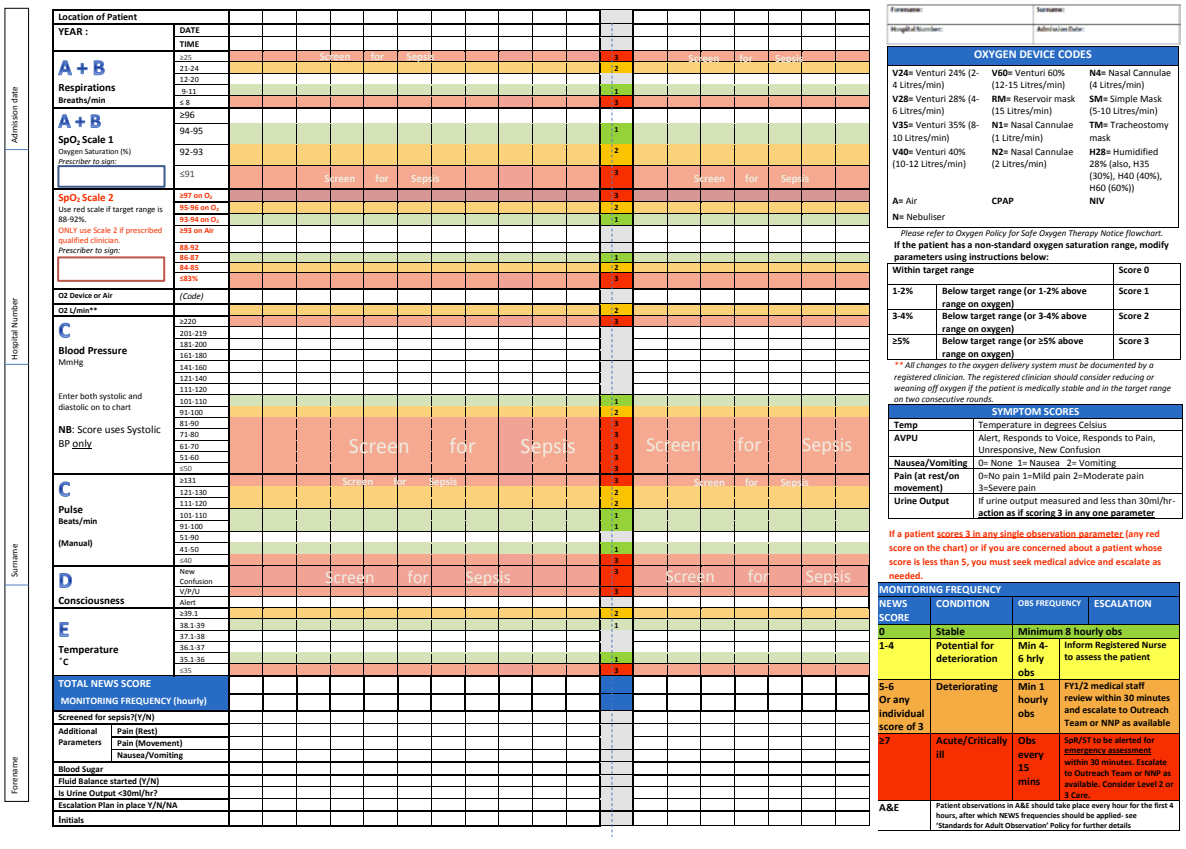
The image right shows Sir David Dalton and collaborative ward teams releasing 25 helium balloons; each balloon represents a life saved since commencing this improvement work in November 2016.

Between August 2017 and March 2018 we have seen a statistically significant reduction in the cardiac arrest rate for collaborative wards at Fairfield General Hospital and the same across all wards at The Royal Oldham Hospital.

We have confidence in the changes which the innovation wards have tested, and we hope to see a continued reduction in cardiac arrests to achieve our aim as all wards adopt the changes outlined in the package, and embed each one reliably in every day processes.

Further improvements achieved

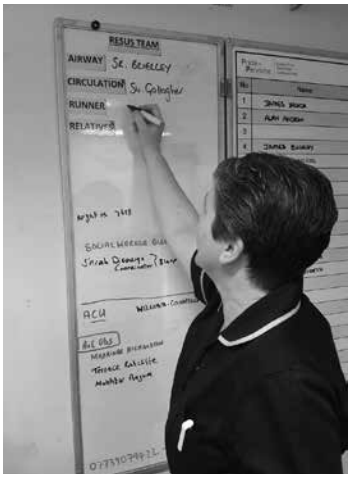
- In April 2017, the National Early Warning Score (NEWS) observation chart and revised Standards for Adult Observation Policy was launched.
- The NEWS observations chart is now in use across all wards and inpatient departments and utilises coloured visual cues to prompt the earlier identification of deterioration and escalation of care.
- The NEWS observations chart also incorporates the neurological observations screening tool and prompts staff to 'screen for sepsis' when a patient triggers any of the Red Flag Sepsis indicators (National Institute for Health and Care Excellence, NG51 Sepsis Guidelines, 2016).
- In summer 2017, we began the rollout of the Patientrack electronic observation system. This system is now live across all wards at Fairfield General Hospital, with rollout ongoing at North Manchester and The Royal Oldham Hospital. Rochdale Infirmary will be added to the rollout in August 2018.
- The Patientrack system requires clinical staff to input physiological observations at the patient's bedside using a handheld iPad in order to provide an automated calculation of the EWS score which removes the risk of calculation error. The system will also alter the monitoring frequency and provide escalation prompts in line with the trust's escalation protocol.



Further improvements identified

- All collaborative wards are working towards the implementation of all six key changes by December 2018. The wards will focus on how reliably each change has been implemented to ensure the change package is sustainably embedded in order to achieve the cardiac arrest reduction target.
- The NEWS observation chart will be updated to align with the Royal College of Physicians' national guidelines which were updated in December 2017. NEWS2 will be launched in summer 2018 and supported by staff training and communication.
- By December 2018 the Patientrack electronic observation system will be rolled out across all wards and inpatient departments at all three NES Care Organisations, on four hospital sites.

Case study



The Acute Medical Unit (AMU) team at The Royal Oldham Hospital decided to test the use of cardiac arrest role allocation. This was seen as an opportunity to improve the response to a cardiac arrest by a pre-allocated team, whilst also ensuring ward cover for all other patients on the unit.

Initially, communications were developed to inform staff of the test and its importance and these were shared during staff handover. The team used a 'Plan-Do-Study-Act' (PDSA) cycle to test the allocation of roles to a team of 4 staff members (both qualified and unqualified) and additional training was given to support the individual allocated as 'relatives nurse'.

During testing, staff feedback and comments were welcomed and, as further testing took place, initial reluctance from staff was replaced with recognition that role allocation contributed to a more streamlined response to a cardiac arrest. During testing, staff identified the importance of having a robust process to ensure roles are handed over if a staff member was to leave the ward.

They also identified training gaps and supported staff using 1:1's to increase confidence in undertaking each of the roles. The staff are now very positive; everybody is aware of their role thus allowing resuscitation to commence immediately in an arrest. This has improved patient outcomes, whilst all other patients on the unit remain observed and cared for at the same time.

"We heard about the allocation of cardiac arrest roles during Learning Session 3 from colleagues on AMU and also participated in a simulation exercise with the Resuscitation Team which evidenced the value of allocating roles prior to an arrest. As an Infectious Diseases ward, thankfully we have very few arrests. However, we have a unique layout of our two wards so when the alarm was previously raised, everyone on the ward would rush over potentially leaving other patients without care. We believed that cardiac arrest role allocation would not only enable us to commence resuscitation in a more timely manner if an arrest were to occur, but it also allowed us to facilitate a conversation with staff at all levels regarding their confidence and competence in Basic Life Support. Since testing and implementing the cardiac role allocation during safety huddle, we have unfortunately had an arrest on the ward- but, we found that having roles pre-allocated (using a badge) enabled a much more timely response, whilst also ensuring the rest of our patient remained cared for."

Lindsay Clark, Ward Manager J3/J4, North Manchester General Hospital

Sepsis

In March 2018 (Q4), 100% of patients in A&E with an EWS score of ≥5 were screened for sepsis.

In March 2018 (Q4), 79.5% of patients in A&E with 'red flag sepsis' received antibiotics within one hour of identification.

In March 2018 (Q4), 94.1% of patients in in-patient ward areas with 'red flag sepsis' received antibiotics within one hour of identification.

What:	To treat patients who have sepsis with antibiotics within 1 hour
Target:	75% of patients with red flag sepsis to be given antibiotics within 1 hour of identification
By when:	March 31st 2018
Outcome:	In March 2018 (Q4) 79.5% of A&E patients and 94.1% of inpatients with red flag sepsis were given antibiotics within 1 hour of identification
Progress:	≥

Sepsis is a highly complex disease process which is difficult to diagnose and complicated to treat. The mortality rates associated with septic shock remain unacceptably high (up to 50%) with an estimated 37,500 deaths per year in the UK. Evidence has shown that early identification and treatment of these patients with antibiotics can lead to improved survival.

The early identification and timely treatment of sepsis remains an organisational priority for Pennine Acute and is therefore a key component within The Quality Improvement Strategy. In 2017/18, The Trust has focused primarily on improving the identification and management of sepsis within emergency departments as well as developing prevention strategies and sepsis pathways within community services to avoid acute admission.

Improvements achieved

- The trust has nominated Sepsis Clinical Leads across all four hospital sites
- Our Sepsis 'essential training' e-learning module became mandatory for all clinical staff to complete from August 2017
- A new sepsis screening and action tool was developed and implemented across the Pennine Acute sites in April 2017
- The NEWS observation chart visually prompts staff to 'screen for sepsis' if a patient triggers any of the red flag sepsis criteria outlined within the National Institute for Health and Care Excellence Sepsis Guidelines (NG51, 2016)
- The trust updated its antibiotics policy for adult patients to align clinical practice to changing national guidelines. Staff were supported through additional training and communications and provided with a 'quick reference sheet' to support decision making

Further improvements achieved

In addition to the improvement work taking place across the trust's acute hospital sites, in 2017 an improvement group was established to improve the management of sepsis in community settings. The following areas of improvement have been targeted:

- An in-depth process mapping took place to understand how Sepsis is currently identified and managed across a range of community services

- A group of clinical experts established an improvement group and began to identify change ideas which aimed to make improvements to the current state community processes across Heywood, Middleton and Rochdale and North Manchester
- This group identified a key priority for improvement was earlier prevention within the community which would prevent the need for acute admissions
- The multi-disciplinary group have designed a Community Sepsis Screening & Action Tool which has been benchmarked against national tools provided by the UK Sepsis Trust and also aligned to the tool used within the trust's acute services
- In addition, a community physiological observations chart has been designed to support the early identification of deterioration in patients and prompt community teams to screen patients for sepsis
- The team are also designing sepsis training materials to be used in community settings

Further improvements identified

- In summer 2018, a sepsis module will be added to the Patientrack electronic observation system and rolled out across all in-patient wards by December 2018. This module will flag to clinical staff when patients' observations trigger against any of the NICE red flag sepsis parameters and will enable staff to complete the screening and action tool electronically.
- The acute sepsis screening tool and action tool will also be integrated within the software used in our A&E departments to track the patient journey. This will support clinical staff to screen for sepsis during triage and commence the sepsis treatment pathway more promptly if sepsis is identified.
- The community improvement group will pilot the new observation chart and screening tool with the aim of spreading its use across our Community Services.

Infection Prevention

In 2017/18 the North East Sector Care Organisations have achieved a 26% reduction in the number of C Diff cases compared to 2016/17.

The Trust considers Infection Prevention to be one of its most important priorities. Over the past year, the organisa-tion has undertaken extensive work to prevent patient harm from infection. The improvement work has been struc-tured under a number of workstreams testing which test ideas for improvement in pilot areas, and then spread suc-cessful change across our organisation (wherever possible across both Acute and Community sectors).

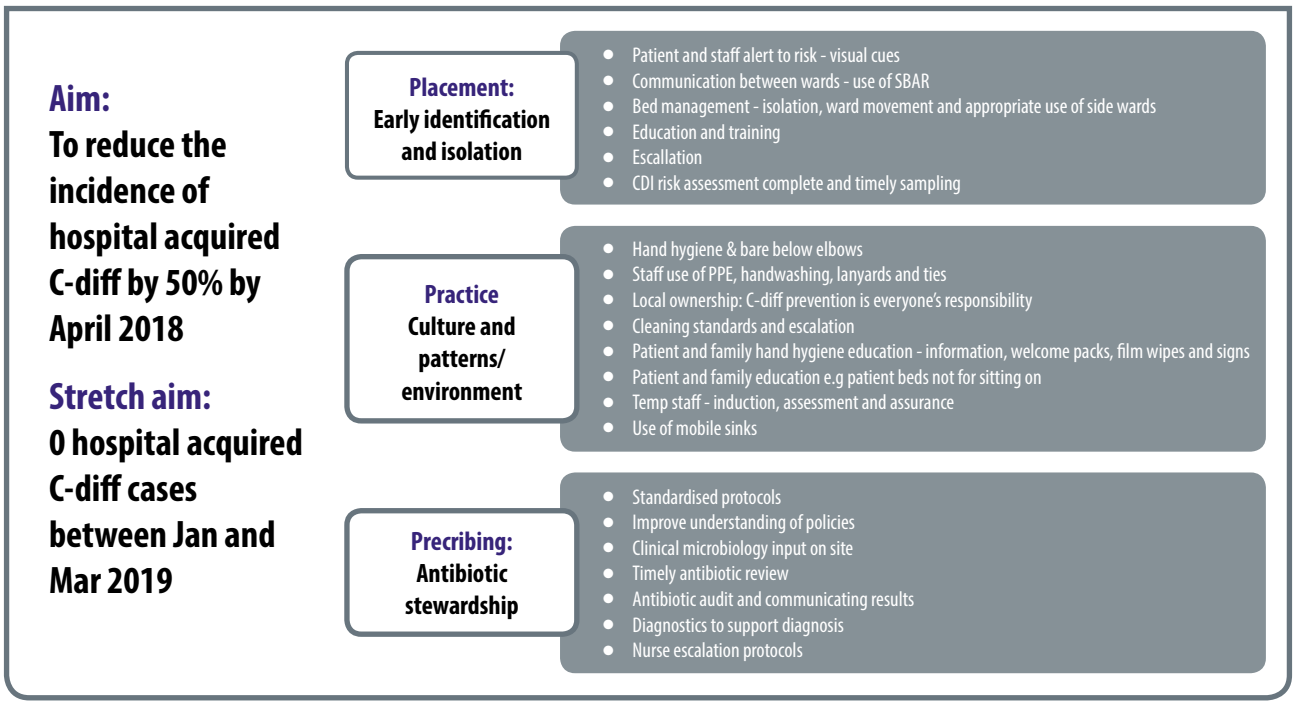
Improvements achieved

Clostridium Difficile at Fairfield General Hospital

In August 2017, the senior management team at Fairfield General Hospital (Bury) began a small scale improvement project to address the issue of Clostridium Difficile (C Diff). The main themes identified as potential areas of improvement were:

- Insufficient/absent anti-microbial stewardship
- Conflicting opinions with regard to the cleanliness of the environment
- Culture and leadership – there is capacity in some areas, this is not consistent. There is also evidence of poor practice which has not been challenged.

A selection of wards were chosen to participate in this improvement project and lead on the development and testing of change ideas. The driver diagram below was developed by clinical experts across Fairfield General Hospital to outline the project aim and priorities for improvement:



Following a 90-day cycle of improvement, a selection of successful change ideas were identified as having a positive impact on reducing the number of hospital acquired C Diff cases. These changes include:

- The trust introduced a revised programme of cleaning on ward areas
- A new role of Antibiotic Pharmacist has been introduced across all 3 care organisations; Bury/ Rochdale, Oldham and North Manchester.
- Wards have fed back positively on the presence of the Antibiotic Pharmacist on the ward to provide the face-to-face training to the doctors and pharmacists to resolve antibiotic queries.
- The role of the Antibiotic Pharmacist has been standardised across the three Care Organisations. The external auditor, Mersey Internal Audit Agency (MIAA), came to audit the three COs in November 2017 and produced a very positive report.
- The impact of the Antibiotic Pharmacist role can be demonstrated in the table below which shows that the number of C Diff cases per site has decreased year on year:

Year/ CDI cases per site	TROH	NMGH	FGH/RO	TRUST-WIDE
17/18	17	13	12	42
16/17	21	16	20	58
15/16	23	15	16	56
14/15	40	15	17	72

Further improvements achieved

- In addition to the C Diff improvement work at Fairfield General Hospital, the Trust has introduced a risk assessment tool to aid rapid diagnosis for patients with infection. This aims to improve the knowledge and understanding by healthcare professionals of how to interpret symptoms of C Diff
- The trust has also developed a urinary tract infection (UTI) screening toolkit to support effective and accurate diagnosis of UTI with appropriate antibiotic prescribing
- The trust undertook an improvement project which aimed to improve hand hygiene for patients using an innovative 'Five Moments of Hand Hygiene' model. This improvement work consisted of :
    1. Staff education of the 'patient hand hygiene moments' (the occasions when patients should undertake hand hygiene)
    2. Patient awareness posters and leaflets distributed
    3. Hand hygiene wipes made available to all patients
- These actions were tested in two pilot areas and resulted in a significant increase in patient hand hygiene from 0% to 80.5% over the test period. Both pilot areas also reported a reduction of other commonly reported healthcare acquired infections by 40% from 47 cases to 28 cases.

The Trust is also committed to a zero tolerance approach to MRSA bactereamias and has implemented the following measures:

- A programme of screening high-risk patients on admission
- Provision of topical treatments for those at risk of MRSA infection, including an antiseptic body wash which is continued for the duration of a patient's stay.
- An investigation involving the clinical and nursing team is undertaken for each MRSA and actions from lessons learnt are implemented with specified training in the area of clinical practice requiring improvement.
- A multi-disciplinary group focus on improving the diagnosis and rapid treatment of severe sepsis. This forms part of the trust's patient safety programme.

Further improvements identified

During 2018/19, Pennine Acute will continue its focus on robust practices to reduce healthcare acquired infections, by supporting staff to:

- Ensure rapid clinical assessment of patients with diarrhoea for risk of CDI is part of routine clinical practice, and is shared with other specialist colleagues for wider adoption.
- Sustain and continually improve antibiotic prescribing to enhance and support the national "Start Smart, then Focus" antibiotic stewardship programme. This will be achieved through audits of antibiotic prescribing and feedback to clinical teams.
- Evaluate an innovative programme of emphasis on improving facilities and support for patient hand hygiene as a quality improvement programme.
- Re-evaluate our approach to hand hygiene including the addition of extras sinks, education packages and training for staff, and an innovative re-branding of hand hygiene.
- Review further innovative methods of evaluating environmental cleaning and surface contamination through the use of UV light decontamination.
- During 2018-2019, Pennine Acute will be taking part in the national ambition to reduce Gram-negative bloodstream infections in England by 50% by March 2021, and to reduce E.coli bacteraemias (which account for more than 70% of these infections) by 10% during 2018. We aim to support this new initiative by working with the Greater Manchester Collaborative in identifying innovative improvement programmes in early diagnosis and management strategies for E.coli urinary tract infections. This will also support the national ambition to reduce antimicrobial prescribing.

Pressure ulcers

32% reduction in grade 2 pressure ulcers across our pilot areas over the last 12 months

34% reduction in grade 2, 3 and 4 pressure ulcers across all Pennine (acute and community)

80% reduction in grade 3 & 4 pressure ulcer in hospital over the last 12 months

43% reduction in grade 2 pressure ulcers in the community

What:	Reduce the number of pressure ulcers acquired by patients whilst under our care
Target:	20% reduction in grade 2 pressure ulcers Zero tolerance of grade 3 & 4 pressure ulcers 20% reduction in pressure ulcers in community
By when:	1st April 2018
Outcome:	34% reduction in grade 2, 3 and 4 pressure ulcers across Pennine (acute and community)
Progress:	≥

Reducing Pressure Ulcers

A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device) resulting from sustained pressure. The damage can be present as intact skin or an open ulcer and may be painful (NHS Improvement, 2017).

All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity.

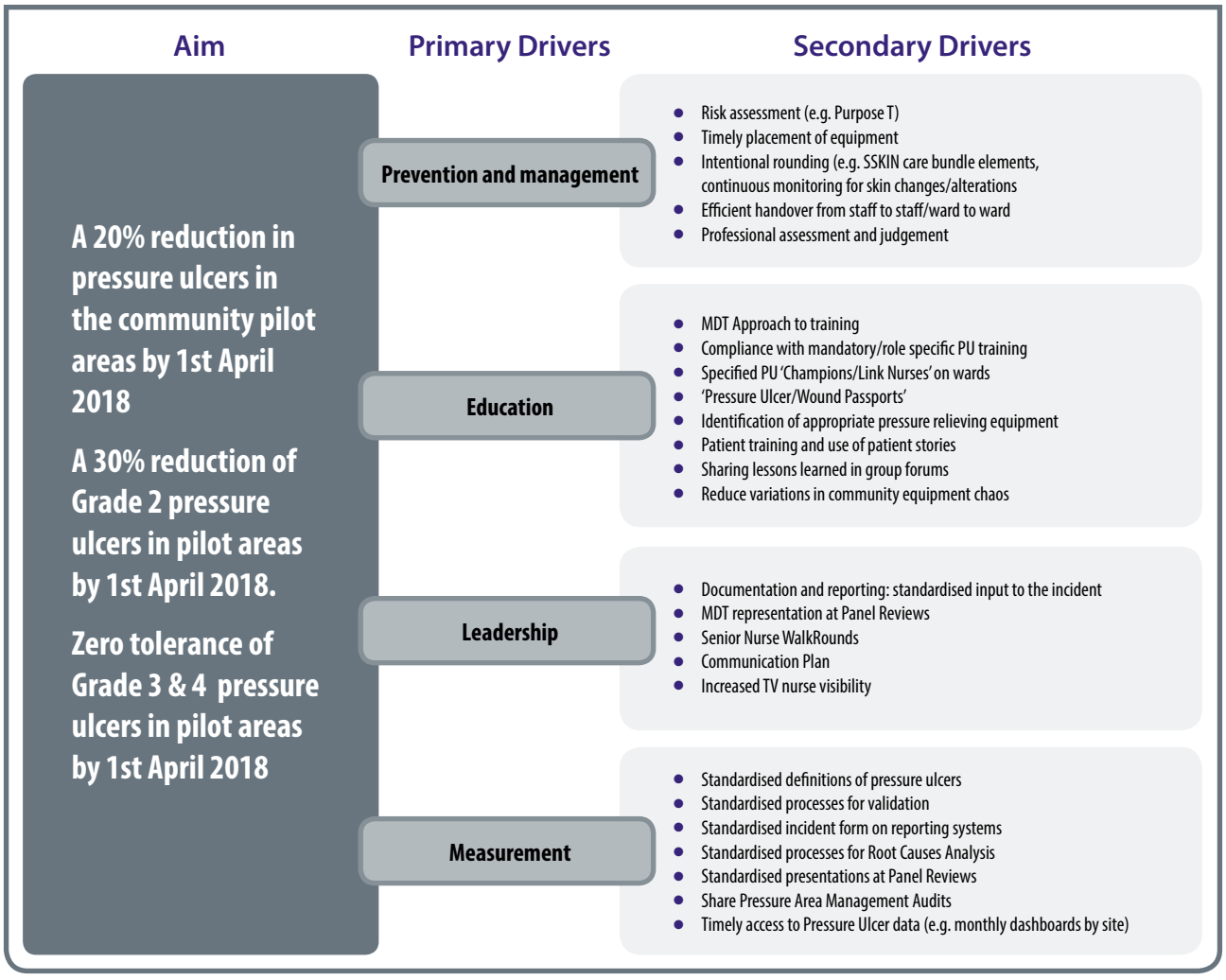
The trust has endeavoured to reduce harm to patients by setting up a 'Pressure Ulcer Collaborative' whereby a number of pilot wards and community areas actively work together to reduce the number of pressure ulcers that develop.

Improvements achieved

- Testing underway in all areas of the driver diagram (see p23).
- Added skin integrity to WHO briefings at start of theatre list
- Training local care home staff on the prevention and management of pressure ulcers

Further improvements Iidentified

- Wards and community areas have pledged to make key tests of change 'business as usual' whilst continuing to test additional ideas that will support the prevention of pressure ulcers.
- Learning sessions will occur three times a year to ensure opportunities to share good practice will be available for the wards.
- The Tissue Viability Team will endeavour to support pilot areas fortnightly to ensure progress.
- Alliance-wide 'Intentional rounding' document is being revised to ensure that frequent skin care inspections occur across our organisation.



Nursing Assessment and Accreditation System (NAAS)

The Nursing Assessment and Accreditation System (NAAS) is designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed.

What:	To conduct an initial assessment of all 59 wards
Outcome:	100% of all adult inpatient wards/departments were assessed by the end of September 2017
Progress:	⛔

The introduction of NAAS in September 2016 was a key part of Pennine's improvement plan. It aims to ensure there is a culture of continuous improvement supported by robust governance and accountability arrangements 'from board to ward' and that ward managers are focused on the key risks to the delivery of excellent care.

A NAAS team at Pennine was created to develop and implement the Salford Royal NAAS model which has been in place since 2008.

Improvements achieved

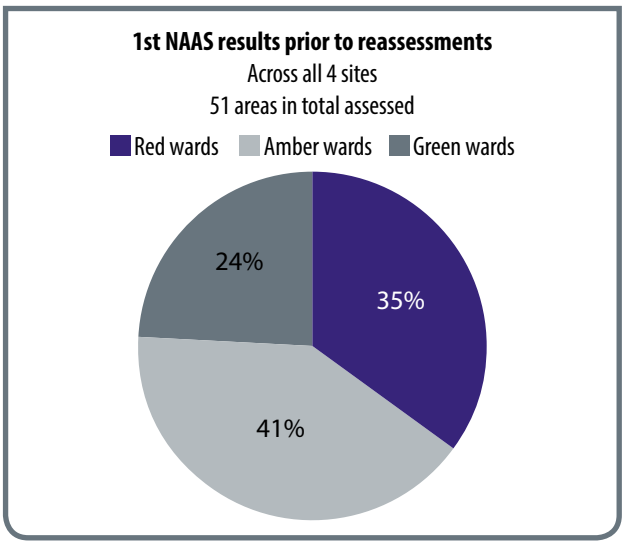
All wards have received their first assessment as planned and over half have also received a second assessment. Wards scoring a 'red' assessment have decreased form 35% to 10%.

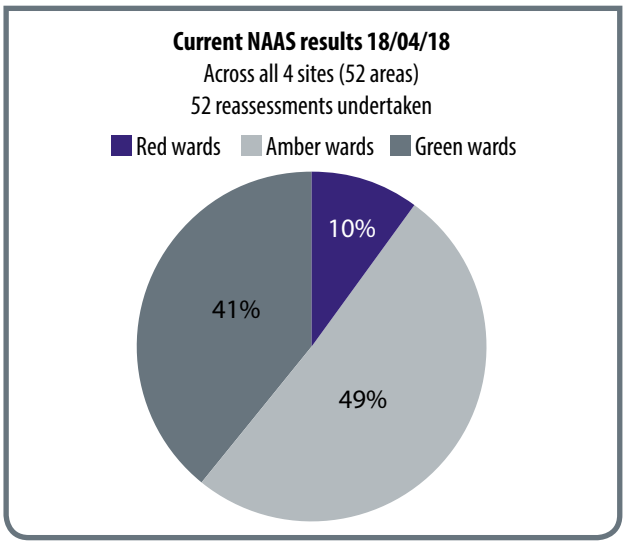
Further improvements identified

The aim for the next 12 months is to ensure all adult inpatient ward areas have had a second assessment and that wards are showing improvements. Where progress is not seen, additional attention is given to understand the problems and provide appropriate support.

The NAAS team have met with senior nurses within paediatrics and aim to include paediatric inpatient areas next and undertake a NAAS assessment in these areas.

Three Corporate Quality NAAS matrons are now in post and assigned to a specific Care Organisation. They support the ward teams with their action plans to ensure safe, effective care is being delivered.





Implementing the 'Helpline Scheme'

Aim: To have a senior member of staff available by phone 24/7 on each site whom patients and their families can contact if they feel there is a risk of preventable harm that is not being managed to their satisfaction.

The Helpline scheme provides a mechanism for patients or their families to contact a senior member of staff who has responsibility to respond to their call. Since early 2017 it has been available across every Care Organisations.

Improvements achieved

Each Care Organisation is responsible for managing an on-call rota 24/7, and during 2017 the rotas were adapted to meet the changing structures within the organisation. Some rotas were streamlined to avoid the mobile phone handset being transferred between managers as often.

The Helpline scheme is advertised by displaying posters in each of the bed/bay areas. In addition, each ward & department entrance has a larger A3-sized multi-lingual version of the poster.

During the summer months of 2017 it was noted that calls to each of the Helplines had reduced in number, and in response to this a number of specific actions were undertaken:

- Further promotion of the Helpline was undertaken to ensure that posters were displayed and staff were aware of Helpline and could promote it.
- Senior managers commenced visual checks to ensure the Helpline scheme was advertised appropriately and incorporated this as part of their senior nurse walk rounds, safety huddles, and ward and patient safety meetings.
- Each Care Organisation was provided with templates to produce small sized Helpline Cards to display on wards and departments, that could be taken off site by patients or their families and used to contact the Helpline.
- On call managers identified that the old style mobile phone handsets were problematic and could be contributing to the reduction of receiving/ recording calls, therefore each Care Organisation was provided with an up to date smart mobile.
- To ensure calls made to the Helpline were captured effectively, and make it as easy as possible for managers to record them, an alternative method of recording them was explored: the Risk Management System (Datix) is currently being modified to allow calls to be recorded, managers notified and information of call content produced accordingly.

Impact of improvements

Information from the calls placed to the Helpline contributes to identifying areas for safety or patient experience improvement within the Care Organisation.

Since the implementation of the scheme, there have been 49 calls made to the Helplines that have all been successfully managed and resolved. Some calls were escalated for senior management information or input.

The types of calls received included themes such as communication problems, patient/clinical care, prescribing, and admission & delayed discharges.

- **North Manchester Care Organisation:**

  A total of 38 Helpline calls were received. Some calls were made by the same family: Five calls to the Helpline were made by one family over a number of days. Another family rang three times and two other families rang the Helpline twice.

  There were three calls that had an associated incident report generated and subsequent investigation undertaken.

- **Bury & Rochdale Care Organisation:**

  A total of eight Helpline calls were received. One family rang the Helpline on two occasions.

- **Oldham Care Organisation:**

  A total of three Helpline calls were received.

Mortality Review

Ensuring we have a robust process to learn from deaths

HSMR for Pennine has reduced mortality and is now statistically better than expected.

In September 2017 the trust published the Group Mortality Review Policy in line with the 'national guidance on learning from deaths - a framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in care'. The policy confirms the organisations approach to reviewing and reporting deaths and the development of an organisational learning framework to achieve the aim of year on year reduction in the trust's hospital standardised mortality rate (HSMR).

The organisation aims to be completing mortality reviews for every death by March 2020

Achieving 'No Preventable Deaths' is a key component of the Pennine Acute Quality Improvement Strategy. In 2017, national guidance on how trusts should learn from deaths was published. Since then, we have set out to ensure we implement this as effectively as possible, ensuring we adapt it to our local needs and that it works for relatives and carers as well.

By implementing robust learning from deaths processes, we can capture as much learning as possible to enable us to lower our mortality rates and ensure fewer patients experience harm whilst in our care. In doing so, we can also provide more answers for relatives and carers as well as further improving in areas such as the quality of end of life quality carefor those patients expected to die.

Key Achievements

- Submitted first formal Learning from deaths report to the Board summarising mortality review data for the period April-June 2017
- Trained consultants, nurses, allied health professionals and other support staff to undertake mortality reviews using the Structured Judgement Review (SJR) methodology. The SJR mortality review methodology is a national tool that provides a structured way to assess quality of care.
- SJR reviews have now commenced alongside the current independent mortality review process.
- Improvement in accuracy of coding
- Reduction in the HSMR to be statistically below expected as at October 2017 for the North East Sector Care Organisations.

Further Improvements Identified

The mortality review process will continue to evolve over the next few years with the implementation of improved information technology systems to support the process and introducing additional step processes to provide a death summary and coding review and a named consultant care quality review. With a strong emphasis on learning, the new process will support the identification of care quality themes and enable the organisation to focus on addressing key issues.

Current and future mortality review process

Current

Current Practice

- Separate processes to provide
- Dr to coroner referral within 24 hrs
- Clinical coding validation
- Hand over of care for GPs for deceased patients
- Clinical audit select cases for review

Case reviews from safety alerts

Audit/mortality reviews commissioned by mortality surveillance group, speciality following trend alert - clinical coding/ CUSUM or HMSR/SHMI Mortality Indicators

M&M meetings

Selection of cases for M&M review selected by clinician with interest or speciality

Independent mortality review

Independent mortality reviews completed by small cohort of reviewers

Future

Death summary and coding form

Death summary for coroner referral to include; GP death summary; clinical coding; NHS BT tissue donation; early triggers for reporting problems in healthcare; triggers to select for SJR mortality review

Consultant - Care Quality Review

CQR completed by patients named consultant to improve the efficacy of mortality review to promote shared learning

- Care is rated from very poor (1) to excellent (5) and may trigger an independent SJR review
- Concludes with an overall care rating and frontline judgement on whether the death was considered more likely than not to have resulted from problems in care

M&M meetings

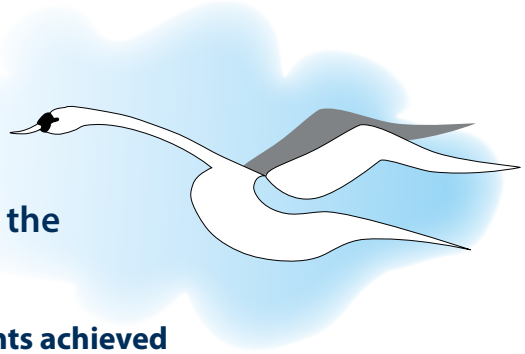
Specialist Mortality and Morbidity meetings are embedded places of learning; creating learning opportunities to capture and monitor patient safety improvements by;

- Creating and monitoring SMART actions from mortality reviews
- Independent sampling of themes within speciality, or alerts
- Providing triggers for Independent Structured Judgement Reviews (SJR)

Independent SJR mortality review

- Explicit qualitative judgements to promote organisational and shared learning through thematic analysis
- Improved patient safety, improved liaison with bereaved families and Bereavement & EOL Teams
- Preventability scores allocated during review

End of life and bereavement care



Every ward and department trust-wide is involved in the 'Swan' model of end of life care and bereavement

Pennine Acute Hospitals NHS Trust is committed to providing equitable care, for every patient, every family, and every time. We are privileged to deliver this care with dignity, honesty and compassion; we only have one chance to get it right, and to fail is unacceptable. We must create treasured memories of dying and death, to become that memory living on for each and every family.

There is no 'end' date for this fundamental part of care, that is the responsibility of everyone. End of life and bereavement care are ongoing and constant, at any time, in any setting, if we are to achieve an improved grief journey for the bereaved.

At end of life, at death and after death, we aim to ensure that families feel at that moment they are the only people who matter. Their experience is unique and they are cared for with compassion and sensitivity, and given the time they need.

The dedicated Swan Bereavement Nurses support families at the time of death in any place by being there; listening, diffusing, calming, offering mementos, providing care, compassion and helping to turn situations support into a moment that becomes a memory. They also provide education, training and real time coaching to enable all staff to provide this care, wherever they are, whatever their role. They collect data, complete audits and are involved in supporting families before, during and after Inquest and Complaints. Support extends to the dying and bereaved families of all ages and includes people from all communities and belief systems found in the trust's localities.

Improvements achieved

The Swan model is now fully implemented across the Trust. All departments have their own end of life file and resource box and every site has an accessible fully stocked end of life resource room. This ensures that quick reference guides and resources are always close at hand.

The End of life and bereavement care team (Swan bereavement nurses, Swan educators) undertake ward/department walks regularly on each site delivering informal training and updates to raise awareness of end of life care initiatives and increase knowledge. The End of life and bereavement care team also provides real-time coaching to staff to enable and empower them to give high standards of end of life care, care at death and to the bereaved.

Education, knowledge, confidence and competence of all staff groups within the organisation are paramount to provide them with true ownership and engagement in relation to end of life care and bereavement.

In 2017/18 the Trust has introduced the following:

- End of Life Care 6 Modules of Education
- Monthly Swan Bereavement Study Days including Tissue Donation
- Link Professionals
- Audit
- Patient stories are used to open meetings at all organisational levels
- Attendance by a bereavement nurse at every Mortality Group across the organisation
- Upward reporting / feeding back to and from the End of Life Care Committee
- Regular clinical supervision sessions

Each hospital site has a comfortable and calm environment called 'The Swan Suite' in the Bereavement Offices, where families are offered refreshments, time and the chance to talk about their loved one, their experiences and sign the condolence book. This important time can also highlight care and compassion for the excellence reporting system, and sometimes poor care that needs to be investigated thoroughly. In some cases this can prevent a Complaint and resolve family's concerns in a timelier manner, enabling them to grieve.

Further improvements achieved

- The Trust has established a Multi Faith Group which supports improving care after death for our Faith communities
- We work closely with the HM Coroner and police
- We have undertaken a full service review of Specialist Palliative Care and End of Life Care Teams
- Mortuary facilities have been improved including the environment for families
- Close working and engagement with portering staff including joint education and training regarding the safe transport of deceased patients
- Dashboard of data collection for every death of every patient – adults and children
- Bespoke training with police, Family Liaison Officers, HM Coroner's staff, bereavement office staff
- Notification of Death Form fully implemented across all sites following joint initiative with police and HM Coroner to include the 'Statement of Truth' for formal identification by relatives of their loved one. This is very valuable as it hugely reduces the number of families who have to endure the added distress of attending a mortuary sometimes weeks after death, with a coroner's or police officer, to identify their loved one. Time and Costs are also saved for the police and coroner's office.

Further improvements identified

Pennine Acute remains committed to providing the highest standard of end of life and bereavement care. Therefore, moving into 2018/19 we aim to prioritise the following improvements:

- Scoping taking place across organisations to plan and commence bereavement support groups
- Development of more bespoke education, training and real time coaching
- Quarterly service reports for end of life care, bereavement and specialist palliative care including patient stories, data, complaints, good news
- Development and implementation of revised Coroner's Reporting Form
- Continued improvement of Trust Mortuary environment and facilities
- Relaunching the End of Life Support Volunteer service
- Staff trained and empowered to offer mementos every time to every family – already offering locks of hair and personal message cards, now training to take handprints, footprints, lip 'kisses'.
- Engagement with Medical Illustration service for producing personal and sensitive photographs of deceased – holding hands, a kiss…
- Further work with HM Coroner and the police as the bereavement service reaches every area, every family, to offer support in even the most traumatic circumstances.

#End PJ Paralysis / Last 1000 Days

Just ten days of bed rest can result in 10 years of muscle ageing.

100% of Pennine Acute inpatient wards/departments engaged in the #EndPJParalysis/Last 1000 Days campaign!

What:	Engage wards in the End PJ Paralysis/Last 1000 Days campaign
Target:	95% of wards engaged
By when:	December 2017
Outcome:	100% of wards engaged as of February 2018
Progress:	=

The End PJ Paralysis / Last 1000 Days campaign is designed to highlight the importance of the most valuable currency in healthcare – patients' time. Whilst we can always replenish stocks and review budgets, we cannot replace time lost.

The campaign was launched by Professor Brian Dolan and colleagues who highlighted the impact on patients' well-being whilst time is wasted in hospital.

In many hospitals, pyjamas can appear as a patient 'uniform'. As such, an 'action' element of the campaign was the introduction of the End PJ Paralysis initiative, with the goal of getting patients up, dressed and moving.

Not being active whilst in hospital can increase the risk of falls, harms (such as pressure ulcers, infections and VTE), restrictions to everyday life and mobility. There is a risk of incontinence with over-reliance on catheters or bedpans, instead of assisting or encouraging patients to toilet as normal.

Improvements achieved

The Last 1000 Days / End PJ Paralysis project was launched in early 2017 across the Northern Care Alliance, following awareness events held at all sites. The events were attended by colleagues from different grades and roles.

A change package has been developed to summarise all of the successful testing which has taken place. The changes are:

Change 1: Social Mealtimes

Change 2: Engaging Activities

Change 3: What Matters Most To Me Today?

Change 4: Team Awareness

Change 5: Public Awareness

Change 6: Introducing the principles into everyday practice (including the Fit2Sit Campaign)

The above changes have been tested by staff and shared for feedback with patient focus group representatives and the wider public at the 'Medicine for Members' event in February 2018.

Further improvements identified

- The team are currently discussing how to spread the initiative further into other areas of the hospital, and embedding the Fit2Sit campaign within the emergency departments.
- Additionally, the Alliance has been asked to host the first national End PJ Paralysis / Last 1000 Days conference in June 2018, which will take place at Salford Royal, welcoming professionals from other hospitals' and Care Organisations to discuss best practice and share new approaches to delivering patient-centred care.

Case Study

Healthy older people spend around 6 hours on their feet per day. When in a healthcare setting, this can be reduced to just 43 minutes, and in some cases, this can be even less.

Activities within the hospital provide an opportunity for patients to engage with other patients, staff and volunteers away from traditional mealtimes, and can help to keep patients mentally and physically active while they are in hospital.

Providing activities throughout the day also breaks up periods of time which can reduce the likelihood of loneliness for patients.

Activities can be either at the patient's bedside, or in other locations, such as in a day room. Some wards have tested having a simple box of activities which can be used by patients, carers, families and volunteers.

Ward 21 opened in 2014 as a dementia-friendly facility for patients at Fairfield General Hospital. The ward was designed with a specific room for relaxation, away from the main ward beds, with soft furnishings and a music system to help patients recover in a more 'homely' environment.

At the launch of the #EndPJParalysis project, the ward began to create an 'activity programme' to include events such as afternoon teas and craft events. They have hosted different themed parties; open to both patients and their relatives on the ward.

"My dad was very happy and not 'bored' when in the activity room!"

Relative of patient
Ward 21, Fairfield General Hospital

Maternal and Neonatal Health Safety Collaborative

Pennine Acute was successful in its application to join the first phase of NHS Improvement's national Maternal and Neonatal Health Safety Collaborative

What:	Reduce rates of maternal and neonatal deaths
Target:	20%
By when:	2020
Outcome:	Benchmarking and foundation work undertaken. Visible reduction anticipated in 2018/19
Progress:	⛔

The Maternal and Neonatal Health Safety Collaborative is a three-year programme which launched in February 2017. The collaborative is led by the Patient Safety team at NHS Improvement and covers all maternity and neonatal services across England.

The aim is to:

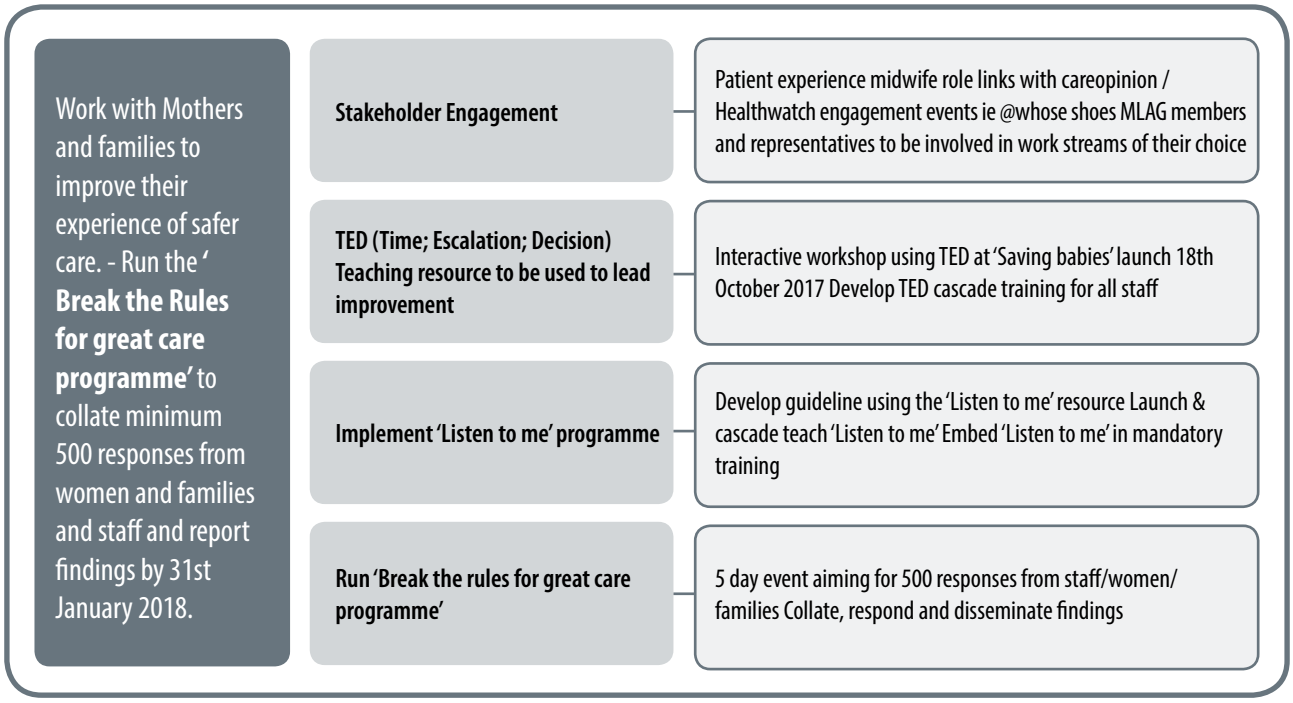
- Support maternal and neonatal care services to provide a safe, reliable and quality healthcare experience to all women, babies and families across maternity care settings in England
- Create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system
- Contribute to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020

Improvements achieved

- Nominated 'Improvement Leads' representing maternal and neonatal services across the North East Sector Care Organisations are supported by NHS Improvement to develop new ideas and approaches to improve clinical practices, ensure a reliable quality of care and to measure improvement and impact
- The 'Improvement Leads' have created a local improvement plan which outlines a series of workstreams which will contribute to reducing rates of maternal and neonatal deaths
- An example of the system-level improvements within these workstreams include:
  - Implementing the "Saving babies lives" care bundle
  - Improving the identification and management of sepsis in babies
  - Improving the use and interpretation of foetal monitoring
  - Human factors – using "Breaking rules for better care" philosophy
- A detailed review of resources and available funding has taken place as part of the 'pre-work' for this collaborative
- Smoking during pregnancy is directly related to an increased rate of still births and neonatal complications. Therefore, funding has been secured to provide CO2 monitors for staff providing antenatal care, along with training in the use and interpretation of this equipment to identify risks during pregnancy and refer expectant mothers who smoke to additional support services which will encourage them to quit

- The rollout of the 'K2' monitoring system has commenced which supports staff to monitor and interpret babies' heartrates during the antenatal period and labour

- The Pennine antenatal and maternity services also ran a successful staff engagement programme called: "Break the rules for better care' - the below driver diagram outlines the associated aims and deliverables:

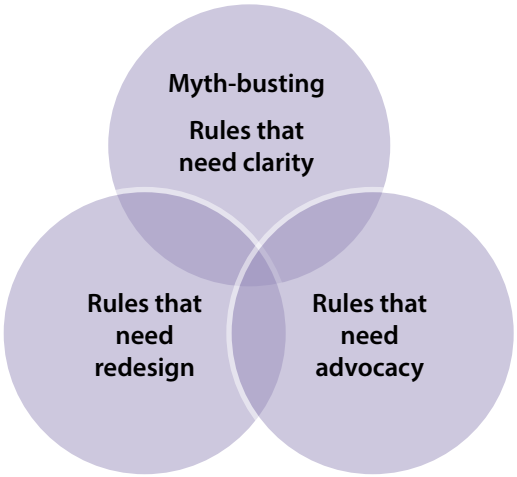


- This initiative involved asking staff the following two questions which they could answer anonymously:

"If you could break one rule for better care what would it be and why?"

"If you could change one aspect of your care what would it be and why?"

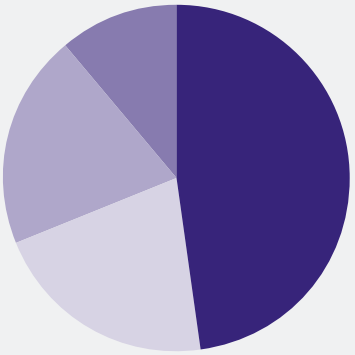
495 responses were received and staff feedback was grouped into the following categories:



The results, themes and initial actions were shared with staff and are summarised in the image below:

Analysis and themes

Results



Themes

- Medication processes
- Agency staff capability
- IT systems
- Lumber puncture process
- Birth companions
- Paperwork
- Pain relief

Myth / clarity fact sheet to go out to all staff → Break the rules compliment board to display all the positive comments for our service → Rules that need redesign / clarity will be themed and established as workstreams

Further improvements identified

- The North East Sector Care Organisations will be introducing the use of "traffic light" hats for the babies on the postnatal ward - this simple red / amber / green visual aid will help staff identify at a glance those babies that have been highlighted as needing additional observations and support
- Implementation of a revised Maternal Early Warning Score (MEWS) chart to support earlier identification and management of deterioration
- Full content review of the current foetal monitoring training and the introduction of competency assessments for staff

Case Study: Is it tops or pants?

In May 2017, the paediatric services across Pennine Acute devised an innovative and fun initiative to listen and hear the views from children and young people about their services.

In May 2017, the paediatric services across Pennine Acute devised an innovative and fun initiative to listen and hear the views from children and young people about their services.

The initiative is called 'Tops and Pants' and gives children and their families across Paediatric services, the opportunity to feed back by writing comments and hanging them on a washing line.

Children and their families tell staff in their own words, pictures and colours, what is great about the hospitals service in 'tops' and any areas which the service could do better in 'pants'.

The tops and pants are displayed on a washing line for all to see, read and review.

Each month the washing is gathered up and the feedback received is shared with staff at ward meetings to enable the whole team to be involved in celebrating what is done well and also talk about how they can improve.

Sally Dever, paediatric matron at North Manchester General Hospital who has helped to lead and implement the initiative, said: "The paediatric wards at Pennine Acute Hospitals NHS Trust are keen to develop a culture that encourages children and their families to feedback in real time on our services as this enables real improvements to be made which will ensure that every child and family has a positive experience that is personal to them."

Some of the feedback received has included: "There are lots of toys and the staff are friendly" and "the nurses are very good and communicated well with us as a family." Feedback is included on a 'You Said …We Did' board on the wards which shows how comments have been acted upon and addressed.

Sally added: "Tops and Pants is an effective but simple method of real time feedback that can influence change. It is fun and interactive and truly captures the imagination of children, family and staff."

Since May 2017, Tops and Pants' has expanded to our neonatal services and a number of our maternity wards across Pennine Acute.

Our Plans for the future

Priorities for improvement

Progress made since 2016/17 Quality Accounts

In the 2016/17 Quality Accounts, Pennine Acute Hospitals NHS Trust outlined three overarching priorities for improvement for the 2017/18 reporting period. Overarching progress made towards delivering these priorities over 2017/18 is outlined through a selection of metrics in the table below:

2017/18 Priority	Measured by	2017/18	2016/17
No avoidable deaths	HSMR	98.3 ↓	101.1
	SHMI	1.01 ↓	1.07
	Cardiac arrest rate (per 1000 admissions)	Data for collaborative wards provided on Pg. 13	
	% of patients waiting a maximum of 4 hours in A&E	83.59% →	82.15%
Reduce harm to patients	Patient safety thermometer	98.60% ↑	98.44%
	Number of C Diff cases	43 ↓	58
Improve reliability to key patient pathways	Measures of improvement dependent on specific areas of improvement chosen- please see project pages for more detail		

The project pages found in Part 1 (pages 8-35) provide more detail regarding the improvement programmes undertaken over 2017/18 to achieve the above priorities and the appropriate measure of progress.

Further information regarding PAHT's progress against locally-selected and national metrics can be found in Part 3 (page 88).

Priorities for 2018/19

In 2017, The North East Sector Care Organisations that make up Pennine Acute launched a new Quality Improvement Strategy. This strategy outlines a number of projects which we committed to work on. The following pieces of work as key priorities going forwards into 2018/19 from that strategy:

Pursue quality improvement to assure safe, reliable and compassionate care

OBJECTIVE:

We will demonstrate continuous improvement towards our goal of being the safest health and social care organizations in England.

One of the ways to reduce harm and lower mortality rates is to study the care pathways of those patients who have died so that lessons can be learned to improve care. Whilst it is rare that we encounter a case where death could have been prevented, the review of most patient pathways can teach us valuable lessons about improving care. In 2018/19, the North East Sector (NES) Care Organisation's Mortality Surveillance Committees will continue to increase the number of deaths that receive a case review to spread the learning from these cases across the Northern Care Alliance.

In addition, NES will have a particular focus on care for the deteriorating patient and update to our Early Warning Scoring system.

As measured by:

- HSMR, SHMI (these are standardised measures of mortality that show the number of actual deaths against the number of 'expected' deaths- based on certain criteria. For more information please see section 2.2 for assurance against 'learning from deaths')

- Cardiac arrest rate (per 1000 admissions) - (please see 'Deteriorating Patient Collaborative' project page)
- Achievement of Sepsis CQUIN targets (please see 'Sepsis' project page)
- Patient safety thermometer and locally selected measures for: pressure ulcers, venous thromboembolism, catheter associated urinary tract infections, falls, infection control etc. (please see section 3 for performance against locally selected indicators)

Improve care and services through integration, collaboration and growth

OBJECTIVE:

We will improve patient and care pathways to deliver improved prevention, earlier diagnoses, earlier treatment and earlier discharge across the system (including care at home or in a supportive environment)

Each of the NES Care Organisations will work collaboratively with Commissioners and other local delivery organisations to deliver new models of care to reduce hospitalisation and reduce the number of 'stranded' patients (those who are medically ready to go home but are waiting for community resources to be put in place to enable this).

As measured by:

- 'Stranded' patient metrics (defined as a patient who has had a length of stay of 7 days or more)
- Inpatient flow and stranded patients workstream metrics i.e. number of discharges before 12pm, #10by10 etc. (see improving urgent care & patient flow project page)

Deliver Operational Excellence

OBJECTIVE:

We will ensure good operational planning and execution to:

- **Deliver on our urgent care, cancer and elective plans and trajectories**
- **Deploy relevant standard operating models**

We know that poor experiences of care and patient harm can occur wherever there are blockages in the smooth flow of treatments and service to our patients. Taking a critical look at the interlinked operational systems and pathways that are common across our Care Organisations, and redesigning them where necessary, is fundamental to ensuring we deliver safe and effective care.

In order to best manage our daily operations, and support our flow and productivity improvement work, we aim to deliver several flow improvement work-streams to address such issues as delayed transfers of care and urgent care improvement. The NES will also work to deliver a standard operating model in elective access, and booking and choice at scale.

As measured by:

- Performance against national targets and locally selected indictors such as: A&E 4 hour targets, access to cancer services, % cancelled operations etc. (please see section 3 for performance against locally selected indicators)

Support our staff to deliver high performance and continuous improvement

OBJECTIVE:

We will support staff to have rewarding, productive and fulfilling careers, enabling us to recruit and retain talented people.

Over the last 18 months, the NES Care Organisations have had great success in using Quality Improvement principles and tools and we will continue to embed these principles in the daily work of all our staff. In 2018/19, we will be further developing our methods of change management and working on a 'method' to ensure this is embedded with all staff at all levels of the organisation and indeed across the Northern Care Alliance.As measured by:

- Staff survey scores (please see section 2 for performance against core indicators)
- Associated improvements outlined in previous project pages as an indication of staff engagement in Quality Improvement principles and projects

The above priorities for 2018/19 were selected to address key areas for improvement as identified through internal diagnostics and audits as well as external recommendations provided by the Care Quality Commission and other stakeholder colleagues. Ideas for improvement are also generated by staff across the NES Care Organisations through their participation in Quality Improvement initiatives with these ideas being translated into tests of change which will support the delivery of our improvement priorities in 2018/19.

The NES Care Organisations are also committed to engaging with patients and the wider public and specific examples of patient participation in relation to the above improvement priorities are outlined within the previous project pages (for example, please see '#End PJ Paralysis/ Last 1000 Days project page).

The progress of these priorities and the associated improvement initiatives will be monitored and reported on through the NES Care Organisation's assurance committees over the 2018/19 reporting period.

Statement of assurance from the Board

Review of services

During 2017/18 the Pennine Acute Hospitals NHS Trust provided and or sub-contracted 58 relevant health services

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

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by The Pennine Acute Hospitals NHS Trust.

Participation in clinical audit

National clinical audit

During 2017-18, 41 national clinical audits and five national confidential enquiries covered NHS services that the Pennine Acute Hospitals NHS Trust provides.

During that period, the Trust participated in 38 (93%) of the national clinical audits, and 100% of the 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 the PAHT was eligible to and did participate in, and for which data collection was completed during 2017-18, 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.

The table below shows:

- The national clinical audits and national confidential enquiries that Pennine Acute Hospitals NHS Trust was eligible to participate in during 2017/18.
- The national clinical audits and the national confidential enquiries that Pennine Acute Hospitals NHS Trust participated in during 2017/18.
- The national clinical audits and the national confidential enquiries that Pennine Acute Hospitals NHS Trust participated in and for which data collection was completed during 2017/18, are listed below alongside the number of cases to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Eligible	Participated	% submitted
Neonatal intensive and special care (NNAP)	Yes	Yes	100
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes	100
National Maternity and Perinatal Audit	Yes	Yes	100
Child health clinical outcome review programme (NCEPOD)	Yes	Yes	100
ICNARC (Case Mix Programme)	Yes	Yes	100
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100
National Joint Registry (NJR)	Yes	Yes	100
Female Urinary Stress Incontinence	Yes	Yes	100
Diabetes (National Adult Diabetes Audit)	Yes	Yes	100
Diabetes (National Paediatric Diabetes Audit)	Yes	Yes	100
UK IBD Registry (IBD) - Biologistics	Yes	No	N/A
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Yes	Yes	100
UK Parkinson's Audit	Yes	Yes	100

Title	Eligible	Participated	% submitted
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	100
Adult Bronchoscopy Audit (BTS)	Yes	Yes	98
Adult Bronchiectasis Audit (BTS)	Yes	Yes	100
Elective Surgery (National PROMs Programme)	Yes	Yes	71
National Ophthalmology Audit	Yes	No	N/A
Nephrectomy Audit	Yes	Yes	100
Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	100
Endocrine & Thyroid National Audit	Yes	No	N/A
Bowel cancer (NBOCAP)	Yes	Yes	>100
Head & Neck Cancer Audit	Yes	Yes	100
Lung cancer (NLCA)	Yes	Yes	100
Oesophago-gastric cancer (National Audit O-G Cancer)	Yes	Yes	100
National Prostate Cancer Audit (CEU-RCSE)	Yes	Yes	100
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	100
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	100
Cardiac Rhythm Management (CRM)	Yes	Yes	100
Coronary angioplasty / National Audit of PCI (NICOR)	Yes	Yes	100
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100
National Heart Failure Audit (NICOR)	Yes	Yes	100
National Vascular Registry	Yes	Yes	100
National Comparative Audit of Blood Transfusion programme	Yes	Yes	100
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Yes	100
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100
National Audit of Intermediate Care(NAIC)	Yes	Yes	100
Major Trauma (Major Trauma and Research Network)	Yes	Yes	100
Fracture Neck of Femur - Emergency Department (RCEM)	Yes	Yes	100
Procedural Sedation in Adults – Emergency Department (RCEM)	Yes	Yes	84
Pain in Children – Emergency Department (RCEM)	Yes	Yes	100

Note: For information on non-participation please see the Trust's Clinical Audit 2017/18 Annual Report

National clinical audit: actions to improve quality

Title	Outcome
National Dementia Audit	The report has been reviewed by the Trust Lead for Dementia who has worked with the Care Organisations to develop action plans linked to their services, identifying areas for improvement. The Care Organisations have identified dementia leads that will be responsible for supporting the implementation of bespoke patient pathways for this cohort of patients, their families and or their carer. At the present time the Care Organisations are awaiting guidance as to the structure within the Group which is planned to be completed by 31st March 2018. The availability of the 'This is Me' documentation is available to all wards and departments and its use is audited via the monthly ward dementia audit, which has shown an improvement in the use of this tool. Provision of the document is identified within a pathway provided to ward staff. Wards are aware of the process for ordering finger foods as required. Training sessions have been provided for Mental Capacity Act, including consent, appropriate use of best interest's decision making, the use of Lasting Power of Attorney and Advance Decision Making on all sites across the Trust. Bespoke training sessions have been provided at ward and department level and staff have been provided with aide memoir pocket cards to guide them through the processes. The John's Campaign information leaflet is available on the Trust intranet for staff to give to carers of people living with dementia. In addition, many wards have developed a John's Campaign information board and information banners have been designed and are displayed on each hospital site. The Trust has developed a dementia care pathway and is awaiting the guidance as to the structure within the Group which is planned to be completed by 31st March 2018.
National Audit of Inpatient Falls	The national report along with the key findings has been sent to the Trust's falls leads requesting a review of the data and to provide action plans on the areas identified for improvement. The action plan has been developed and includes process mapping against the patient pathway with a series of audit platforms to monitor test of change. Actions to be implemented by 31st October 2018. Monitoring of the plan will be undertaken by the Trust falls leads.
National Heart Failure Audit	The report has been sent to the heart failure teams and they are in the process of developing an action plan linked to the audit recommendations. The results have supported the need to recruit additional staff and the case for recruitment has been completed and authorised. The directorate is aware of the issues surrounding the lack of capacity to perform echocardiogram within 48 hours with this issue being included in the cardiac strategy. Ambulatory pathway developed and has been signed off at the Drugs & Therapeutic committee in November 2017. This is presently awaiting DQUARK to sign off – This was an agenda item for 6th March 2018 but has been deferred until 10th April 2018.

Title	Outcome
National Acute Myocardial Infarction Audit (MINAP)	Since the publication of this report the cardiology directorate have implemented the following: ● Consultant Hot weeks at Oldham and Fairfield General Hospital and are in discussion with the North Manchester teams. ● The cardiac rehab teams are reviewing all ACS referrals and referring patients on outlying wards to the cardiologist and consultant to consultant referral for inpatients. ● Education and training delivered to medical and nursing staff on prescribing secondary prevention medication to eligible patients. ● The team have been advised and informed that they need to document contra-indications clearly in the notes. ● The cardiac rehab teams query medications not prescribed where there is no clear contra-indication.
National Percutaneous Coronary Intervention (PCI) Audit	The results of the audit link to patients submitted from 22nd January 2017 to 22nd January 2018 and during this time period the Trust achieved ≥ 98% data completeness in all but the following areas: ● Creatinine levels not recorded in 4% ↑ compared to 77% of cases previously reported. ● Overall success rate of PCVU procedures is 93.2%. The team is constantly reviewing the results and continues to use the audit sheet (developed in January 2017) which has demonstrated improved data completeness and outcome measures.
Sentinel Stroke National Audit programme (SSNAP) and Acute Organisational Report	The data submitted for stroke patients demonstrates that the Trust has provided good quality care, with all indicators being above the national average. The data is published on a quarterly basis and the overall level of compliance with the quality of care measures provides assurance that the Stroke Unit is providing care consistent with good practice. The team reviews the data at the Stroke directorate meetings for each quarter and continue to act on the findings as appropriate.
National Joint Registry	The directorate has been asked to review the national findings and if required develop an action plan in the areas that require improvement. Work continues supporting the clinical teams to improve the data submission in a timely manner across the Trust. The clinical audit department is working with the directorate on the completion of the validation audit. The deadline for completion is 31st March 2018.

Title	Outcome
National Hip Fracture Database	The results have been presented at the Trust-wide Trauma & Orthopaedic meeting and each hospital has developed action plans. • A capacity review has been completed identifying the need for an increase in beds to increase the number of patients admitted to the trauma ward. • Appointment of an operational & improvement lead for six months to support the number of patients admitted to theatre. • A capacity review of theatre utilisation has been completed identifying that NMGH requires additional theatre time/lists to meet the demands of the service. TROH has implemented two all day trauma lists and is working with the senior anaesthetic trauma lead to ensure that they have appropriate anaesthetic cover. • Multi-disciplinary meetings have been expanded and include the clinical director and the directorate management team. • Physiotherapy assessment to continue and improve mobilisation.
National Intermediate Care Audit (NAIC)	The published report has been sent to the Trust's intermediate care lead for monitoring. The team has developed a comprehensive action plan and are in the process of compiling a series of audits linked to the areas requiring improvement. The action plan is on track to be completed by 30th April 2018.
National Bowel Cancer Audit	The national report, executive summary and key findings have been sent to the directorate highlighting that the Trust has achieved a higher compliance against the national average in eight key areas. The findings are due to be presented at the Upper & Lower GI Audit and Governance meeting in March 2018 at which time the action plan will be agreed. Since May 2017 the directorate has also ensured that all deaths are discussed as part of the national learning from deaths programme supporting lessons learnt initiatives within the directorate.
National Oesophago-Gastric Cancer Audit	The national report, executive summary and key findings report have been sent to the directorate for discussion and the report will be presented at the May 2018 Audit & Governance meeting. The team have been asked to review the findings and for those areas requiring improvement to compile an action plan and provide regular updates on the progress of its implementation.
National Prostate Cancer Audit	The national report, executive summary and key findings reports have been sent to the directorate and the results are due to be discussed at the next Audit and Governance meeting. The directorate has been asked to review the findings and for those areas requiring improvement to compile an action plan and they provide regular updates on the progress of its implementation. Correspondence has been sent to the directorate for progress updates.
National Lung Cancer Audit	The national report, executive summary and key findings report will be sent to the directorate with a recommendation that the report findings are discussed at the next Business/Governance meeting. They have been asked to review the findings and for those areas requiring improvement to compile an action plan and provide regular updates on the progress of its implementation.

Title	Outcome
National Breast Cancer in Older Patients	The report has been sent to the Chief Executive and the Executive team, and it has been presented within the Breast Clinical Audit and Governance meeting in November 2017. Networking with the breast team and the cancer lead for this audit has occurred with the aim of reporting on progress and the development and implementation of an action plan.
National 3rd Emergency Laparotomy Audit	The national report along with the key findings has been sent to the respective Care Organisations requesting a review and provision of action plans on the areas identified for improvement. ● The results of the audit were presented at the Upper & Lower Gi audit meeting in Novebmer 2017 and it was agreed that the directorate management team would review how to involve the physicans in assessing patients aged 70 years and above. ● The directorate is reviewing the criteria for the recruitment of a physician specialising in geriatric medicine to support assessment of its elderly patients. ● The clinical audit department has compiled a comparison report up to the end of August 2017 which highlights that the teams are meeting the expected standards with the exception of elderly medical review.
Carotid Endarterectomy (CEA)	National Clinical Guidelines for Stroke recommends that a CEA is performed as soon as the patient is fit for surgery. Preferably within two weeks of the index event, if maximum stroke prevention benefit is to be achieved. However the 'Getting It Right First Time' (GIRFT) report January 2018 recommends reducing the time from symptom to surgery for all patients to 7 days. The vascular team are to liaise with the stroke team to further streamline services. A multidisciplinary approach is required from both primary and secondary care providers to meet the 7 day target for all patients.
Abdominal Aortic Aneurysm Repairs	The vascular team reviewed waiting times for elective AAA repairs and concluded that delays in treatment of AAA are multifactorial. Delays include: Cardiopulmonary exercise testing (CPET), device approval, lack of intensive care facilities, investigation and optimisation of associated medical conditions which required further assessment and treatment. The vascular team recognises the immense bed pressures the NHS faces on a daily bases and how supportive the bed management and directorate teams are at prioritising beds for elective major vascular cases. However it is important to timely schedule elective repairs to mitigate the risk of a patient's AAA rupturing whilst waiting for treatment. The GIRFT report recommends; accelerate the referral to treatment time for all patients identified as in the need of AAA surgery, whether identified via a screening programme or any other route. PAHT is looking to improve delays in CPET investigations to improve the patient's journey.
Lower Limb Bypass	The Trust is achieving good clinical outcomes and performing within our expected range for major surgical procedures. The vascular team will continue to monitor the clinical outcomes to ensure continued sustainability in performance.
Lower Limb Angioplasty	Our in-hospital survival rate for major lower limb angioplasty, over a three-year time period 2014 – 2016, is 99.1% compared to national in-hospital survival rate of 98.4% over the same time period. Despite efforts case-ascertainment within PAHT and across the UK lags behind other procedures. Intervention radiology at Oldham Care Organisation opened a day unit in November 2017. The unit can treat up to five patients at a time, which means up to an additional 760 patients can be treated each year. A radiology admin support officer is now supporting the data entry of lower limb angioplasty onto the NVR.

Title	Outcome
National Pregnancy in Diabetes Audit	The results of the audit have been sent to the consultant lead for diabetes requesting that the results of the audit be reviewed and action plans be developed linked to the areas requiring improvement.
National Paediatric Diabetes Audit	The results have been discussed at the Neonatal & Paediatric Audit & Governance meeting held in May 2017 ● The results to continue to be benchmarked against practices of care where high levels of performance have been found. ● The directorate continue to work with the network and quality assurance (peer review) to support achieving quality improvements across the service.
Neonatal Intensive and Special Care	The report has been sent to the neonatal directorate leads and all the neonatologist consultants. ● A poster has been developed and displayed highlighting the key findings. ● The results of the audit were presented at the Women & Children's Quality and Performance Committee in September 2017. ● An action plan has been received from the Oldham Care Organisation neonatal lead. ● Presently awaiting update from the North Manchester neonatal lead.
National College of Emergency Medicine Audit of Consultant Sign Off in Emergency Departments	The results of the audit were published in May 2017 and have been presented at the three Emergency Departmental Audit meetings. Localised action plans have been developed to include: ● Introduction of a two hourly consultant-led ward round for all patients in the department at the time of review. ● Criteria of these ward rounds include review of care plans, observations and treatment regimes. ● The reviewer to ensure all care bundles are followed accordingly and treatments given in a timely manner and to highlight areas of the care bundles that are not being followed at the point of delivery. Snapshot reviews to be undertaken during 2018/19 to monitor compliance against the action plan.
National College of Emergency Medicine Audit of Asthma Management in Adults and Children	The results of the audit were published in May 2017 and have been presented at the three Emergency Departmental Audit meetings. Localised action plans have been developed to include: ● Introduction of an Emergency Assessment for Acute Asthma proforma which prompts the clinician to assess, treat and re-assess against key criteria set in each section of the document. ● Introduction of a discharge summary prompting the clinician to: • Review of medication and dose • Review of patient inhaler techniques / educate inhaler techniques • Provide the patient with their asthma action plan • Encourage patients to visit their GP/Practice Nurse within two working days Snapshot reviews to be undertaken during 2018/19 to monitor compliance against the action plan.

Title	Outcome
National College of Emergency Medicine Audit of Sepsis and Severe Sepsis	The results of the audit were published in May 2017 and have been presented at the three Emergency Departmental Audit meetings. • The national standards have been linked to the Sepsis CQUIN requirements and the Advancing Quality Care Bundle. • Real time data collection has been introduced and the data is validated on a monthly basis. • The quality improvement team are working across the emergency departments to support the embedment of standards. • In addition the results of the CQUIN and Advancing Quality are highlighted in the Clinical Audit Activity Reports.
NCEPOD - Chronic Neuro-disability	The national report was received by the Trust on 8th March 2018. The clinical teams across the Trust are in the process of reviewing the study results and will then develop action plans linked to their services to address any areas requiring improvement.

NCEPOD confidential enquiries

Title	Eligible	Participated	% of cases submitted	% questionnaire submitted
Chronic Neuro-disability	Yes	Yes	100%	73%
Young People's Mental Health	Yes	Yes	100%	31%
Cancer in Young Children, Teens & Young Adults	Yes	Yes	100%	100%
Acute Heart Failure	Yes	Yes	100%	72%
Peri-operatives Diabetes Patient	Yes	Yes	100%	On-going

The reports of 29 national clinical audits were reviewed by the provider in 2017/18 and Pennine Acute Hospitals NHS Trust has taken or intends to take the following actions to improve the quality of healthcare provided. (Please see Appendix A).

Local Clinical Audit

The reports of 86 local clinical audits were reviewed by the provider in 2017/18.

The table below includes examples of local audits reported in 2017/18. Further actions planned and undertaken in response to the audit findings will be detailed in the Trust's 2017/18 Clinical Audit Annual Report.

Local clinical audit: actions to improve quality

The reports of 86 local clinical audits were reviewed by the provider in 2016/17. The table below includes examples of local audits reported in 2017/18. Further action, both planned and undertaken, in response to the audit findings will be detailed in Pennine Acute Hospitals NHS Trust's 2017/18 Clinical Audit Annual Report.

Bury & Rochdale Care Organisation	
Title	**Actions planned / undertaken**
72 hour re-attender audit in Accident &Emergency	The findings of the audit have been presented at the emergency department meetings. It was agreed that the emergency department consultants: ● Inform all doctors about the GMC guide in regard to good documentation and highlight the issue during junior doctor induction. ● Ensure patients are provided with proper analgesia and education upon discharge and that medical education is provided to the juniors during board rounds and induction. ● Ensure the COPD pathway and community service is promoted by the senior clinician and nursing staff. The department's lead consultant is leading on discussions with the governance team to develop leaflets for patients being discharged with guidance on when to re-attend.
Accident & Emergency waiting times for patients referred to an offsite speciality	The results of the audit have been presented at a local departmental meeting to improve A&E clinician awareness of the results and implications. ● All junior doctors are advised during induction to discuss with the most senior available clinician for referrals. ● A referral policy has been approved by the clinical director and added to the A&E hot topic publication. ● Posters of the DTA (decision to admit) policy have been placed in the staff room and nursing station. Trackers escalate any delays in decision. ● Meetings have also taken place with the surgical directorate regarding the referral issue and an action plan has been verbally agreed. ● A new pathway is awaiting sign off but has been included in the induction pack.
Audit of Severe Sepsis and Septic Shock in Accident & Emergency	The results of the audit have been shared with the Medical Director for the Bury and Rochdale Care Organisation and senior clinicians at Bury ED. The audit will also be presented and sent to all juniors by Trust email. ● Education to the medical and nursing staff and a sepsis awareness event will be arranged to highlight areas of good practice as well as areas that needs to be improved. ● A sepsis card and sepsis tray has been implemented to identify patients with neutropenic sepsis/severe sepsis, fast track and manage them appropriately. ● The need for managing sepsis is highlighted on the notice board in the clinical area and during daily board rounds. ● It will be made mandatory to discuss and record patients with severe sepsis with a senior member of staff. ● Reasons for the delay in giving antibiotics within the four hours will be identified in order to implement solutions.

Management of Patients with Hypocalcaemia Following Total Thyroidectomy - ENT	Overall the audit has revealed a good compliance with PAHT guidelines; however variations in dosing and frequency were noted. The length of hospital stay was also noted to have varied from patient to patient with no clear guideline regarding when to discharge. The BTA and BAETS guidelines are similar to THE Trust's guidelines, but those guidelines do require amending in order to bring them fully in line with national standards and guidelines. Based on the results of the audit the following recommendations have been devised: ● Updating PAHT guidelines to BTA guidelines ● Discuss audit results with endocrine team ● Discharge patients only when calcium levels are within the normal range (>2.10). ● Complete 2nd audit cycle prospectively in June 2018.
Chest X-ray Discrepancies - Radiology	The results of the audit were presented at the Trust-wide Radiology Audit & Governance meeting in January 2018 and it was agreed that the following actions will be implemented: ● Compare with previous scans after initial scan & correlate with clinical history. ● Secondary scan after review of clinical history and previous scans. ● In accordance with RCR remove forced bias choice by using control film for comparison instead of retrospective scrutiny. A modality specific meeting to be held every 3 months and more attendees of various levels of training are to be invited. Email learning points and overall outcomes from meetings regularly across department while maintaining anonymity and raise awareness amongst department of meetings as learning resource. ● Request second scan if inadequate/suboptimal. Prioritize PA positioning & technicians should ask for assistance in positioning patient in department and on wards. The above actions are planned to be implemented by 1st June 2018.
Re-audit of Adult Patients Presenting at the Urgent Care Centre with Abdominal Pain	The results of the audit are to be presented at the local audit meeting in January 2018. Staffs working on the UCC were reminded of the importance of females of childbearing age having a Beta HCG recorded and all patients presenting with abdominal pain to have a urine analysis recorded. This was actioned via email and at the audit meeting.
Re-audit of Cataract Surgery – Final Review	The findings of the audit have been presented at the local ophthalmology audit meeting which took place on 11th July 2017. ● Continuous effort in highlighting the Royal College of Ophthalmologist guidelines has been undertaken at clinical governance meetings, local teaching sessions and departmental meetings. ● A cataract surgery final review proforma has been introduced into clinical practice. ● It is recommended that effort should also be made in attempting to implement this on an electronic copy level where the majority of the department's documentation will be taking place in the future.

North Manchester Care Organisation	
Title	**Actions planned / undertaken**
Management of Head Injury in Accident & Emergency	The results of the audit were presented at the A&E Audit Presentation Meeting on the 27th September 2017. ● The results of the audit have been circulated to staff highlighting the stricter use of the head injury proforma and clearer documentation of timescale of symptoms, diagnosis, and specifics of safety-netting. ● Leaflets and posters of head injury signs have been made available for patients and staff to support verbal discussion and the management of head injuries.
Audit & Re-audit of Antidote Stock in Accident & Emergency	The results of the audits were discussed at the senior team meeting in November 2017. ● Checks of expiry dates and stock now forms part of the resus check list. ● A copy of the guideline has been made available inside the cupboard. ● Regular reviews are being carried out to ensure changes are upheld and all drugs are stored in the correct areas.
Is urine analysis done in all cases where it is indicated; and are the results documented correctly and easily accessible?	The results of the audit were presented at the Medicine audit meeting on 23rd May 2017. In addition further presentations have been given to Acute Medical Unit staff members and discussed with Accident & Emergency staff. ● It has been highlighted to staff the importance of using the designated sticker which supports the clear documentation of urinalysis. ● The stickers have been distributed across the A&E department and the Acute Medical Unit. ● Awareness of the new documentation and the importance of this in diagnosing and treating UTIs is a continuous processes. ● It has been proposed that the development of posters be designed to explain the indications for sending urine samples to the lab.
Re-audit of Adult Medical Patients VTE Risk Assessment and Prescription – Acute Medicine	The results of the audit were presented at September 2017 NMGH Adult Medicine Clinical Governance/Audit Meeting. ● All new staff will continue to be trained during induction to the Trust. ● Refresher training is being provided to staff during protected teaching times to all grades. ● Each patient's VTE prophylaxis risk assessment (including 24 hour review and weekly review purple form) will be discussed and documented during board/ward rounds by nursing team leads/doctors.
Annual Audit on Compliance against Community Nurse Controlled Drugs Policy	The results of the audit were presented at the North Manchester Community Quality & Performance Meeting. Actions will focus on: ● Targeting documented evidence of Destruction of Old Pharmaceuticals Denaturing Kits to destroy unused controlled drugs. ● Achieving 100% on recording of the drug's batch number, expiry date and route of administration. ● All community staff administrating and/or prescribing controlled drugs demonstrating compliance to controlled drugs policy. ● All new community staff administrating and/or prescribing controlled drugs demonstrating that they have read, signed and understood the policy.

Audit of Physiotherapy-related Standards within the National Hip Fracture Database	The results of the audit have been presented at the NMGH Physiotherapy Audit Group Meeting and NMGH site Orthopaedic Directorate Meeting. ● The acute orthopaedic physio team are to focus on acute therapy provision as a primary team function. Acute patients to be identified and prioritised at daily morning handover sessions. The team also always see any hip fracture patient not achieving the NHFD mobility standard for a second session on their first post-operative day. ● The trauma co-ordinator staff have been provided with confirmation of the official description as listed in the NHFD user guide which states "A patient would be described as 'mobilised' if they are able to sit or stand out of bed on the day of their return from operation, or on the following day." The physiotherapy team now also identifies on initial assessment documentation whether or not the two NHFD standards have been achieved or not. ● Two physio team members have been designated to monitor all hip fracture patients' management in regards to the NHFD standards, with a focus on identifying episodes of patients not meeting the standards. This information will be discussed at all weekly orthopaedic physio team meetings and monthly NMGH site orthopaedic directorate governance meetings.
VTE Prophylaxis on the Post-Natal Ward	The results of the audit were presented at the November 2017 Audi t & Governance meeting. ● The guideline updates have been disseminated via the Labour Ward Forum and Safety Huddle. ● VTE Risk Assessment posters are being developed - plan for completion 30th April 2018. ● The team are currently in the process of updating the post-natal ward package to include VTE risk assessment and booking weight – plan for completion is 31st March 2018.
Re-audit of Paediatric Escalation and Care Quality	The results of the audit were presented at the November 2017 Paediatric & Neonatal Audit & Governance meeting. ● Staff education has been included on daily nursing and doctors' handover meetings to ensure compliance with the Trust policy. ● The medical team has elected a MANCHEWS champion and will continue to recruit more champions ● It has been agreed to undertake an additional audit to monitor improved compliance.
Re-audit to Evaluate Whether Thyroid Nodules are Appropriately Graded and Investigated - Radiology	The results of the audit were presented at the Radiology Audit & Governance meeting in September 2017. The directorate agreed the following actions were to be taken: ● For relevant staff to be educated on ultrasound grading of thyroid nodules. ● To be stricter with choice of nodules for FNA (exclude cystic lesions and those <U3). ● Continue current practice and continue to encourage improvement. ● Obtain a regional consensus on cytology inadequacy rate. A further re-audit will be undertaken in two years.

Anaesthetic Audit on the Management of patients with hypocalcaemia following total thyroidectomy	Overall the audit has revealed a good compliance with PAT guidelines; however variations in dosing and frequency were noted. In addition the length of hospital stay was also noted to have varied from patient to patient with no clear guideline regarding when to discharge. The BTA and BAETS guidelines are similar to what is contained within the Trust; however the Trust guidelines do require amending in order to bring them fully in line with national standards and guidelines. Based on the results of the audit the following recommendations have been devised: ● Updating PAT guidelines to BTA guidelines ● Discuss audit results with endocrine team ● Discharge patients only when calcium levels within the normal range (>2.10) ● Complete 2nd audit loop prospectively once the above has been actioned

Oldham Care Organisation	
Title	**Actions planned / undertaken**
Management of Guillain-Barre Syndrome in a Typical DGH	The results have been presented at The Royal Oldham Hospital, Medicine Audit & Governance meeting in July 2017. ● The audit won a Distinction at Medical School 4th Year MB ChB. ● The medical assessment clinical lead has highlighted the key areas for improvements to the junior medical teams based on the Medical Assessment Unit and will continue to do this at each intake of junior medical staff.
BIG Acute Kidney Injury (AKI) Audit – General Medicine	The audit highlighted persistent challenges in delivering consistent and reliable acute kidney injury care and achieving Advancing Quality standards of care. As a result, the following key recommendations have been highlighted: ● Wider discussion and planning at divisional/directorate audit and clinical effectiveness meetings ● Identification and support of AKI clinical leads for each Care Organisation ● Development and delivery of AKI training and awareness to coincide with implementation of Patient Pass ● Development of AKI pathway as part of GDE Fast Follower program ● Primary-secondary coordination of medicines management and provision of patient information ● Review of induction content for doctors and nurses and/or training program to include Advancing Quality care bundles and provision of renal alert cards ● Linkage to deteriorating patient collaborative and other quality improvement initiatives: getting the basics right including prevention of hospital acquired AKI
Re-audit on the Compliance of Operation Notes - Vascular	In total of the four areas requiring improvement from the first audit cycle, the results of the second cycle identified improvements, however further improvement is still required in these areas: ● Documented time of operation 60% (16% 1st audit) ● Documented blood loss 57% (7% 1st audit) ● Documented DVT prophylaxis 57% (21% 1st audit) ● Documented tissues removed/added/altered In addition the Royal College of Surgeons' Operation poster is displayed in the vascular theatres to prompt clear and concise documentation. ● All hand written operation notes to be scanned onto ALS ● Re-design the operation note to add prompts re DVT prophylaxis, tissues removed/added/altered

Anaesthetic Audit of 'Stop Before You Block'	Looking through the audit results the compliance with documenting 'Stop Before You Block' was as expected and as a result of the audit, the team has undertaken the following actions: ● Education on improving awareness of current sub-optimal practice is on-going and is highlighted at departmental meetings ● Dr Vivek Sinha, anaesthetic consultant will send department 'Stop Before You Block' email reminders periodically 3 -4 times a year ● Stop Before You Block Posters have been displayed in all the appropriate anaesthetic rooms: ● Rochdale Infirmary: Theatre 5 & 6 ● The Royal Oldham Hospital: Theatre 1, 2, 3, 6 & 7 ● Fairfield General Hospital: Theatre 1 and 2 Re-audit planned to be undertaken in September 2018.
Anaesthetic Audit on Post-operative pain relief following total abdominal hysterectomy	The audit results show the compliance with documenting 'Stop Before You Block' was be as expected and as of results of the audit the team has undertaken the following actions: ● The gynaecology directorate has been informed that they need to prescribe and give admission medication. ● Formulate guidelines and ePMA package for analgesia after major surgery has been developed. ● Spot check audits are undertaken by the pain team to ensure: • the maximum analgesia is given for patient's pain • two doses of opioids administered before removal of PCA ● The directorate has highlighted the importance of pain score should be checked before the removal of the PCA with the gynaecology directorate and ward staff. In addition the directorate has raised with the medical records team the lack of availability of notes on Evolve.
Re-audit of Practice of Long term Nephrostomies - Radiology	The results of the re-audit were presented at the local audit meeting on 12th July 2017. Targets from the initial audit included: ● All patients deemed to be on long-term nephrostomy should have complete nephrostograms at six monthly intervals or at least every third exchange, whichever is shorter – **Partly achieved** ● Staggered six monthly clinical review by urology – **Partly achieved** ● Formal anaesthetic review before classifying patients as unfit for general anaesthesia – **Not achieved** (This will begin once we introduce metal stents) ● Interventional radiology and urology to explore feasibility of metallic stenting Business plan – **On-going** Recommendations from the re-audit are: ● Updated nephrostograms for remaining patients to be organised by radiology – further review by urology MDT if appropriate. ● Metallic stent business case (already being worked on by interventional radiology and urology). ● Re-audit at one year to assess impact on long-term nephrostomy numbers.

Re-audit of Omitted Dose 2017	The Pharmacy team across the trust have taken the following actions: ● Nursing staff and ward pharmacists to highlight those patients repeatedly refusing analgesia and/or laxatives and work with doctors and prescribing pharmacists to stop or change medication to "when required". ● Ward pharmacists to work with ward managers to educate staff on wards on missed doses – provide a ward specific breakdown of results to allow a more tailor-made approach to be adopted by each ward. ● Ward pharmacists to routinely review medicines omitted due to the drug being unavailable and adjust the ward stock list accordingly. ● Pharmacists to repeat education sessions to nursing staff. The annual audit will be undertaken in 2018.
IURG Audit - Obstetric	The audit results have been presented at the Audit & Governance meeting on 11th July 2017. The following actions have ensued: ● Umbilical artery Doppler PI SD and charts are now available in the antenatal clinics. ● Discussion is taking place with the radiology department as to the feasibility of reporting growth centiles in addition to estimated foetal weight.
Management of Labour and Birth – Obstetric	The results of the audit have been shared with supervisors of midwives who have disseminated the key findings to all midwives. In addition the key findings of the audit are to be included in the August 2017 lessons learnt bulletin.
Re-audit of the use of fluconazole prophylaxis in extremely low birth weight infants - Neonates	● Overall we have become more compliant with guidelines, showing that all babies appropriately received fluconazole. ● When babies were started on fluconazole, they were all correctly commenced on the correct dose. ● All doses were appropriately increased on day 14. ● There was 100% compliance with monitoring whilst the line was in place and discontinuation of fluconazole at line removal. ● In addition new guidelines were circulated to all members of staff.

Participation in clinical research

The Trust is committed to research and transformation as a driver for improving the quality of care we provide to our patients.

Our engagement with clinical research demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques. During 2017-18, we recruited patients to 118 National Institute for Health Research Clinical Research Network (NIHR CRN) clinical research studies.

The number of patients receiving NHS services provided or sub-contracted by The Pennine Acute Hospitals NHS Trust in 17/18 that were recruited during that period to participate in research approved by a Research Ethics Committee was 5,500.

Goals agreed with commissioners: use of the CQUIN payment framework

A proportion of Pennine Acute NHS Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Pennine Acute NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2017/18 the baseline value of the CQUIN for Acute clinical contracts was 2.5% of the contract value, this has been split 1% and 1.5% between specific CQUIN schemes and Sustainability and Transformation Funding performance respectively; for NHS England

specialised services the CQUIN value equates to 2.8% of the contract value – this is because NHS England are using the CQUIN framework to incentivise those Trusts that lead one or more operational delivery networks. Pass through costs such as high cost drugs and devices do not attract CQUIN payments. The value of the schemes for the acute clinical contracts is £6m with a further £4m associated with STF. The value of NHS England CQUIN schemes is £1.1m. There is a further £0.2m related to community service contracts.

For year to date performance 2017/18 (Q1 to Q3 inclusive) Commissioners for the NHS England contract have indicated that all milestones have been met satisfactorily but final performance for Q4 has yet to be appraised. For the community contract CQUIN schemes Q1 – 3 performance has been judged as achieving the required milestones. For the acute activity contracts commissioners have indicated that milestones have either not been satisfactorily met for some discrete areas of specific schemes. It has been agreed that where milestones have not been met but there is an opportunity to address in the final quarter that these milestones will be judged in Q4. Q4 data will be shared with commissioners at the end of April 2018; and a final response is usually to be expected for the end of the following month.

Further details of the CQUIN performance in 2017/18 and the goals for 18/19 are available on request via neil.prudham@pat.nhs.uk

Goals agreed with commissioners: commissioning for Quality and Innovation Payment Framework (CQUIN)

Indicator number	Applicable To	Indicator Name	Indicative Value Year One Community	Indicative Value Year One Acute
	Acute and Community	NHS staff and wellbeing.		
		Part 1	£9,076	£370,548
		Part 2	£9,076	£370,548
		Part 3	£9,076	£370,548
	Acute	Reducing the impact of serious infections		
		Part a		£277,911
		Part b		£277,911
		Part c		£277,911
		Part d		£277,911
	Acute	Improving services for people with mental health needs who present in A&E		£1,111,645
	Acute	Offering advice and guidance		£1,111,645
	Acute	E-referrals (Y1)		£555,822
	Acute	Pro-active and safe discharge		£1,111,645
	Community	Supporting Proactive and Safe Discharge – Community Providers	£27,228	
	Acute - 2018/19 Community - 2017-19	Preventing ill health by risky behaviours		
		Part 1	£1,361	
		Part 2	£5,446	

Indicator number	Applicable To	Indicator Name	Indicative Value Year One Community	Indicative Value Year One Acute
		Part 3	£6,807	
		Part 4	£6,807	
		Part 5	£6,807	
	Community	Wound Care	£27,228	
	Community	Personalised care and support planning	£27,228	
	NHS England	Improving HCV treatment pathways through ODNs (Y2)		£591,029
	NHS England	Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT) (Y2)		£50,000
	NHS England	Activation System for Patients with Long Term Conditions (Y2)		£60,000
	NHS England	Medicines Optimisation (Y1)		£219,523
	NHS England	Neonatal Community Outreach (Y1)		£200,000
	Oldham CCG Community - Diabetes	Practice support clinic.	£6,530	
	Oldham CCG Community - Respiratory	Structured review and Education re: improving asthma care	£9,886	

Applicable To	Name	Indicative Value Year One Community	Indicative Value Year One Acute
Oldham CCG Community - Ophthalmology	Demand management / review of pathways	£24,564	
HMR Community - anticoagulant therapy	Advice & Guidance	£18,533	
		£195,652	£7,234,598

Statements from Care Quality Commission

The Pennine Acute Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and is fully registered for the services it provides. Its current registration status is 'registered without conditions'. The Pennine Acute Hospitals NHS Trust has the following conditions on registration- 'none'.

The CQC has not taken enforcement action against The Pennine Acute Hospitals NHS Trust during 2017/18.

CQC Inspection October/November 2017

Between 17th October and 16th November 2017 the Care Quality Commission inspected services at North Manchester General Hospital, The Royal Oldham Hospital and Fairfield General Hospital. After the previous inspection in August 2016, the Pennine Acute Hospitals NHS Trust was rated overall as 'inadequate'.

At North Manchester General Hospital the CQC inspected urgent and emergency care, medical services, maternity and children and young people because these services were rated as inadequate at the last inspection. The CQC also inspected surgical services which were rated as requires improvement.

At The Royal Oldham Hospital the CQC inspected critical care services, maternity and children and young people which were rated as inadequate at the last inspection. We also inspected urgent and emergency services, medical services and surgery which were rated as requires improvement.

At Fairfield General Hospital the CQC inspected urgent and emergency care, medical services and surgery because these services were rated as requires improvement at the last inspection.

The CQC did not inspect Rochdale Infirmary or Community Services which were rated as good overall at the last inspection.

In March 2018 the CQC published the results of their inspection of Pennine Acute rating the Trust as 'Requires Improvement'

The Pennine Acute Hospitals NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

Bury & Rochdale Care Organisation

Key to tables					
Ratings	Not Rated	Inadequate	Requires Improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

Ratings for Fairfield General Hospital

2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Medical care (including older people's care)	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
Surgery	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
Critical care	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
End of life care	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016

2017-18

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Good ↑ Feb 2018	Good ↑ Feb 2018	Outstanding ↑ Feb 2018	Outstanding ↑↑ Feb 2018	Good →← Feb 2018	Outstanding ↑↑ Feb 2018
Surgery	Good ↑ Feb 2018	Good ↑ Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good ↑ Feb 2018
Critical care	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
End of life care	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires Improvement →← Feb 2018	Good ↑ Feb 2018	Good →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018

Ratings for Rochdale Infirmary

2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
Medical care (including older people's care)	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

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	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
Medical care (including older people's care)	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community health inpatient services	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community end of life care	Good Aug 2016	Good Aug 2016	Outstanding Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community Health Services for Children, Young People and Families	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall*	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

**Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.*

Key Areas for Improvement	Bury and Rochdale Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Bury & Rochdale Care Organisation has made the following progress by 31st March 2018 in taking such action
MCA and DOLS				
The Trust must ensure the principals of the MCA 2005 are followed so that patients' rights are fully maintained and valid consent is consistently obtained.	90% compliance in adult safeguarding training level 2	Safeguarding Team	31st July 2018	Quarterly audits are carried out by Safeguarding team and as part of the NAAS
Documentation of Care				
The Trust must ensure that appropriate records of patients' care and treatment are up to date and accurate to ensure that risks to patients are consistently assessed or action taken to reduce those risks.	To increase reliability of patient documentation via NAAS. Record keeping audits for services not using NAAS	Divisional Directors of Nursing	30th September 2018	An initial baseline audit to be undertaken, with an improvement trajectory to be agreed pertinent to the outcome of this audit
The Trust must ensure that patient records are completed appropriately in order to allow staff to effectively monitor the care of patients.	To increase reliability of patient documentation via NAAS. Record keeping audits for services not using NAAS	Divisional Directors of Nursing	30th September 2018	An initial baseline audit to be undertaken, with an improvement trajectory to be agreed pertinent to the outcome of this audit
The Trust must ensure that management of pain is consistently recorded, monitored and actioned, particularly for patients with a cognitive impairment where the assessment of pain is more complex.	Pain assessment element of part of intentional rounding to assess consistent use of cognitive impairment tool.	Divisional Directors of Nursing	End of July 2018	Monthly intentional rounding audits in place.
The Trust should ensure that administration of intravenous fluids is accurately recorded.	To increase reliability of patient documentation via NAAS.	Divisional Directors of Nursing	30th September 2018	Documentation of Fluid Balance is an element of the NAAS Standard Local monthly audits
The Trust should consider what actions could be taken to improve the use of paediatric pathways and formal guidance within the department	Devise a standard assessment form for all children having short and long term care and management	Safeguarding Team	31st May 2018	Standard assessment form in production. Audit and monitoring programme will be implemented once the form has been introduced
The Trust should consider what actions could be taken to improve and monitor the quality and completion of paediatric assessment forms.	Devise a standard assessment form for all children having short and long term care and management	Safeguarding Team	31st May 2018	Standard assessment form in production. Audit and monitoring programme will be implemented once the form has been introduced
The Trust should ensure it continues to improve its compliance in the use of the Manchester Children's Early Warning scoring system.	Monthly "manchews" audits on 10 random attendees to be carried out by Practice Based educator and reported to the Divisional Management Teams.	Divisional Directors of Nursing	31st May 2018	Audits in place and on schedule to meet the deadline date

Key Areas for Improvement	Bury and Rochdale Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Bury & Rochdale Care Organisation has made the following progress by 31st March 2018 in taking such action
Training				
The Trust must ensure that theatre staff are trained in appropriate levels of resuscitation to provide safe emergency care and treatment to patients.	Undertake an training needs analysis to ensure that theatre staff have appropriate level of training	Associate Director of HR Divisional Directors of Nursing (Fairfield)	31st Dec 2018	ALS training to be given to all appropriate theatre staff
The Trust must ensure that all levels of staff, including medical staff, have completed mandatory training in line with the Trust's targets.	Monitor compliance levels against mandatory training modules and act accordingly	Divisional Medical Director Medical director	90% compliance 30th June 2018	Compliance with training requirements being monitored by the divisional management teams and reported to the organisation's Workforce Committee
Patient Safety				
The Trust should ensure staff compliance with patient related infection prevention and control training.	Monitor compliance levels against mandatory training modules and act accordingly	Divisional Directors of Nursing	90% compliance 30th June 2018	Compliance with training requirements being monitored by the divisional management teams and reported to the organisation's Workforce Committee
The Trust should ensure rates of surgical site infections are monitored.	Monitor instances of surgical site infections	Divisional Medical Director (Fairfield)	Ongoing	Monitored as a kpi on the Quality and People Experience / Clinical Effectiveness Committee CQC dashboard.
The Trust must ensure that staff have the knowledge and training to recognise what patient safety incidents to report.	A briefing for all staff and bespoke training as needed	Associate Director of Governance	30th September 2018	A brief has been written for cascade at safety huddles and via team talks
The Trust must ensure that WHO surgical safety checklist is completed accurately including verbalising counts of instruments (surgery and maternity.	Bury & Rochdale Care Organisation continue to audit and monitor compliance monthly with exception reporting as needed	Medical Director	Ongoing	Bury & Rochdale Care Organisation continue to audit and monitor compliance monthly with exception reporting as needed and added to Quality and People Experience / Clinical Effectiveness Committee CQC dashboard.
The Trust must ensure that incidents are investigated appropriately, actions are managed and completed and learning results in improved practices.	Ensure that all overdue actions for both Serious Incidents (SI) and Moderate Incidents (Concise) are implemented	Associate Director of Governance	End of April 2018 (SI) End of May (Concise)	A review of the overdue actions has been undertaken by the senior divisional teams and systematically closed off in order to meet the deadline date.
The Trust should consider how it can improve patients' and carers' knowledge of how to alert staff to the deterioration of a child within the paediatric waiting area at Fairfield Hospital.	Signage has been put in place to inform patients' and carers' knowledge.	Divisional Directors of Nursing	Complete	The signage has been put in place. Qualitative audit to be undertaken to ascertain if the signage is effective

Key Areas for Improvement	Bury and Rochdale Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Bury & Rochdale Care Organisation has made the following progress by 31st March 2018 in taking such action
The Trust should ensure that time is allocated for medical staff to attend mortality and performance management meetings.	Issue to be reviewed and action plan developed	Medical Director	30th June 2018	The issue is under review
The Trust should consider removal of potential ligature points in the toilet next to the mental health assessment room within the "majors" at Fairfield Hospital.	Ligature points to be removed	Divisional Director of Nursing (Fairfield)	Complete	Ligature points removed at point of identification.
The Trust should ensure that all cleaning fluids are in locked cupboards when not in use.	Security of cleaning fluids to be monitored as part of the H&S, Senior Nurse Quality walk rounds and Director walk rounds at weekend	Associate Director of Governance Associate Director of Facilities	No instance found by end April 2018	Monitoring in progress
Responsiveness				
The Trust should ensure that complaints are responded to in line with Trust policy.	To achieve 100% compliance with response timeframes for 6 consecutive months.	Divisional Directors of Nursing	End of August 2018	B&R CO are currently responding to 100% of complaints within agreed timeframes.
The Trust should consider how patient information is consistently displayed in all areas.	Mystery Shopper reviews of available patient information across the Bury and Rochdale sites	Divisional Directors of Nursing	30th September 2018	
Effectiveness				
The Trust should continue to ensure that it meets key national targets for caring for patients in urgent and emergency care.	Systematic monitoring of performance against the performance indicators, with actions to be taken accordingly.	Managing Director (Fairfield and Rochdale)	Ongoing monitoring	Performance was benchmarked against national targets and was found to have significantly improved across a range of measures and was in line with or better than the expected improvement trajectory. Reports given into the organisation's assurance committees.

Key Areas for Improvement	Bury and Rochdale Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Bury & Rochdale Care Organisation has made the following progress by 31st March 2018 in taking such action
The Trust should ensure that unplanned re-attendance rates are reduced.	Review the reasons for the higher than target reattendance rate and action accordingly	Managing Director (Fairfield)	TBC	Reattendances monitored via Urgent Care Directorate dashboard and divisional heat map High rates partially due to the coding of the ambulatory care activity as an admission. A resolution to this is currently being sought. Action plan being developed to implement the national CQUIN re unplanned reattendance rates for mental health patients.
The Trust should ensure action is taken to improve compliance with best practice in the taking of consent so that patients are given sufficient time to understand the information about their care and treatment.	Review the impact upon out-patient clinic times if consent is taken prior to the patient attending for surgery	Medical Director	End July 2018	Review of the impact on out-patient clinic times underway.
Staffing				
The Trust must ensure availability of clinical workforce with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment (medicine, surgery, critical care, children and young people services).	Nursing: Recruitment and retain staff and develop business cases as needed. Medical staff: Recruitment and retain staff and develop business cases as needed.	Director of Nursing Associate Director of HR Medical director/ ADW	Maintain vacancies below GM average of 10%	Nurse staffing (RN & HCA) is currently at 5% vacancy rate with ongoing recruitment. There is a rolling recruitment programme for medical staff for UCC and CAU. Bank and locum staff employed to ensure patient safety Vacancy and fill rates monitored at the Workforce Committee.
The Trust should ensure that staff movements to different wards are recorded, in order that accurate staffing levels on the critical care unit are documented.	Daily monitoring and recording of all moves	Divisional Director of Nursing (Fairfield)	Complete	Daily conference call is undertaken and a proforma is completed for all moves Monitored through safer staffing levels at the Workforce Committee.
The Trust should ensure that all staff feel safe to speak up if they have concerns.	Implement freedom to speak up guardian system	Chief Officer	Complete	Freedom to speak up guardian in post with direct reporting to directors

Key Areas for Improvement	Bury and Rochdale Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Bury & Rochdale Care Organisation has made the following progress by 31st March 2018 in taking such action
Risk Management				
The Trust should improve systems for identifying risks, planning to eliminate risks or reduce risks.	Ensure there is a systematic process for identification and assessment of risk which will include action plans and a clear process for monitoring.	Associate Director of Governance	30th September 2018	All existing risks which are current have now been migrated to the Datix system. Risks of grade higher than 10 are monitored at the organisation's assurance committees with divisional oversight of risks of grade less than 10
The Trust should consider more clearly defining and recording the dates that risks were first entered onto the risk register.	Ensure there is a clear audit trail of when a risk is entered onto a risk register	Associate Director of Governance	Complete	All existing risks which are current have now been migrated to the Datix system; date of entry onto this electronic risk register is a mandatory field.

North Manchester Care Organisation

Key to tables					
Ratings	Not Rated	Inadequate	Requires Improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

Ratings for North Manchester General Hospital

2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
Medical care (including older people's care)	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
Surgery	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Critical care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016
Maternity	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
Services for children and young people	Inadequate Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
End of life care	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016

2017-18

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑↑ Feb 2018	Good ↑ Feb 2018	Good →← Feb 2018	Requires Improvement ↑ Feb 2018	Good ↑↑ Feb 2018	Good ↑↑ Feb 2018
Medical care (including older people's care)	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018
Surgery	Requires Improvement →← Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good ↑ Feb 2018	Requires Improvement →← Feb 2018
Critical care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016
Maternity	Requires Improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑↑ Feb 2018	Requires Improvement ↑ Feb 2018
End of life care	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Good ↑↑ Feb 2018	Requires Improvement ↑ Feb 2018

Key Areas for Improvement	North Manchester Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	North Manchester Care Organisation has made the following progress by 31st March 2018 in taking such action
MCA and DOLS				
The Trust must ensure the principals of the MCA 2005 are followed so that patients' rights are fully maintained and valid consent is consistently obtained.	90% compliance in adult safeguarding training level 2.	Safeguarding Team	31st July 2018	Quarterly audits are carried out by Safeguarding team and as part of the NAAS.
Documentation of Care				
The Trust must ensure that appropriate records of patients' care and treatment are up to date and accurate to ensure that risks to patients are consistently assessed or action taken to reduce those risks.	To increase reliability of patient documentation via NAAS. Record keeping audits for services not using NAAS	Divisional Directors of Nursing	30th September 2018	An initial baseline audit to be undertaken, with an improvement trajectory to be agreed pertinent to the outcome of this audit.
The Trust must ensure that patient records are completed appropriately in order to allow staff to effectively monitor the care of patients.	To increase reliability of patient documentation via NAAS. Record keeping audits for services not using NAAS.	Divisional Directors of Nursing	30th September 2018	An initial baseline audit to be undertaken, with an improvement trajectory to be agreed pertinent to the outcome of this audit.
The Trust must ensure that management of pain is consistently recorded, monitored and actioned, particularly for patients with a cognitive impairment where the assessment of pain is more complex.	Pain assessment element of part of intentional rounding to assess consistent use of cognitive impairment tool.	Divisional Directors of Nursing	End of July 2018	Monthly intentional rounding audits in place.
The Trust should ensure that administration of intravenous fluids is accurately recorded.	To increase reliability of patient documentation via NAAS.	Divisional Directors of Nursing	30th September 2018	Documentation of Fluid Balance is an element of the NAAS Standard Local monthly audits.
The Trust should consider what actions could be taken to improve the use of paediatric pathways and formal guidance within the department.	Devise a standard assessment form for all children having short and long term care and management.	Safeguarding Team	31st May 2018	Standard assessment form in production. Audit and monitoring programme will be implemented once the form has been introduced. Review of paediatric emergency pathway with action plan developed.
The Trust should consider what actions could be taken to improve and monitor the quality and completion of paediatric assessment forms.	Devise a standard assessment form for all children having short and long term care and management.	Safeguarding Team	31st May 2018	Standard assessment form in production. Audit and monitoring programme will be implemented once the form has been introduced.

Key Areas for Improvement	North Manchester Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	North Manchester Care Organisation has made the following progress by 31st March 2018 in taking such action
The Trust should ensure it continues to improve its compliance in the use of the Manchester Children's Early Warning scoring system.	Monthly "manchews" audits on 10 random attendees to be carried out by practice based educator and reported to the Divisional Management Teams.	Divisional Directors of Nursing	31st May 2018	Audits in place and on schedule to meet the deadline date
Training				
The Trust must ensure that theatre staff are trained in appropriate levels of resuscitation to provide safe emergency care and treatment to patients.	Undertake a training needs analysis to ensure that theatre staff have appropriate level of training.	Associate Director of HR Divisional Directors of Nursing	31st Dec 2018	ALS training to be given to all appropriate theatre staff.
The Trust must ensure that all levels of staff, including medical staff, have completed mandatory training in line with the Trust's targets.	Monitor compliance levels against mandatory training modules and act accordingly.	Divisional Medical Director Medical director	90% compliance 30th June 2018	Compliance with training requirements being monitored by the divisional management teams and reported to the organisation's Workforce and Organisational Development Committee as part of the dashboard.
Patient Safety				
The Trust should ensure staff compliance with patient related infection prevention and control training.	Monitor compliance levels against mandatory training modules and act accordingly.	Divisional Directors of Nursing	90% compliance 30th June 2018	Compliance with training requirements being monitored by the divisional management teams and reported to the organisation's Workforce and Organisational Development Committee . IPC compliance also shared at Quality, Patient Experience and Clinical Effectiveness Committee.
The Trust should ensure rates of surgical site infections are monitored.	Monitor instances of surgical site infections.	Divisional Medical Director	Ongoing	Incidents of surgical site infection are monitored and root cause analysis completed where required.
The Trust must ensure that staff have the knowledge and training to recognise what patient safety incidents to report.	A briefing for all staff and bespoke training as needed.	Associate Director of Governance	30th September 2018	Patient safety incident training rolled out across all areas during implementation of datix system.
The Trust must ensure that WHO surgical safety checklist is completed accurately including verbalising counts of instruments (surgery and maternity).	North Manchester Care Organisation continue to audit and monitor compliance monthly with exception reporting as needed.	Medical Director	Ongoing	Audit and monitoring of WHO checklist compliance and performance takes place and is reported within the Division of Surgery and to the Quality, Patient Experience and Clinical Effectiveness Committee.

Key Areas for Improvement	North Manchester Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	North Manchester Care Organisation has made the following progress by 31st March 2018 in taking such action
The Trust must ensure that incidents are investigated appropriately, actions are managed and completed and learning results in improved practices.	Ensure that all overdue actions for both Serious Incidents (SI) and Moderate Incidents (Concise) are implemented.	Associate Director of Governance	End of April 2018 (SI) End of May (Concise)	Overdue actions are reported to the Quality, Patient Experience and Clinical Effectiveness Committee. A review of overdue actions will be completed by the end of April 2018 for serious incidents and May for concise.
The Trust should ensure that time is allocated for medical staff to attend mortality and performance management meetings.	Issue to be reviewed and action plan developed.	Medical Director	30th June 2018	This issue is currently under review. North Manchester Care Organisation has a Mortality Lead and the process of M&M is undergoing improvement and development.
The Trust should ensure that all cleaning fluids are in locked cupboards when not in use.	Security of cleaning fluids to be monitored as part of the H&S, Senior Nurse Quality walk rounds and Director walk rounds at weekend.	Associate Director of Governance Associate Director of Facilities	No instance found by end April 2018	Monitoring in progress. Health and Safety Officer for site continues to work with wards to ensure safe management and risk assessment of cleaning fluids.
Responsiveness				
The Trust should ensure that complaints are responded to in line with Trust policy.	To achieve 100% compliance with response timeframes for 6 consecutive months.	Divisional Directors of Nursing	End of August 2018	North Manchester CO monitors complaint response times at Quality, Patient and Clinical Effectiveness Committee and at Divisional Level.
The Trust should consider how patient information is consistently displayed in all areas.	Mystery Shopper reviews of available patient information across the site.	Divisional Directors of Nursing	30th September 2018	
Effectiveness				
The Trust should continue to ensure that it meets key national targets for caring for patients in urgent and emergency care.	Systematic monitoring of performance against the performance indicators, with actions to be taken accordingly.	Managing Director	Ongoing monitoring	National targets are monitored on an on-going basis with agreed improvement trajectories in place where performance is not currently meeting target. National targets are monitored at COARC and also at the Finance, Operations, Performance Information and Capital Committee.
The Trust should ensure that unplanned re-attendance rates are reduced.	Review the reasons for the higher than target reattendence rate and action accordingly.	Managing Director	TBC	Re-attendance rates are monitored via the dashboard that is presented to COARC.

Key Areas for Improvement	North Manchester Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	North Manchester Care Organisation has made the following progress by 31st March 2018 in taking such action
The Trust should ensure action is taken to improve compliance with best practice in the taking of consent so that patients are given sufficient time to understand the information about their care and treatment.	Review the impact upon out-patient clinic times if consent is taken prior to the patient attending for surgeryt	Medical Director	End July 2018	Consent audits are undertaken by the Trust audit team and reported to the Quality, Patient Experience and Clinical Effectiveness Committee.
Staffing				
The Trust must ensure availability of clinical workforce with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment (medicine, surgery, critical care, children and young people services).	Nursing: Recruitment and retain staff and develop business cases as needed. Medical staff: Recruitment and retain staff and develop business cases as needed.	Director of Nursing Associate Director of HR Medical director/ ADW	Maintain vacancies below GM average of 10%	The Workforce and Organisational Development Committee review a full suite of workforce indicators via the dashboard and takes action accordingly. This includes training data, fill and vacancy rates. Business cases are received by the Management Board to ensure that staffing is appropriate. Divisional teams utilise bank and agency staffing to ensure patient safety.
The Trust should ensure that staff movements to different wards are recorded, in order that accurate staffing levels on the critical care unit are documented.	Daily monitoring and recording of all moves.	Divisional Director of Nursing	Complete	Daily conference call is undertaken and a proforma is completed for all moves. Monitored through safer staffing levels at the Workforce and Organisational Development Committee.
The Trust should ensure that all staff feel safe to speak up if they have concerns.	Implement freedom to speak up guardian system.	Chief Officer	Complete	Freedom to speak up guardian in post with direct reporting to Directors. Freedom to Speak Up Guardian has attendance at leadership team meeting, and at Workforce and Organisational Development committee to provide feedback.

Key Areas for Improvement	North Manchester Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	North Manchester Care Organisation has made the following progress by 31st March 2018 in taking such action
Risk Management				
The Trust should improve systems for identifying risks, planning to eliminate risks or reduce risks.	Ensure there is a systematic process for identification and assessment of risk which will include action plans and a clear process for monitoring.	Associate Director of Governance	30th September 2018	All existing risks which are current have been now migrated to the Datix system. Risks of grade higher than 10 are monitored at the organisation's assurance committees with divisional oversight of risks of grade less than 10. On-going development of location specific risk registers.
The Trust should consider more clearly defining and recording the dates that risks were first entered onto the risk register.	Ensure there is a clear audit trail of when a risk is entered onto a risk register.	Associate Director of Governance	Complete	Risks entered onto the Datix risk management system have a clear date of entry.

Oldham Care Organisation

Key to tables					
Ratings	Not Rated	Inadequate	Requires Improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

Ratings for The Royal Oldham Hospital

2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Medical care (including older people's care)	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
Surgery	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016
Critical care	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
Maternity	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
Services for children and young people	Inadequate Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
End of life care	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Outpatient and Diagnostic imaging	Requires Improvement Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016

2017-18

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Requires Improvement →← Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↓ Feb 2018	Requires Improvement →← Feb 2018
Surgery	Requires Improvement →← Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018
Critical care	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018
Maternity	Requires Improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good ↑ Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018
End of life care	Good Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Outpatient and Diagnostic imaging	Requires Improvement Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires Improvement ↑ Feb 2018	Requires Improvement →← Feb 2018	Good →← Feb 2018	Requires Improvement →← Feb 2018	Requires Improvement ↑ Feb 2018	Requires Improvement ↑ Feb 2018

Key Areas for Improvement	Oldham Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Oldham Care Organisation has made the following progress by 31st March 2018 in taking such action
MCA and DOLS				
The Trust must ensure the principals of the MCA 2005 are followed so that patients' rights are fully maintained and valid consent is consistently obtained.	90% compliance in adult safeguarding training level 2	Safeguarding Team	31st July 2018	Quarterly audits are carried out by Safeguarding team and as part of the NAAS.
Documentation of Care				
The Trust must ensure that appropriate records of patients' care and treatment are up to date and accurate to ensure that risks to patients are consistently assessed or action taken to reduce those risks.	To increase reliability of patient documentation via NAAS. Record keeping audits for services not using NAAS.	Divisional Directors of Nursing	30th September 2018	An initial baseline audit to be undertaken, with an improvement trajectory to be agreed pertinent to the outcome of this audit.
The Trust must ensure that patient records are completed appropriately in order to allow staff to effectively monitor the care of patients.	To increase reliability of patient documentation via NAAS. Record keeping audits for services not using NAAS	Divisional Directors of Nursing	30th September 2018	An initial baseline audit to be undertaken, with an improvement trajectory to be agreed pertinent to the outcome of this audit.
The Trust must ensure that management of pain is consistently recorded, monitored and actioned, particularly for patients with a cognitive impairment where the assessment of pain is more complex.	Pain assessment element of part of intentional rounding to assess consistent use of cognitive impairment tool.	Divisional Directors of Nursing	End of July 2018	Monthly intentional rounding audits in place.
The Trust should ensure that administration of intravenous fluids is accurately recorded.	To increase reliability of patient documentation via NAAS.	Divisional Directors of Nursing	30th September 2018	Documentation of Fluid Balance is an element of the NAAS Standard Local monthly audits.
The Trust should consider what actions could be taken to improve the use of paediatric pathways and formal guidance within the department	Devise a standard assessment form for all children having short and long term care and management.	Safeguarding Team	31st May 2018	Standard assessment form in production. Audit and monitoring programme will be implemented once the form has been introduced. Review of paediatric emergency pathway with action plan developed.
The Trust should consider what actions could be taken to improve and monitor the quality and completion of paediatric assessment forms.	Devise a standard assessment form for all children having short and long term care and management.	Safeguarding Team	31st May 2018	Standard assessment form in production. Audit and monitoring programme will be implemented once the form has been introduced.

Key Areas for Improvement	Oldham Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Oldham Care Organisation has made the following progress by 31st March 2018 in taking such action
The Trust should ensure it continues to improve its compliance in the use of the Manchester Children's Early Warning scoring system.	Monthly "manchews" audits on 10 random attendees to be carried out by a practice based educator and reported to the Divisional Management Teams.	Divisional Directors of Nursing	31st May 2018	Audits in place and on schedule to meet the deadline date.
Training				
The Trust must ensure that theatre staff are trained in appropriate levels of resuscitation to provide safe emergency care and treatment to patients.	Undertake a training needs analysis to ensure that theatre staff have appropriate level of training	Associate Director of HR Divisional Directors of Nursing (Fairfield)	31st Dec 2018	ALS training to be given to all appropriate theatre staff.
The Trust must ensure that all levels of staff, including medical staff, have completed mandatory training in line with the Trust's targets.	Monitor compliance levels against mandatory training modules and act accordingly	Divisional Medical Director Medical director	90% compliance 30th June 2018	Compliance with training requirements being monitored by the divisional management teams and reported to the organisation's Workforce Committee as part of the dashboard.
Patient Safety				
The Trust should ensure staff compliance with patient related infection prevention and control training.	Monitor compliance levels against mandatory training modules and act accordingly.	Divisional Directors of Nursing	90% compliance 30th June 2018	Compliance with training requirements being monitored by the divisional management teams and reported to the organisation's Workforce Committee. IPC compliance also shared at Quality and Patient Experience committee.
The Trust should ensure rates of surgical site infections are monitored.	Monitor instances of surgical site infections.	Divisional Medical Director (Fairfield)	Ongoing	Incidents of surgical site infection are monitored and root cause analysis completed where required.
The Trust must ensure that staff have the knowledge and training to recognise what patient safety incidents to report.	A briefing for all staff and bespoke training as needed.	Associate Director of Governance	30th September 2018	Patient safety incident training rolled out across all areas during implementation of datix system.
The Trust must ensure that WHO surgical safety checklist is completed accurately including verbalising counts of instruments (surgery and maternity).	Oldham Care Organisation continue to audit and monitor compliance monthly with exception reporting as needed.	Medical Director	Ongoing	Audit and monitoring of WHO checklist compliance and performance takes place and is reported within the Division of Surgery and to the Clinical Effectiveness Committee.

Key Areas for Improvement	Oldham Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Oldham Care Organisation has made the following progress by 31st March 2018 in taking such action
The Trust must ensure that incidents are investigated appropriately, actions are managed and completed and learning results in improved practices.	Ensure that all overdue actions for both Serious Incidents (SI) and Moderate Incidents (Concise) are implemented.	Associate Director of Governance.	End of April 2018 (SI) End of May (Concise)	Overdue actions are reported to the Quality and Patient Experience Committee. A review of overdue actions will be completed by the end of April 2018 for serious incidents and May for concise.
The Trust should consider how it can improve patients' and carers' knowledge of how to alert staff to the deterioration of a child within the paediatric waiting area at Oldham Hospital.	Signage has been put in place to inform patients' and carers' knowledge.	Divisional Directors of Nursing	Complete	The signage has been put in place. Qualitative audit to be undertaken to ascertain if the signage is effective
The Trust should ensure that time is allocated for medical staff to attend mortality and performance management meetings.	Issue to be reviewed and action plan developed.	Medical Director	30th June 2018	This issue is currently under review. Oldham Care Organisation has a Mortality Lead and the process of M&M is undergoing improvement and development.
The Trust should ensure that all cleaning fluids are in locked cupboards when not in use.	Security of cleaning fluids to be monitored as part of the H&S, Senior Nurse Quality walk rounds and Director walk rounds at weekend.	Associate Director of Governance Associate Director of Facilities	No instance found by end April 2018	Monitoring in progress. Health and Safety Officer for site continues to work with wards to ensure safe management and risk assessment of cleaning fluids.
Responsiveness				
The Trust should ensure that complaints are responded to in line with Trust policy.	To achieve 100% compliance with response timeframes for 6 consecutive months.	Divisional Directors of Nursing	End of August 2018	Oldham CO monitors complaint response times at Quality and Patient Experience Committee and at Divisional Level with improving performance.
The Trust should consider how patient information is consistently displayed in all areas.	Mystery Shopper reviews of available patient information across the site.	Divisional Directors of Nursing	30th September 2018	
Effectiveness				
The Trust should continue to ensure that it meets key national targets for caring for patients in urgent and emergency care.	Systematic monitoring of performance against the performance indicators, with actions to be taken accordingly.	Managing Director	Ongoing monitoring	National targets are monitored on an on-going basis with agreed improvement trajectories in place where performance is not currently meeting target. National targets are monitored at COARC and also at the Ops & Performance Committee.

Key Areas for Improvement	Oldham Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Oldham Care Organisation has made the following progress by 31st March 2018 in taking such action
The Trust should ensure that unplanned re-attendance rates are reduced.	Review the reasons for the higher than target reattendence rate and action accordingly.	Managing Director	TBC	Re-attendance rates are monitored via the dashboard that is presented to COARC.
The Trust should ensure action is taken to improve compliance with best practice in the taking of consent so that patients are given sufficient time to understand the information about their care and treatment.	Review the impact upon out-patient clinic times if consent is taken prior to the patient attending for surgery.	Medical Director	End July 2018	Consent audits are undertaken by the Trust audit team and reported to the Clinical Effectiveness Committee.
Staffing				
The Trust must ensure availability of clinical workforce with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment (medicine, surgery, critical care, children and young people services).	Nursing: Recruitment and retain staff and develop business cases as needed. Medical staff: Recruitment and retain staff and develop business cases as needed.	Director of Nursing Associate Director of HR Medical director/ ADW	Maintain vacancies below GM average of 10%	The Workforce, Learning and Development Committee review a full suite of workforce indicators via the dashboard and takes action accordingly. This includes training data, fill and vacancy rates. Business cases are received by the Management Board to ensure that staffing is appropriate. Divisional teams utilise bank and agency staffing to ensure patient safety.
The Trust should ensure that staff movements to different wards are recorded, in order that accurate staffing levels on the critical care unit are documented.	Daily monitoring and recording of all moves.	Divisional Director of Nursing	Complete	Daily conference call is undertaken and a proforma is completed for all moves. Monitored through safer staffing levels at the Workforce Committee.
The Trust should ensure that all staff feel safe to speak up if they have concerns.	Implement freedom to speak up guardian system.	Chief Officer	Complete	Freedom to speak up guardian in post with direct reporting to Directors. Freedom to Speak Up Guardian has attendance at leadership team meeting, and at Workforce committee to provide feedback.

Key Areas for Improvement	Oldham Care Organisation is taking the following action to address the conclusion of requirement reported by the CQC	Lead	Target Completion Date	Oldham Care Organisation has made the following progress by 31st March 2018 in taking such action
Risk Management				
The Trust should improve systems for identifying risks, planning to eliminate risks or reduce risks.	Ensure there is a systematic process for identification and assessment of risk which will include action plans and a clear process for monitoring.	Associate Director of Governance	30th September 2018	All existing risks which are current have been now migrated to the Datix system. Risks of grade higher than 10 are monitored at the organisation's assurance committees with divisional oversight of risks of grade less than 10. On-going development of location specific risk registers.
The Trust should consider more clearly defining and recording the dates that risks were first entered onto the risk register.	Ensure there is a clear audit trail of when a risk is entered onto a risk register.	Associate Director of Governance	Complete	Risks entered onto the Datix risk management system have a clear date of entry.

NHS number of GMP code validity

Pennine Acute Hospitals NHS Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:

  99.7% for admitted patient care
  99.8% for outpatient care and
  98.2% for accident and emergency care

- Which included the patient's valid General Medical Practice Code was:

  100.0% for admitted patient care
  100.0% for outpatient care and;
  99.9% for accident and emergency care

Above are the latest published available at the time of writing, i.e. not for the full 2017/18, based on provisional April 2017 to February 2018 SUS+ Data at the Month 11 inclusion date.

Information governance toolkit attainment level

The IG Toolkit is an online system, which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It is fundamental to access to the NHS N3 secure network and to promote safe data sharing. It also allows members of the public to view participating organisations' IG Toolkit assessments.

The Pennine Acute Hospitals NHS Trust IG Toolkit score for 2017/18 is graded green, satisfactory.

Clinical coding error rate

The Pennine Acute Hospitals NHS Trust was not subject to the Payment by Results Assurance framework clinical coding audit during 2017/18 by the Audit Commission / regulatory bodies that decide which NHS Trust is to be audited for clinical coding.

Following an annual clinical coding audit in line with the IG Toolkit requirement 505 the Trust achieved level 2 based on the following audit results:

Audit Area	% correct
Primary Diagnosis	92.04%
Secondary Diagnosis	93.66%
Primary Procedure	92.66%
Secondary Procedure	92.70%

Data quality: relevance of data quality and action to improve data quality

Good quality information underpins the effective delivery of safe and effective patient care. Reliable data of high quality informs service design and improvement efforts. High quality information enables safe, effective patient care delivered to a high standard.

High quality information is:

- ✔ Complete
- ✔ Accurate
- ✔ Relevant
- ✔ Up-to-date (timely)
- ✔ Free from duplication (for example, where two or more different records exist for the same patient)

Pennine Acute Hospitals NHS Trust will be taking the following actions to improve data quality:

- Identification and review of potential duplicate patient records.
- Submissions to demographic batch service to trace records against the national portal to ensure accurate data.
- Monitoring of patients exceeding expected length of stay in short stay areas to improve live ATD (Admission/Transfer/Discharge) information
- Periodic review of outpatient activity to promote timely recording of attendances/appointment outcomes.
- Review of rejected GP correspondence sent via electronic document transfer to promote accuracy of registered GP in local data.
- Review of inpatient and outpatient activity that has not undergone automatic contract (purchaser) allocation.
- Review of death reports from national portal to promote timely recording of out-of-hospital deaths in the Trust's Patient Administration System (PAS).

Learning from deaths

The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure:

During 2017/18 (between 1st April 2017 and 31st March 2018) 2364 of The Pennine Acute Hospitals NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

592 in the first quarter;

575 in the second quarter;

726 in the third quarter;

790 in the fourth quarter (Jan and Feb).

The number of deaths included above which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure:

By 31st January 2018, 465 case record reviews and 32 investigations have been carried out in relation to 2364 of the deaths included in item 27.1.

In 17 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Mortality Reviews	SI Reviews	
162 in the first quarter;	8	Total 170
124 in the second quarter;	9	Total 133
101 in the third quarter;	3	Total 104
56 in the fourth quarter.	2	Total 58

An estimate of the number of deaths during the reporting period included above for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this:

9 representing 0.38% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

3 representing **0.52%** for the first quarter;

0 representing **0%** for the second quarter;

0 representing **0 %** for the third quarter;

0representing **0 %** for the fourth quarter.

These numbers have been estimated using the Hogan et al scoring system, as follows

- Reviews scoring 1 (definitely not preventable) and 2 (Slight Evidence of Preventability) are allocated <50% preventability i.e. not preventable.
- Reviews scoring 3 (Possibly preventable) are split with 50% allocated to <50% preventability i.e. not preventable and 50% >50% preventability i.e. preventable
- Reviews scoring 4 (Probably Preventable) 5 (Strong Evidence of Preventability) and 6 (Definitely Preventable) are allocated >50% preventability i.e. preventable

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified above:

Key Findings from the three mortality reviews identified as >50% preventable:

1. Delays in diagnosis and investigations
2. Lack of regular review by a senior doctor
3. Lack of nursing review
4. Poor documentation
5. Poor communication between clinical teams
6. Delays or lack of escalation for deteriorating patient

Additional findings

7. Fair Documentation

A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period):

In September 2017 the Trust launched a revised Mortality Review Policy and has been establishing robust governance structures within each of the three Pennine Acute Care Organisations (COs) to complete, analyse and learn from mortality reviews.

Each Care Organisation has established a Mortality Oversight Group to:

- monitor and manage the mortality review process
- ensure that sufficient mortality reviewers are trained and active
- allocate (with the support of clinical audit) mortality cases to reviewers
- manage the mortality and morbidity (M&M) meetings in each speciality to capture and share learning
- provide assurance that the minimum criteria of reviews are being competed with progress on the trajectory to complete a mortality review for every death by March 2020

To address the key findings of mortality reviews and investigations the primary quality strategy aim of 'No Preventable Deaths' the Trust is implementing a series of interventions designed to contribute towards an environment where patients are given the best outcome. The organisation identified a cardiac reduction aim for the Deteriorating Patient Collaborative which commenced in August 2016.

The main tests of change from the collaborative wards have focused on identification and communication of the deteriorating patient with more recent tests focussed on end of life, however, the 6 tests of change address the following mortality themes

- Lack of regular review by a senior doctor
- Failure to escalate
- Poor communication between clinical teams
- Delays in the delivery of care and treatment

There are additional improvement projects underway across all Care Organisations addressing key findings of the mortality reviews, with shared outcomes and learning to replicate good practice across all sites.

For example:

- '13 steps to good record keeping' programme to improve patient case note documentation.
- 'Your test, your responsibility' programme to improve delays in diagnosis and investigation.
- 'Reliable ward round' programme as part of the overall flow programme improvement work will focus on increasing reliability of ward rounds on surgical wards and involves the systematic approaches for communicating with families and loved ones, with a particular emphasis on conversations with patients and families through the Do Not Attempt Resuscitation masterclass programme.

An assessment of the impact of the actions described which were taken by the provider during the reporting period:

Since the launch of the revised Mortality Review Policy in September 2017 there has been considerable change in the mortality review process within each Care Organisation to enhance the current review process and develop robust governance systems to focus on learning.

Across all Care Organisations consultants, nurses and allied health professionals have been trained in Structured Judgement Review (SJR) mortality review methodology to enable cascade training by adopting a buddying system to share knowledge and experience.

The SJR mortality review methodology provides a review of the quality of the care provided, with each review being undertaken by a consultant and senior nurse. The reviewers request additional support as required from bereavement nurses, end of life teams, occupational therapists and resuscitation officers to enable a comprehensive review of the care provided.

Impact assessment of the actions is an ongoing process, with learning becoming the focus following a period of in-depth analysis.

The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in the relevant document for that previous reporting period:

0 case record reviews and 0 investigations completed after 01/04/17 related to deaths which took place before the start of the reporting period.

An estimate of the number of deaths included above which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this:

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number would be estimated using local case record review tools and Datix platform Serious Incident Reporting which at present is not available as this is the first year of implementation of the National Guidance on Learning from Deaths.

A revised estimate of the number of deaths during the previous reporting period stated above of the relevant document for that previous reporting period, taking account of the deaths referred to in above:

0 representing 0% of the patient deaths during 17/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Seven Day Hospital Services

Pennine Acute NHS Trust has committed to implementing the NHSI standards for seven day hospital services. Please see below for the progress that has been made against the four priority standards:

Standard 2- Time to first consultant review

- The September 2017 audit showed that the trust overall score or this was 69% (79% at North Manchester, 74% at Oldham & 53% at Bury).
- All sites have increased presence of acute / general medical consultants on site for a minimum of 12 hours per day at weekends & 14 hours per day presence of Emergency Medicine consultants.
- The trust has expanded the paediatric consultant base to improve evening cover. Areas where the standard is difficult to achieve are the smaller surgical specialties (e.g. ENT, Head & Neck & Urology).
- A Consultant for general surgery is on-site at the weekend to review admissions & operate 8am – 8pm.
- There is 7 day consultant presence for obstetrics & gynaecology, including overnight shifts.

Standard 5- Access to diagnostic tests

- Radiology services are provided 24/7 for all core procedures in the urgent and emergency patient. Seven day services are offered for CT, MR, Ultrasound and plain x-ray examinations for routine inpatients wherever possible. The hours for ultrasound (9am – 12pm) & MRI (8am – 8pm) are limited due to availability of radiographers & funding.
- Echocardiography for critically ill patients can be accessed via the on call cardiology consultant if needed.

Standard 6- Access to consultant-directed interventions

- Consultant delivered interventional radiology service 24 hours per day (one of the few in the region).
- Consultant review of emergencies (and sick inpatients) daily including each weekend day in urology, obstetrics gynaecology and orthopaedics.
- We have a 24/7 gastrointestinal bleed service from our gastroenterologists.

Standard 8- On-going review by consultant twice daily if high dependency patients, daily for others

- Complete revision of the working practices in medicine at the weekend. There are now up to four (3 for most of the year, 4 with peaks in activity) Consultant Physicians (including acute physicians and general physicians) working each weekend, which facilitates Consultant review of medical patients referred to medicine in A&E, continuous post take ward rounds 8am-8pm and Consultant review of the most unwell ward patients. On-call Physician visit all post-acute medical wards on Saturday and Sunday
- Increased establishment of Acute Physicians has enabled seven-day working on EAU with acute physicians and/or general physician present and working in EAU from 8am to 8pm, seven days per week. This has also led to a daily consultant ward reviews of new EAU medical admissions seven days a week, until 8pm.
- Business cases are being developed or further expansion of acute & general medical consultant numbers to further facilitate improved consultant presence.

Reporting against core indicators

Since 2012/13, NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital.

The core indicators are listed in the table below:

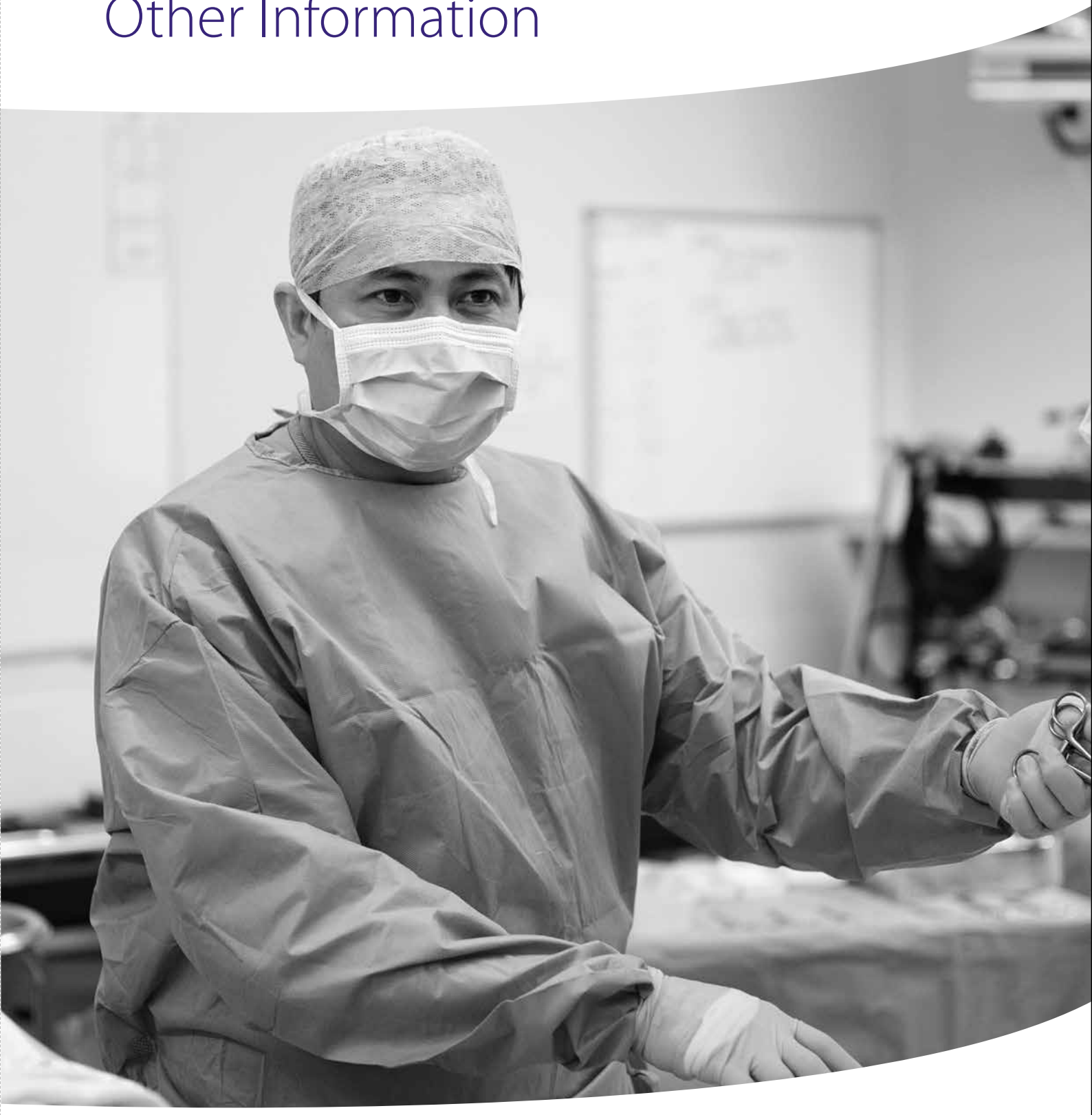
Domain	Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2016/2017	2015/2016	2014/2015
Preventing people from dying prematurely	SHMI value and banding (most recent: October 2016 - September 2017)	SHMI value = 1.01 As expected	**1.00**	**N/A**	**N/A**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. Mortality reduction is a focus for the Trust following the publishing of the Quality Improvement Strategy. The Pennine Acute Hospitals NHS Trust has taken the following actions to improve this rate and so the quality of its services through the implementation of wide ranging Quality Improvement initiatives which have aimed to improve mortality and harm by focussing on a series of interventions including: Mortality improvement work (as is detailed throughout this Quality Report)	**1.07** As expected	**1.11** Above expected	**1.01** As expected
Enhancing quality of life for people with long-term conditions	% patient deaths with palliative care coded at either diagnosis or speciality level (October 2016 – September 2017)	**21.3%** (data taken from SHMI data – provided by NHS Digital)	**29.6%**	**N/A**	**N/A**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust now has an established palliative care team who provide in reach across the hospital. The Pennine Acute Hospitals NHS Trust continues to take the actions highlighted in this Quality Account to improve this percentage and so the quality of its services, by continuing to place the upmost importance on high quality palliative care for our patients.	**20.0%**	**21.7%**	**22.1%**
Helping people recover from episodes of ill health or following injury	Patient reported outcome scores for groin hernia surgery (April 16 – March 2017 is the final published data provided by NHS Digital)	Data collection for this procedure ceased on 1st October 2017. Finalised data for 2017/18 is due to be published in May 2018.	**0.086**	**N/A**	**N/A**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust has undertaken work in the pre-operative assessment clinics to improve patient compliance and expectation following surgery. The Pennine Acute Hospitals NHS Trust continues to take the following actions to improve this outcome and so the quality of its services, by implementation of our Quality Improvement strategy.	**0.077**	**0.102**	**0.1**
	Patient reported outcome scores for varicose vein surgery April 16 – March 2017 is the final published data provided by NHS Digital)	Data collection for this procedure ceased on 1st October 2017. Finalised data for 2017/18 is due to be published in May 2018.	**0.092**	**N/A**	**N/A**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust has undertaken work in the pre-operative assessment clinics to improve patient compliance and expectation following surgery. The Pennine Acute Hospitals NHS Trust continues to take the following actions to improve this outcome and so the quality of its services, by implementation of our Quality Improvement strategy.	**0.07**	Less than 30 modelled responses	Less than 30 modelled responses

Domain	Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2016/2017	2015/2016	2014/2015
	Patient reported outcome scores for hip replacement surgery (April 16 – March 17 is the most up to date provisional year data provided by NHS Digital)	Full year 2017/18 data currently not available PAHT continues to participate in the audit	**0.437** April 16 – March 2017 is provisional year data provided by NHS Digital)	**N/A**	**N/A**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust has undertaken work in the pre-operative assessment clinics to improve patient compliance and expectation following surgery. The Pennine Acute Hospitals NHS Trust continues to take the following actions to improve this outcome and so the quality of its services, by implementation of our Quality Improvement strategy.	**0.439**	**0.43**	**0.429**
	Patient reported outcome scores for knee replacement surgery (April 16 – March 17 is the most up to date provisional year data provided by NHS Digital)	Full year 2017/18 data currently not available PAHT continues to participate in the audit	**0.445** April 16 – March 2017 is provisional year data provided by NHS Digital)	**N/A**	**N/A**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust has undertaken work in the pre-operative assessment clinics to improve patient compliance and expectation following surgery. The Pennine Acute Hospitals NHS Trust continues to take the following actions to improve this outcome and so the quality of its services, by implementation of our Quality Improvement strategy.	**0.447**	**0.339**	**0.297**
Helping people to recover from episodes of ill health or following injury	28 day readmission rate for patients aged 0 – 15	NHS Digital hasn't updated this metric since 2013, therefore we have included our own data on readmissions on the Trust Selected Metrics page.							
	28 day readmission rate for patients aged 16 or over	NHS Digital hasn't updated this metric since 2013, therefore we have included our own data on readmissions on the Trust Selected Metrics page.							
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs: CQC national inpatient survey score	**63.8%**	**69.6%**	**9.2%**	**7.4%**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: there are nationally regulated assurance processes in place to ensure the accuracy and validity of the data. Improving patient experience is one of the Corporate Priorities for the Northern Care Alliance NHS Group within which Pennine Hospitals are part of; continually learning about and from patient experiences through a range of patient focused metrics such as the Friends and Family Test (FFT), Patient Stories and PALS contacts. The Pennine Acute Hospitals NHS Trust has taken the following actions to improve the percentage, and so the quality of its services by supporting Care Organisations to develop locally responsive systems and process which are both real- time and Near real time which are acted upon to improve care. The Care Organisations will continue to work with the Group based patient experience team, stakeholders, community representative groups including; Healthwatch, schools and charities to co-produce service developments in line with their local and Group improvement plans.	**7.5**	**7.7**	**7.6**

Domain	Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2016/ 2017	2015/2016	2014/2015
	Percentage of staff who would recommend the provider to friends or family needing care Staff Survey 2017	56%	83% (QI 2017/18)	100% The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	55% Cumbria Partnership NHS Foundation Trust	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust has implemented a number of actions from April 2016 onwards, such as the Pioneers' programme, 1000 voices, open surgeries with directors. These were aimed at further improving staff engagement and we can see from the 2017 survey that these have had a positive impact on staff which in turn benefits patients and patient care. The Pennine Acute Hospitals NHS Trust continues to take further actions to improve these outcomes and so the quality of its services, by continuing to deliver against any actions following the 2017 results and throughout 2018.	52%		
Treating and caring for people in a safe environment and protecting them from avoidable harm	% of admitted patients risk-assessed for Venous Thromboembolism	95.43% (excluding March 2018)	96%	100%	76.48%	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust has a number of ongoing VTE projects which are aimed at maintaining and increasing VTE risk assessment compliance through the trust electronic prescribing system. Recent improvements in reviewing cases of hospital acquired VTEs ensures all identified hospital acquired VTEs have a root cause analysis undertaken in a timely manner. The Pennine Acute Hospitals NHS Trust continues to undertake improvement work to improve this outcome and so the quality of its services, by developing systems to ensure the patients receive risk assessments for venous thromboembolism.	96.30%	96.72%	96.25%
	Rate of C.Difficile per 100,000 bed days (2015 /2016, is the most recent data release, please see Trust reported data pages for more current data))	14.7	13.2 England 12.2 Non-Teaching Trust	George Eliot Hospital (2.8)	Harrogate and District (28.4)	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. Infection control is seen as one of the Trust's highest priorities with all cases of Hospital Acquired C.Difficile reviewed and opportunities for learning are shared. Each case of Clostridium difficile is subject to a rigorous root cause analysis investigation involving a multi-disciplinary team (MDT) including colleagues from the CCGs, and any lessons learned are identified and shared with the MDT and reported to the Trust to promote best practice and facilitate a whole health economy engagement process. The Pennine Acute Hospitals NHS Trust has taken the following actions to improve its percentage and so the quality of its services, by improving both the assessment and management of diarrhoea of unknown origin, improve timely isolation of patients with diarrhoea with the use of a risk assessment tool. Education and audit around assessment and management, an increase in cleaning where infection is suspected, high level disinfection of wards where patients are particularly vulnerable, the use of hydrogen peroxide vapour in areas with confirmed cases or where periods of increased incidence of infection are identified through surveillance.	58	56	72

Domain	Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2016/2017	2015/2016	2014/2015
Treating and caring for people in a safe environment and protecting them from avoidable harm	Rate of patient safety incidents per 1000 bed days Prior to 2014/15 rate was based on 100 admissions	Number reported = **7950** Number per bed days = **41.7** Note: 17/18 data taken from NHS improvement report. 17/18 Q3&Q4 data not yet available	Number reported = **5,226** Number per bed days = **42.8** Data taken from Acute trusts only	By highest number of incidents reported per bed day: CROYDON HEALTH SERVICES NHS TRUST (n=111.69)	By lowest number of incidents reported per bed day: SOUTH TYNESIDE NHS FOUNDATION TRUST (N=23.47)	Pennine Acute Hospitals considers that this data is as described for the following reasons. The Trust continues to promote a culture of open and honest reporting and endorsing a fair blame culture. Pennine Acute Hospitals continues to take the following actions to improve this outcome and so the quality of its services, by encouraging a culture of voluntary reporting and endorsing a fair blame culture.	Number reported = **15484** Number per bed days = **34.6**	Number reported = **13901** Number per bed days = **35**	Number reported = **13980** Number per bed days = **34.6**
	Rate of patient safety incidents that resulted in severe harm or death per 1000 bed Prior to 2014/15 rate was based on 100 admissions	Number reported = **62** Number per bed days = **0.3** Note: 17/18 data taken from NHS improvement report. 17/18 Q3&Q4 data not yet available	Number reported = **270** Number per bed days = **0.0081** Data taken from Acute trusts only	By lowest number of Severe and Death incidents reported. ROYAL BERKSHIRE NHS FOUNDATION TRUST and SOUTH TYNESIDE NHS FOUNDATION TRUST (N=0)	By highest number of Severe and Death incidents reported. UNITED LINCOLNSHIRE HOSPITALS NHS TRUST (N=121)	Pennine Acute Hospitals considers that this data is as described for the following reasons. The Trust continues to promote a culture of open and honest reporting and endorsing a fair blame culture. Pennine Acute Hospitals continues to take the following actions to improve this outcome and so the quality of its services, by encouraging a culture of voluntary reporting and endorsing a fair blame culture.	Number reported = **190** Number per bed days = **0.5**	Number reported = **149** Number per bed days = **0.4**	Number reported = **68** Number per bed days = **0.2**
Ensuring that people have a positive experience of care	Inpatient Friends and Family Test	**92%**	**96%** (February 2016)	**100%** (Several Trusts)	**76%** (Sheffield Children's NHS Foundation Trust)	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust continues to promote a culture of open and honest reporting and encourages as many patients to participate as possible. The Pennine Acute Hospitals NHS Trust continues to take actions to improve these outcomes and so the quality of its services, by prioritising patient experience and engagement.	**91%** (February 2017)	**93%** (January 2016)	**98%** (February 2015)
Ensuring that people have a positive experience of care	Accident and Emergency Friends and Family Test	**83%**	87% (February 2016)	**92%** (Liverpool Women's NHS Foundation Trust)	**48%** (North Middlesex University Hospital NHS Trust)	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust continues to promote a culture of open and honest reporting and encourages as many patients to participate as possible. The Pennine Acute Hospitals NHS Trust continues to take actions to improve these outcomes and so the quality of its services, by prioritising patient experience and engagement.	**82%** (February 2017)	**81%** (January 2016)	**92%** (February 2015)

Other Information



Performance against locally selected indicators

	Metric	Target	2017/18	Comments
Infection control	Number of Cdiff cases	**Local trajectory: 55 avoidable cases**	**43**	
	Number of MRSA Bacteremia	**Local target: 0**	**2**	
Access to cancer services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	**National target: 96%**	**98.3%**	
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)	**National target: 98%**	**98.7%**	
	% of Cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	**National target: 94%**	**95.7%**	
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)	-	-	
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to treatment	**National target: 85%**	**82.1%**	
	% of cancer patients waiting a maximum of 62 days from the consultant screening service referral to treatment	**National target: 90%**	**69.0%**	
	% of cancer patients waiting a maximum of two weeks from urgent GP referral to date first seen	**National target: 93%**	**89.7%**	
	% of symptomatic breast patients (cancer not ini-tially suspected) waiting a maximum of two weeks from urgent GP referral to date first seen	**National target: 93%**	**97.4%**	
Access to treatment	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - % patients on an incomplete pathway	**National target: 92%**	**89.61%**	
Access to A&E	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or dis-charge	**National target: 95%**	**83.59%**	Prior to July 2015 A&E was reported weekly
Cancelled operations	% of patients whose operations were cancelled by the hospital for non-clinical reasons on the day of or after admission to hospital	**Local target: 0%**	**1.69%**	
Cancelled operations not treated within 28 days	% of those patients whose operations were can-celled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days	**Local target: 0%**	**10.60%**	
Patient safety outcomes	Hospital standardised mortality rate (calculated using annual benchmark) - Dr Foster no longer used, we only have this figure since July	**Expected ratio= 100. Under 100 is better than expected**	**93.3**	17/18 (rolling 12m Dec 17)
	Hip Replacement SSI	**National benchmark: 0.5%**	**1.0%**	Please note that data collection within the trust only began in April 2017 and this was only select categories. From 1st July 2017 all mandatory orthopaedic categories were collected on each site therefore the above data is not a true recollection of our operations and infections.
	Knee Replacement SSI	**National benchmark: 0.4%**	**0.4%**	
	Reduction of Long Bone SSI	**National benchmark: 1.0%**	**3%**	
	Repair of Neck of Femur SSI	**National benchmark: 1.1%**	**3.1%**	
	Safety thermometer acute - % of patients safe from new harm	**Local target: Above 95%**	**98.60%**	

	Metric	Target	2017/18	Comments
	Safety thermometer community - number of patients safe from new harm	**Local target: 97.93%**	**98.74**	HMR community teams started completing Safety Thermometer surveys in November 2017. Target is based on national average 2017 - 2018
	Hospital Acquired Pressure Ulcers (grade 2, 3 and 4)	**Local measure not nationally benchmarked**	**164**	See project page for information regarding aims for improvement and outcomes
	MRSA	**Local target: 0**	**2**	
	Cdiff - All cases (including unavoidable)	**Local trajectory: 55 avoidable cases**	**43**	
	28 Day Readmission - overall (Ytd)	**Peer value: 7.5%**	**7.90%**	17/18 YTD = April 17 - January 18
	28 Day Readmission - 0-15	-	**8.59%**	17/18 YTD = April 17 - January 18
	28 Day Readmission - 16+	-	**7.75%**	17/18 YTD = April 17 - January 18
Clinical effectiveness	Advancing quality - Composite Quality score for Alcohol Related Liver Disease	**70.7%***	**51.5%**	
	Advancing quality - Appropriate Quality score for Alcohol Related Liver Disease	**50.0%***	**1.9%**	
	Advancing quality - Composite Quality Care score for AKI	**52.5%***	**35.3%**	
	Advancing quality - Appropriate Quality care score for AKI	**50.0%***	**5.4%**	
	Advancing quality - Composite Quality Care score for Diabetes	**60.7%***	**53.4%**	
	Advancing quality - Appropriate Quality care score for Diabetes	**50.0%***	**9.9%**	
	Advancing quality - Composite Care score for Pneumonia	**87.5%***	**82.1%**	
	Advancing quality - Appropriate Care Score for Pneumonia	**66.0%***	**50.8%**	
	Advancing quality - Composite Care score for Sepsis	**81.9%***	**82.9%**	
	Advancing quality - Appropriate Care Score for Sepsis	**54.8%***	**50.1%**	
	VTE Risk assessment	-	**95.43%**	YTD Feb 2018
Patient Experience	% of adult inpatients who felt they were treated with respect and dignity	-	**77%**	
	% of adult inpatients who had confidence in the Trust doctors treating them	**National Picker score average 85%**	**78.00%**	
	Count of patients who waited more than 52 weeks for treatment	**Local target: 0**	**6**	YTD Feb 2018

* Advancing quality targets are set externally for PAHT by the regional AQuA team

NHS England patient safety alerts information 2017-18

Reference	Alert Title	Issue date	Response	Deadline
NHS/PSA/RE/2017/001	Resources to support safer care for full-term babies	23/02/2017	Alert disseminated and assurance of compliance received. Action completed: Saving Babies' Lives is an already established work programme within the Trust. Action plan produced	23-Aug-17
NHS/PSA/RE/2017/002	Resources to support the safety of girls and women who are being treated with valproate	06/04/2017	Alert disseminated and assurance of compliance received. Action Completed to address requirements of the toolkit. Monitored by Medicine management committee	06-Oct-17
NHS/PSA/W/2017/003	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	05/07/2017	Alert disseminated and assurance of compliance received. Only one area affected and action completed	16-Aug-17
NHS/PSA/RE/2017/004	Resources to support safe transition from the Luer connector to NRFit™ for intrathecal and epidural procedures, and delivery of regional blocks	11/08/2017	Alert disseminated and assurance of compliance received. Action Completed. Monitored by Medical Devices Management Team and Medical & Scientific Committee	11-Dec-17
NHS/PSA/W/2017/005	Risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies	20/09/2017	Alert disseminated and assurance of compliance received. Action completed and action plan monitored by Women's & Children's Division	08-Nov-17
NHS/PSA/D/2017/006	Confirming removal or flushing of lines and cannulae after procedures	09/11/2017	Alert disseminated: Action ongoing being lead by Medical Directors in all Care Organisations.	09-Aug-18

Never Events

1 April 2017 to 27 March 2018

Never event	Description	Key findings from root cause analysis	Actions to prevent recurrence
Wrong site surgery North Manchester Surgery	Left retrograde and stent insertion undertaken, but this should have occurred on the right side	Despite the clinician being very experienced in this procedure the mistake still occurred. Theatre lists do not always list which side to operate on and paper work does not always prompt to indicate.	Surgeons to double check marking on both sides of the patient. Cross checks from multiple staff to cross reference lists, PACs and other documentation PACs accessible during the surgery for cross referencing Abbreviations not to be used on consent forms Consent forms must exactly match Theatre Manager database Human factors training
Retained foreign object post-procedure North Manchester Women's and Children	Patient had emergency Caesarean section. Swab not accounted for in theatre. X-ray undertaken at the time and no swab found. Patient became unwell the following day and was x-rayed again. Swab identified and patient returned to theatre for removal of swab	Insertion of a swab into the abdomen with no clip attached/clip became detached. Policy is unclear regarding appropriate radiography action to be taken regarding a lost swab, both in theatre and following post-operatively	Improved communication with the person undertaking the x-ray to ensure that the appropriate area is x-rayed Clinical supervision of the staff involved to be undertaken by line managers and to include a reflection on this case.

Never event	Description	Key findings from root cause analysis	Actions to prevent recurrence
Wrong site surgery North Manchester Surgery	Patient listed and consented for emergency surgery for incision and drainage of pilonidal abscess +/- examination under anaesthesia +/- proctoscopy. A banding of haemorrhoids was undertaken in error. The correct procedure was then undertaken	**Organisational – transfer of knowledge** The consultant surgeon was unaware of the procedure the patient was consented for. He did not read the patient's notes in theatre or check the consent form himself until he was aware that he had conducted an unconsented procedure. No members of the theatre (nursing or anaesthetic) team in theatre challenged the consultant surgeon that he was undertaking the wrong procedure until the procedure had finished. **Organisational – protocols and procedures** The WHO surgical safety checklist policy was not followed. The surgery was not stopped when the Time Out (step 3) demonstrated that the consultant surgeon stated that he did not know what procedure the patient was having done. **Organisational – culture** Cultural working practices in theatres meant that the staff did not feel comfortable to challenge the consultant surgeon about undertaking the incorrect procedure until the procedure was completed and the consultant surgeon stated that the case was finished. On recognising his error, the consultant surgeon stated it was the fault of the scrub nurse who had read out the consent form incorrectly.	A full pre-operative briefing must occur before each emergency patient is sent for, with the fully theatre team for that patient. The nursing staff must ask the surgeon to confirm the position of the patient as part of the pre-operative brief step 1 of the WHO surgical safety checklist All surgeons should be shown the consent form, by the member of staff leading the WHO safer surgery checklist time out. This should be documented on the checklist. Further training for medical and nursing staff on the WHO safer surgery checklist, ensuring that all staff are aware the time out must be stopped if the surgeon is unsure of the procedure the patient is having. Training to be provided for nursing staff to support and encourage them to challenge medical staff and escalate to senior managers when required. All medical and nursing staff to be professionally accountable for their own practice. The consultant surgeon to undertake CPD about consent and to ensure all trainees and colleagues are clear on the Department of Health's Reference Guide to Consent for Examination and Treatment
Wrong site surgery Diagnostics and Pharmacy	Patient referred to Radiology: "Ultrasound Right Shoulder and injection both ACJ & sub-clavian space". The term both was meant to apply to both injections but was interpreted as both sides and procedure was carried out bilaterally.	Investigation still ongoing	Investigation still ongoing

Annex 1:
Statement from local commissioners, local Healthwatch organisations and overview and scrutiny committees

CCG statement for The Pennine Acute Hospitals NHS Trust Quality Accounts 2017/18

Thank you for asking us to respond to the 2017/18 Quality Account for your organisation. The Quality Report describes your quality strategy and sets out a range of quality initiatives and evaluates the improvements achieved during 2017/18. The Quality Report seeks to provide assurance the Trust is continually striving to meet the healthcare needs of the population that it serves. The quality and safety of services continues to be of paramount importance to the CCGs and as such we welcome the opportunity to comment on your report.

Commissioners would like to acknowledge the significant improvements in quality which have been delivered in 2017/18. These are reflected in the CQC inspection report published in March 2018 and form the building blocks for further quality improvements.

We support the strengthened leadership structure of the Northern Care Alliance (NCA) and the quality improvement aims identified by the Board for 2018/19. We look forward to receiving Sir David Dalton's statement on quality which will demonstrate the high level Board commitment to quality improvement across the NCA.

Commissioners are well sighted on the quality improvements required across the Trust to ensure the highest level of reliable clinical care, reduce harm and improve patient and family experience of the care they receive and we agree with the priorities detailed in the Quality Report.

Commissioners welcome the aim of eliminating preventable deaths and are pleased to note the implementation of robust mortality review systems and processes and improved HSMR position. We would expect to see continued focus on mortality review in 2018/19 with the learning from structured judgement reviews being shared widely across all Accountable Care Organisations (ACOs) and used to drive further quality improvements. The Learning Disability Mortality Review (LeDeR) programme is a component of the Trust's mortality review process; however we would like a strengthened collaborative approach to support the programme more widely with partner organisations.

Failure to recognise/act on the deteriorating patient has been a recurring theme in serious incidents. Commissioners are therefore pleased to note on-going work around the deteriorating patient collaborative and launch of the NEWS observation chart and revised Standards for Adult Observation policy. We would expect to see continued focus on this important area of clinical practice and would like to see roll out of the Patientrack electronic observation system across all ACOs.

Recognition and management of sepsis has also been a recurring theme in serious incidents. Whilst recognising the complexity of sepsis and the improvements achieved in 2017/18, performance is not yet at the required level. Commissioners would like to see increased focus and commitment on the achievement of national targets during 2018/19.

Commissioners expect to see a reduction in the number of reported serious incidents where patients have suffered avoidable harm/preventable death resulting from failure to recognise/act on the deteriorating patient or to recognise/manage sepsis. We want to regularly see outcomes from the improvement collaboratives to ensure progress is being made at pace.

We are pleased to see infection prevention is one of the most important organisational priorities and note the achievement of a 26% reduction in C Difficile cases on 2017/18 compared to 2016/17. We note further improvements have been identified for 2018/19 and the Trust will be taking part in the national ambition to reduce Gram negative blood stream infections by 50% by March 2021 and to reduce E coli bacteraemias by 10% during 2018. Commissioners support the

quality improvement initiatives and look forward to supporting this work in 2018/19.

Elimination of avoidable harm and the delivery of consistently high quality care are key priorities for commissioners. We note the significant reduction in reported pressure ulcers of all grades and the further improvements identified. We also note the successful roll out of the Nursing Assessment and Accreditation System which will help to standardise the delivery of nursing care across the ACOs. We look forward to further improvements in 2018/19.

The strengthened safeguarding structures seen across the NCA have been a priority for the trust during the year and we feel the expansion of the safeguarding team was necessary to be able to improve training uptake and to support staff in their clinical practice. Improving understanding and application of the Mental Capacity Act for frontline staff is crucial for the delivery of safe practice across the organisation.

Commissioners would like to see an on-going focus on the prevention and management of venous thromboembolism (VTE) across all ACOs during 2018/19. We would like to see compliance with requirements for RCA analysis of avoidable VTE, roll out of the electronic risk assessment and request quarterly reporting of progress in this key area of avoidable harm at the Clinical Quality Leads meetings.

It is assuring to note the Trust actively participated in national clinical audits and confidential enquiries during 2017/18 and we would expect to see this level of on-going participation in 2018/19. We would also like to see clinical audit being used as a tool to evaluate the implementation and embedding of learning from complaints, serious incidents, mortality reviews and claims.

Commissioners note and support the quality improvement priorities for 2018/19. We would expect each of the four high level objectives set out in the 2017/18 Quality Report to be underpinned by robust outcome measures and would like regular progress updates against these and wider quality improvement initiatives reported to the Clinical Quality Leads meeting during 2018/19.

Locally we have seen enhanced engagement with all stakeholders in the formation of Local Care Organisations. The leadership teams have been open to change processes to enable working in new ways to deliver health care by the right person at the right time in the right place. System-wide solutions to delivering sustainable, high quality care are necessary as we move forward and during 2017/18 real improvements were made in many areas to improve quality.

The Quality Report details much of the improvement work seen over the previous year and it is a transparent and honest account of the organisation.

Additionally we want to commend the front line staff for their dedication and resilience shown throughout the previous 12 months who are embracing change and are positively supporting the Trust's senior leaders.

Catherine Jackson,
Executive Nurse Bury CCG on behalf of:

- NHS Bury CCG
- NHS HMR CCG
- NHS Oldham CCG

MHCC Response to Pennine Acute Hospital NHS Trust (PAHT) 2017/18 Services at North Manchester General Hospital and Community Services

Manchester Health and Care Commissioning (MHCC) is the partnership between NHS Manchester Clinical Commissioning Group (CCG) and Manchester City Council (MCC) which leads the commissioning of health, adult social care and public health services in the city of Manchester. MHCC would like to thank PAHT for their detailed and comprehensive account of their hard work to improve the quality and safety of services for the patients and communities they serve.

On the 22nd of May 2017 a suicide bomber detonated an improvised device at the Manchester Arena. The bomb killed twenty-two people including many children. Over one hundred were physically injured and many more suffered psychological and emotional trauma. The Manchester Arena attack was the deadliest in the UK since the London bombings on 7th July 2005.

Paramedics treated many walking wounded in the city centre. Hospitals in Greater Manchester treated people with serious injuries, transported by the Ambulance Service, whilst others made their way to hospitals across the wider region.

MHCC would like to commend the response from PAHT in relation to this tragedy.

North Manchester General Hospital Services

MHCC works very closely with partner Clinical Commissioning Groups that make up the North East Sector which works together to oversee quality and performance of PAHT as a whole. We have closely monitored improvements especially within the services that were classed as fragile and MHCC recognise the improvements that have been made that were reflected in the most recent Care Quality Commission inspection with the Trust moving overall from inadequate to requires improvement.

Of note at NMGH were the improvements in maternity and gynaecology from inadequate to good, emergency services improving from inadequate to good, children's services improving from inadequate to requires improvement and all other services that were inspected have improved significantly as well. MHCC has seen significant improvements to patient care and safety in the last 12 months and would like to commend the resource and commitment of the Trust in making these improvements.

Urgent care

This year, significant planning and system resilience funding was put in place in order to support the system, to test new models of working such as discharge to assess, and provide additional resource such as staffing and winter beds. However 4 Hour performance across our three acute hospitals has been challenging, particularly during the winter period. Collectively lessons learned from Christmas/New Year planning were applied for Easter planning and we reported a much improved picture over this holiday period.

The Operational Pressures Escalation Levels (OPEL) Framework was established with our system partners and ensured a co-ordinated and robust approach to surge and escalation and appropriate support from organisations during times of pressure.

Improvement action plans for delayed transfer of care (DTOC) patients has resulted in the 3.3% target being met at periods of time, at all sites, particularly during March 2018. We have also reported a notable reduction in 12 hour trolley breaches particularly notable at NMGH. This is an notable improvement and the work continues into 2018/19.

MHCC has undertaken quality visits and walk rounds at NMGH and these have been positive. The feedback on the staff survey has also improved especially for NMGH.

PAHT Community Services

MHCC has worked closely with PAHT community services over the course of 2017/18, and have met regularly with the Trust to review the organisations' progress in implementing its quality improvement initiatives. We remain committed to engaging with the Trust in an inclusive and innovative manner to promote continued improvements in the quality of service provision. We are pleased with the level of engagement from the Trust and hope to continue to build on these relationships as we move forward into 2018/19.

Manchester Local Care Organisation went live on 1 April 18. During Phase 1 (2018/19), the objectives of MLCO will be commissioned through existing contracts supported by an 'umbrella' Partnering Agreement'. This is a positive step forward in establishing more integrated, proactive care delivered in neighbourhoods in the City.

The PAHT Community services have continued to meet the needs of local residents of North Manchester. Services were rated as Good by CQC in their last CQC inspection and the monthly governance meetings have demonstrated their commitment to quality and innovations as well as trying to maintain and improve performance across the range of services provided. MHCC welcomes PAHT's continued commitment to meet regularly to monitor the quality and performance of their community services in 2018/19.

Of note is the development and implementation of the Community Assessment Support Service; this is an integrated service delivery model that aims to avoid admissions (step up), reduce length of stay (step down) and improve experiences through better access to the right intervention, at the right time, delivered by the right health or social care worker.

The CASS service delivers rehabilitation to the citizen and carer promoting independence, and self-management. This service has been successful in reducing admissions and reducing lengths of stay and this model is now being rolled out across the city of Manchester.

The CCG undertook a quality and safety walk-round of two community services in North Manchester Active Case Managers and a District Nurses team in 2017/18 which identified areas of good practice, opportunities for improved operational delivery, and potential connections to wider strategic developments across North Manchester. We commend the engagement of PAHT Community services in the 2017/18 quality and safety walk-round programme.

Conclusion

As commissioners, we have worked closely with PAHT over the course of 2017/18, meeting with the Trust regularly to review the organisations' progress in implementing its quality improvement initiatives and merging from two organisations into one. As the delivery of health care continues to evolve and as we move closer toward a single hospital provider we are committed to engaging with the Trust in an inclusive and innovative manner to support continuous improvement in the health and care of the people of Manchester.

We to continue to build on our relation with the Trust as we move forward into 2018/19.

MHCC is not responsible for verifying data contained within the Quality Account; that is not part of these contractual or performance monitoring processes.

Ian Williamson
Chief Accountable Officer
Manchester Health and Care Commissioning
Date: 25 May 2018

Response of North East Sector Healthwatch organisations (Healthwatch Bury, Healthwatch Rochdale and Healthwatch Oldham) to the Pennine Acute Hospitals NHS Trust Quality Account 2017/18

This is the combined local Healthwatch response to Pennine Acute Hospital NHS Trust draft Quality Report 2017/18. It must be noted that this is a response to the draft account and the draft account's content may not be exactly reflected in the Trust's published Quality Report.

Healthwatch organisations welcome the opportunity to comment on the Trusts' Quality Report 2017-2018.

General Comments

We note that the Quality Report highlights positive work being undertaken by Pennine Acute to improve the quality of the services it delivers. Many of the projects highlighted in the document help to show how the Trust is working to address many of the issues that have been raised by patients, services users, CQC, and health professionals.

The examples show a positive approach to learning with actions from lessons learnt implemented and training identified and rolled out to ensure clinical staff are up to speed.

It is also helpful that the Trust is looking at a number of ways to improve the strategic management and prevention of issues such sepsis and pressure ulcers etc. through improved communication, training and support with the community and wider healthcare providers. The commitment to deliver innovative and integrated care closer to home is really positive and we would encourage the Trust to provide more evidence of how this is working in practice.

The statements from the Care Quality Commission all show a positive direction of travel and compliment the hard work taken by the Trust to address the areas of concern. We note the continued approach by the Trust to improving patient information and records. However, some patients have raised concerns about access to the interpretation service which has to be booked in advance through a paper based system and people struggle to speak to anyone via the dedicated telephone number. We have also received concerns from some service users about the Trusts lack of understanding for some disabilities such as sight and hearing impairments, particularly in an Accident and Emergency setting, and welcome all initiatives that improve training and reasonable service adjustments to ensure ease of access for patients and family/carers with disabilities.

The positive work by the Trust on the production for example, of the communication and information needs passport, is an excellent example of a simple but effective tool to help meet the needs of those with sensory impairment and or learning disabilities. It has also proved a useful communication tool to a wider audience as we have passed it on to a local refugee and asylum group to help with their communication needs.

As a general observation Healthwatch partners recognise the significant improvements pursued by the Trust but have concerns about the inconsistent approach to engaging the public, patients and their families/carers to routinely offer qualitative feedback and help shape the transformation of Pennine Acute services as part of the emerging Northern Care Alliance.

We look forward to working with the Trust and welcome the opportunity to ensure patients and members of the public are actively involved in the co-design of services through regular two way discussion forums and targeted engagement events.

Specific Comments

Aims

- **SAFER Actions for Patient Flow**
  This is a really positive approach designed to standardise practice and speed up appropriate discharge. Under the Anticipate it implies all assessments relate to the patient – we would also suggest including Adult Social Care Carers Assessments to ensure the unpaid carer is assessed for their ability to take on the level of care required following hospital discharge to a home setting. More often this assessment happens at the point of discharge as it involves integrated conversations with Adult Social Care and is not about the patient.
- **Discharge Lounge**
  There have been some concerns raised about the length of time patients have to wait in the ROH Discharge Lounge. We welcome the aim for more timely discharge from beds, but would also

encourage initiatives to reduce waiting times in the Discharge Lounge often due to medication and pharmacy delays.

Targets

- **Cardiac Arrest Rate**
  It is very positive that there has been a reduction in the cardiac arrest rate of 7% since November 2016. The target of a 50% reduction by December 2018 is quite challenging, will the roll out of the change package enable the Trust to reach the target reduction in the timeline set?
- **Infection Prevention**
  The Trust set itself a target of 50% reduction of hospital C-diff by April 2018 and achieved 26% - is the target realistic?
- **Pressure Ulcers**
  The percentage targets look very impressive across the different ulcer types. However, it isn't clear how this translates into actual numbers as a starting point and how these numbers compare nationally.
- **Nursing Assessment and Accreditation System**
  We really welcome this approach to support and develop nursing teams. It would help to understand if the Trust is looking only for clinical improvements here or if this also covers patient experience. If it does include patient experience it would be helpful to include details of how patient feedback will be gathered and used as part of the Accreditation System.
- **End of Life and Bereavement Care**
  Again, this is a really positive development but it would be good to hear how the family/carer voice is included in feedback mechanisms to understand performance.

#End PJ Paralysis

This is a positive campaign and public awareness of the issue would help people understand the importance of getting people up about and discharged is key to a person's health and not simply about the prevention of bed blocking. It would be good to know how the falls prevention work is sustained through transition back into a community setting both with this initiative and with the work to reduce the number of inpatient falls. It would be good to see examples that bring voluntary/community organisations in to run seated exercise and memory sessions to reduce demand on staff and help people transition into these activities in a community setting. This would also help underpin the integration of services.

Tops or pants?

Encouraging real time comments both positive and negative, with the aim of improving service improvement is a constructive approach by the Trust and shows a strong willingness to understand and respond patient's views, carers and family views.

It would be helpful to have more information about the number of comments received and changes made as a consequence and how this approach can be rolled out to other inpatient settings.

National Dementia Audit

We have received some negative views about how carers/families have been involved in the care of their family member, so the Trust's recognition and work to improving the role of carers and families through the John's Campaign is a welcome approach.

Reporting Against Core Indicators

- **Ensuring that people have a positive experience of care**
  Figures from the CQC national survey and the Trust's local Family and Friends surveys present very different readings of patient experience of care. Either way the Trust falls below national averages. We welcome the commitment by the Trust to continue to learn from patient experience gained through a range of different mechanisms and would strongly encourage feedback to be collated on a regular basis and analysed routinely as part of a high level strategy. This could be included as a key strand in the Quality Improvement Strategy and allocated to a senior lead within the Trust. Currently it is not clear how public and patient feedback is included as a central component to help measure quality and performance as part of the Quality Improvement Strategy.

Annex 2:
Statement of responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to April 2018
  - Papers relating to quality reported to the board over the period April 2017 to April 2018
  - Feedback from commissioners dated 21/05/2018 (MHCC) and 18/05/2018 (Bury, HMR and Oldham CCG)
  - Feedback from local Healthwatch organisations dated 11/05/2018
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018.
  - The 2017 national patient survey 17/10/2017
  - The 2017 national staff survey 06/03/2018
  - The annual governance statement taken to audit committee on 24/05/2018
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and;
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they compiled the above requirements in preparing the Quality Report.

By order of the board.

Date: 25 May 2018

James J Potter
Chairman

Date: 25 May 2018

Sir David Dalton
Chief Executive &
Accounting Officer

Independent Practitioner's Limited Assurance Report to the Board of Directors of Pennine Acute Hospitals NHS Trust on the Quality Report.

We have been engaged by the Board of Directors of Pennine Acute Hospitals NHS Trust to perform an independent limited assurance engagement in respect of Pennine Acute Hospitals NHS Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations"). NHS Trusts have the option to include these quality account requirements in a quality report, together with additional requirements for quality reports set out in 'Detailed requirements for quality reports 2017/18' issued by NHS Improvement.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- A&E Waiting Times (% of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge)
- RTT Patient Pathways (% of incomplete pathways within 18 weeks for patients on incomplete pathways)

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

As the Trust has opted to produce a Quality Report for 2017/18 the directors are also responsible for the content and the preparation of the Quality Report in accordance with the additional requirements set out in the 'Detailed requirements for quality reports 2017/18' issued by NHS Improvement .

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 Regulations and "Detailed requirements for quality reports 2017/18';
- "Detailed requirements for quality reports 2017/18';
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; 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 "Detailed requirements for quality reports 2017/18' and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the Regulations and the "Detailed requirements for quality reports 2017/18', and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to April 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to April 2018;
- Feedback from commissioners dated 21 May 2018 from Manchester Health and Care Commissioning;
- Feedback received from Bury, HMR and Oldham CCGs on 18 May 2018;
- feedback from local Healthwatch organisations dated 11 May 2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018
- Multilateral Contract Performance Report dated March 2018 highlighting complaints received in the year;
- the national patient survey dated 17 October 2017
- The local national staff survey dated 6 March 2018
- the local patient survey reports - the 2017 national staff survey;
- the annual governance statement taken to Audit Committee on 24 May 2018;
- the Care Quality Commission inspection report dated 1 March 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2018;

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.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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 Board of Directors of Pennine Acute Hospitals NHS Trust as a body, to assist the Board of Directors in reporting Pennine Acute Hospitals NHS Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Board of Directors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body, and Pennine Acute Hospitals NHS Trust NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the "Detailed requirements for quality reports 2017/18' to the categories reported in the Quality Report; and
- 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 that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the Regulations and 'Detailed requirements for quality reports 2017/18'.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Pennine Acute Hospitals NHS Trust.

Our audit work on the financial statements of Pennine Acute Hospitals NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Pennine Acute Hospitals NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Pennine Acute Hospitals NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Pennine Acute Hospitals NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Pennine Acute Hospitals NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Pennine Acute Hospitals NHS Trust and Pennine Acute Hospitals NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the Regulations and the "Detailed requirements for quality reports 2017/18';
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the "Detailed requirements for quality reports 2017/18' and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

Grant Thornton UK LLP Chartered Accountants
Manchester

Date: 25 May 2018

Glossary of definitions

Term	Explanation
Acute medical unit (AMU)	AMU is a short-stay department which acts as the first point of entry for patients who are either referred to hospitals as emergencies by their GP or who require admission from the emergency department.
Advancing Quality	Is a regional quality improvement programme facilitated by AQuA. Its stated aim is to improve standards of healthcare provided in NHS hospitals across the North West of England and to reduce variation in clinical practice. There are 2 scores provided in the quality accounts: • Appropriate Care Score (ACS) shows the percentage of the AQ population receiving the whole bundle of AQ defined best practice measures • Composite Process Score (CPS) shows the percentage of AQ measures met across the whole AQ population
ADNS	Assistant Director of Nursing Services. A job role in the hospital relating to nursing management.
ADT	Admission, discharge and transfer system.
AKI	Acute kidney injury, previously known as acute renal failure is damage to kidneys which prevents them from functioning properly.
Allied Health Professionals (AHPs)	AHPs provide treatment and help to rehabilitate patients and work across a wide range of different settings. They frequently work alongside doctors, nurses and other healthcare professionals. Examples of AHPs include Dietitians, Occupational Therapists and Physiotherapists.
Bed days	A bed-day is a day during which a person if confined to a bed and in which the patient stay overnight in a hospital.
Breakthrough Series Collaborative (BTS)	A Quality Improvement methodology undertaken at Pennine Acute.
Care bundle	A group of interventions which are proven to treat a particular condition.
Catheter	Catheters are medical devices that are inserted into the body to treat diseases or perform a surgical procedure. Catheters are used for many reasons for example, draining urine and in the process of haemodialysis.
Catheter associated urinary tract infection (CaUTI)	An infection which is believed to have been caused by a urinary catheter.
CCG	Clinical Commissioning Group responsible for most healthcare services available within a specific geographical area.
Change package	A group of changes or interventions developed to help tackle a particular problem or make an improvement.
Clostridium difficilie (C Diff)	A type of infection.
Collaborative	Working together towards a shared purpose.
Control chart/SPC chart	Control charts, also known as Shewhart charts or process control charts (SPC charts), are graphs used to determine whether or not a process is stable. This is helpful in monitoring performance and monitoring improvement work. If there is an active improvement effort going on, these tools can also be used to determine if an improvement has been made.
COPD	Chronic obstructive pulmonary disease. The name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.
CQC	Care Quality Commission- the independent regulator of all health and social care services in England.
CQUIN	Commissioning for quality and innovation. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Term	Explanation
Deep vein thrombosis (DVT)	A blood clot occurring in the deep veins of the leg.
Dementia	Condition includes symptoms such as memory loss and confusion.
Department of Health	Ministerial department responsible for government policy for health care in England.
Driver diagram	A Quality Improvement tool which helps to visualise the aims, drivers and change ideas for a particular improvement project.
E-observations	Patient observations which have been recorded electronically within our e-observation system, Patientrack.
Executive Team	The most senior managers in the Trust consisting of the Group Chief Executive Officer, the Group Chief Nursing Officer, the Group Chief Medical Officer, the Group Chief Finance Officer, the Group Chief Strategy and Organisational Development Officer and the Group Chief Delivery Officer.
General Medical Practice Code	Organisation code of the GP Practice that a patient is registered with.
GP	General Practitioner.
Harm	An unwanted outcome of care intended to treat a patient.
Hospital Episode Statistics	A data warehouse containing details of all admitted patient care, outpatient attendances and A&E attendances in England.
Hospital Standard Mortality Ratio (HSMR)	A system which compares expected mortality of patients to actual mortality based on a patients' risk of dying.
Huddle/Safety huddle	A brief meeting which often occurs at the start or finish of shifts in care areas.
Human Factors	Study of human behaviour and the influence that this has on an environment.
IG toolkit	Information Governance Toolkit is a performance tool produced by the Department of Health.
Intervention	A treatment which is intended to improve a patient's condition.
Intermediate care units	Units which patients go to when they no longer require the acute care of the hospital but are not yet ready to go home.
Mersey Internal Audit Agency (MIAA)	Provide external audits and diagnostics for the Trust.
Maternity Early Warning Score (MEWS)	Early warning tool which aims to improve maternal morbidity through the recording of physiological observations to identify deterioration.
Morbidity	Morbidity comes from the word morbid, which means "of or relating to disease".
Mortality	Mortality relates to death. In health care mortality rates means death rate.
MRSA	Methicillin-resistant staphylococcus aureus (MRSA) is a type of infection.
Multi-disciplinary Team (MDT)	A team consisting of members of staff from different professional groups, for example doctors, nurses, physiotherapists and pharmacists.
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice following a patient death.
North East Sector Care Organisations	The Bury and Rochdale, North Manchester and Oldham Care Organisations (otherwise referred to as Pennine Acute) are together referred to as the North East Sector Care Organisation.
Never event	Never events are patient safety incidents that are preventable and should not occur because: ● there is guidance that explains what the care or treatment should be; ● there is guidance to explain how risks and harm can be prevented; ● there has been adequate notice and support to put systems in place to prevent harm from happening.

Term	Explanation
NEWS/EWS	National Early Warning Score- the NEWS is a scoring system in which a score is allocated to six physiological measurements in order to detect and respond to clinical deterioration. The NEWS was developed by the Royal College of Physicians to provide system-wide standardisation in the measurement and documentation of physiological observations.
NHS England	Executive non-departmental public body, sponsored by the Department of Health.
NHS Improvement	Responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care.
NHS Quest	NHS Quest is a network for Foundation Trusts who wish to focus relentlessly on improving quality and safety.
NICE	National Institute of Clinical Excellence- an independent organisation that provides national guidance and standards on the promotion of good health and the prevention and treatment of ill health.
Nursing Assessment and Accreditation System (NAAS)	The NAAS is designed to support nurses and the wider ward teams to understand how they deliver care and where further improvements are needed. The NAAS measures specific aspects of safety, cleanliness, nursing care and multi-disciplinary working. Wards are then allocated a rating of red, amber or green.
Oesophago-gastric cancer	Refers to cancer of the oesophagus (gullet).
PDSA	The 'Plan, Do, Study, Act' cycle is a Quality Improvement methodology which provides a framework for developing, testing and implementing changes leading to improvement. Using PDSA cycles enables teams to test out changes on a small scale, building on the learning from these test cycles before wide scale implementation.
Process mapping	Process mapping is a tool through which a system/process is visually mapped out in order to identify opportunities for improvement to improve patient experience of make efficiencies.
Prophylaxis	Preventative medicine or care.
Quality Improvement	Quality Improvement is a systematic approach which uses specific techniques and methodologies to improve quality.
Quality Improvement strategy	A document which outlines the aims and objectives of the Trust relating to patient safety and improving quality.
Rapid assessment and treatment model (RAT)	Is a model used within emergency departments to provide early senior assessment of patients in order to improve patient safety and flow within the department.
Red flag sepsis	Is a definition from the national Sepsis Trust which identifies a set clinical parameters. The presence of one of these parameters in the context of infection define sepsis as high risk of death with a requirement for urgent treatment.
Reliability science	The science relating to ensuring that all processes and procedures perform their intended function.
Root cause analysis (RCA)	A method of problem solving that tries to identify the root causes of issues and why they are happening.
Run charts	Run charts are graphs used to display data for quality improvement purposes. Run charts are easier for teams to work with than control charts, although they may be less statistically sensitive. Run charts are helpful for monitoring performance and improvement work. If there is an active improvement effort going on, these tools can be used to determine if an improvement has been made.
SAFER	The SAFER patient flow bundle is made up of five elements of best practice which, when implemented, helps to reduce delays for patients in adult inpatient wards.
Safety thermometer	A point of care survey which is used to record the occurrence of four types of harm (pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism).

Term	Explanation
Secondary uses service	Is a single comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
Sepsis	A life-threatening condition caused when the body is overcome by infection.
SHMI	The Summary Hospital-level Mortality Indicator reports on mortality at trust level across the NHS in England.
SSI (surgical site infection)	A healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure.
Steering group	A group of people who are involved in the management of a piece of work or a project.
Thrombosis	Formation of blood clots within a vessel.
Urinary catheter	A device which is placed into a patient's bladder for the purpose of draining urine.
Venous Thromboembolism (VTE)	A blood clot forming within a vein.
WHO	World Health Organisation.

Accountability Report

Corporate Governance Report

The purpose of the corporate governance report is to explain the composition and organisation of the Trust's governance structures and how they support the achievement of the entity's objectives.

The Directors' Report

The Board of Directors operates according to the highest corporate governance standards. It is a unitary board with collective responsibility for all aspects of the performance of Pennine, including financial performance, clinical and service quality, management and governance. The Pennine Board of Directors comprises the Chairman, 3 Non-Executive Directors and 4 Executive Directors. Additionally, this included the Executive Director of Workforce until 31st May 2017.

Composition of the Pennine Board of Directors

Sir David Dalton
Chief Executive Officer

Sir David has been a Chief Executive for over 20 years; he has a strong profile, both locally within Greater Manchester, and also nationally in the areas of quality improvement and patient safety. In addition to his role at Pennine, Sir David is the Chief Executive of Salford Royal and appointed as the Chief Executive Officer for the Group CiC in March 2017.

Mrs Elaine Inglesby-Burke CBE
Executive Nurse Director

Elaine qualified as a Registered Nurse in 1980 at Warrington District General Hospital and specialised in critical care and general medicine and held various clinical positions at Ward level and Nurse Specialist. In addition to her role at Pennine, Elaine is the Executive Nurse Director at Salford Royal and was appointed Chief Nursing Officer for the Group CiC in March 2017.

Mr Damien Finn
Executive Director of Finance

Damien joined Pennine as the Executive Director of Finance in September 2015. He has 25 years' experience in the NHS in a variety of finance positions, working at very high performing acute hospitals. From April 2017 Damien was appointed as the Chief Officer for North Manchester Care Organisation, assuming full responsibility for all matters relating to the North Manchester site.

Professor Matthew Makin
Executive Medical Director

Matt has been the Medical Director of Pennine since March 2016, supporting the improvement plan and initiatives allied to the devolution of health and social care in Greater Manchester. Prior to this he has held national leadership roles in neurology, neurosciences and cancer and had been involved in Health Policy in NHS Wales. Matt was appointed as the Medical Director for the North Manchester Care Organisation in April 2017.

Mr Jon Lenney
Executive Director of Workforce

Jon stood down on 31st May 2017.

Non-Executive Directors

Mr James (Jim) Potter
Chairman

Jim spent most of his working life in electrical engineering, initially as an engineer before moving into management. In 1990 Jim was made Managing Director of a packaging company based in Salford, a position he held until July 2016. In addition to his role at Pennine, Jim is the Chairman at Salford Royal.

Mr John Willis CBE
Non-Executive Director/Chairman of Audit Committee

John is a qualified accountant and was Chief Executive of Salford City Council from 1992 until his retirement in 2006. In addition to his role at Pennine, John is the Vice-Chairman/Chairman of Audit Committee at Salford Royal.

Mrs Diane Brown
Non-Executive Director

Diane has over 30 years' experience as a HR Director, Talent Director and Global Business Partner. Diane has worked with Senior Global Leaders in FTSE 100 companies including AstraZeneca Pharmaceuticals, M&S Money and Marks and Spencer PLC. Diane is a Fellow of the Chartered Institute of Personnel and Development. In addition to her role at Pennine, Diane is the Senior Independent Director at Salford Royal.

Mrs Christine Mayer CBE
Non-Executive Director

Christine was Chief Executive of Her Majesty's Court Service, accountable for the day to day operation of 550 court centres across England and Wales until 2010. Christine is a consultant in leadership and executive coaching and is an associate with Fiona Macneill Associates. Christine has been a Non-Executive Director at Pennine since 2011 and is also a Non-Executive Director of Salford Royal.

The Board of Directors is legally accountable for the services provided by Pennine, and has delegated the exercise of all functions (other than those required by law, and/or as set out within the Scheme of Reservation of Powers & Delegation of Powers) to the Group CiC, whose key responsibilities include:

- Setting the Trust's vision and governing objectives, with due regard to the ultimate intention of Salford Royal to establish an alliance operation with Pennine;
- setting the Group and Trust's strategic direction (having taken into account the Council of Governors' views) and providing direction to the Care Organisations;
- leading the development of the Trust's workforce and deliver the Trust's Workforce and Talent Management Strategy in conjunction with Care Organisations;
- ensuring that adequate systems and processes are maintained to deliver the Annual Plan;
- setting Group-wide processes and standards (clinical and non-clinical) applicable across Trusts and all Care Organisations;
- ensuring effective processes are in place for regular audit of clinical standards and patient experience to support performance data provided by the Care Organisations;
- ensuring robust governance arrangements are in place supported by an effective assurance framework that supports sound systems of internal control;
- ensuring effective arrangements are in place for holding the Care Organisations to account for the performance of the business;
- leading capability development and provide scale for improvement in Care Organisations

Composition of the Group Committees in Common

The Group CiC comprises the Chairman and six Non-Executive Directors along with six Executive Directors; the Chief Executive, Chief Medical Officer, Chief Nursing Officer, Chief Financial Officer, Chief Strategy & Organisational Development Officer and Chief Delivery Officer. Care Organisation Chief Officers are non-voting members of the Group CiC.

Executive Directors and Non-Voting Members

Sir David Dalton
Group Chief Executive Officer

Mrs Elaine Inglesby-Burke CBE
Chief Nursing Officer

Mr Chris Brookes
Chief Medical Officer

Chris continues to practice as a Senior Consultant in A&E and has a strong focus on reducing mortality and morbidity and infection control. In March 2017, Chris was appointed Chief Medical Officer for the Group CiC in addition to his post as Executive Medical Director for Salford Royal.

Mr Ian Moston
Chief Financial Officer

Ian began his NHS career in 1991 as a Regional Financial Management Trainee and has held Finance Director positions in Primary Care, Acute and Intermediate Tier organisations since 2005. In addition to his role as Executive Finance Director at Salford Royal, Ian was appointed as Chief Financial Officer for the Group CiC in March 2017.

Mrs Judith (Jude) Adams
Chief Delivery Officer

Jude has over 30 years experience in the NHS, starting her career as a Registered Nurse in the North West region and then working in London based hospitals, before moving into operational management. In addition to her role as Executive Director of Group Delivery at Salford Royal, Jude was appointed as Chief Delivery Officer for the Group CiC in March 2017.

Mr Raj Jain
Chief Strategy & Organisational Development Officer

Raj spent the early part of his career in the oil and gas industry. He is an economist by training and a Human Resources and Organisational Development professional. Raj has held senior roles in a number of NHS Trusts, including Chief Executive, and Managing Director of the Greater Manchester Academic Health Science Network. In addition to his role as Executive Director of Corporate Strategy and Business Development at Salford Royal, Raj was appointed as Chief Strategy and Organisational Development Officer for the Group CiC in March 2017.

Mr Steve Taylor
Chief Officer Bury & Rochdale Care Organisation
(Non-voting member of the Group Committees in Common)

Steve has successfully worked at clinical and managerial levels within the NHS for over 30 years. He trained in Rochdale as a Registered General Nurse in 1987 and went on to work in A&E departments in Oxford and Manchester. In April 2017 Steve was appointed as the Chief Officer for Bury & Rochdale Care Organisation, assuming full responsibility for all matters relating to the Bury & Rochdale sites and its community services.

Donna McLaughlin
Chief Officer Oldham Care Organisation
(Non-voting member of the Group Committees in Common)

After graduating from Oxford University as a history graduate, Donna joined the NHS through the National General Management Training Scheme, and during her career has held a number of Director level operational roles. In April 2017 Donna was appointed as the Chief Officer for Oldham Care Organisation, assuming full responsibility for all matters relating to the Oldham site. Donna stood down on 31st March 2018.

Mrs Nicola Firth
Interim Chief Officer Oldham Care Organisation
(Non-voting member of the Group Committees in Common)

Nicola qualified as a Registered Nurse in 1992 working in a number of clinical specialties before progressing into Associate Director level roles. Nicola joined Pennine in October 2016 as Director of Nursing at the Oldham Care Organisation and, from 1st April 2018, was appointed as the Interim Chief Officer for Oldham Care Organisation, assuming full responsibility for all matters relating to the Oldham site.

Mr Damien Finn
Chief Officer North Manchester Care Organisation
(Non-voting member of the Group Committees in Common)

Mr James Sumner
Chief Officer Salford Care Organisation
(Non-voting member of the Group Committees in Common)

James began his NHS career in primary care and has held a number of roles in commissioning, provider and regional health organisations. James brings years of experience in operational management in Board Level Executive roles and, for the last two years, was Deputy Chief Executive at a nearby NHS Foundation Trust. In March 2017 James was appointed as the Chief Officer for Salford Care Organisation, assuming full responsibility for all matters relating to the Salford site and its community services, and is a non-voting member of the Group CiC.

Non-Executive Directors

Mr James (Jim) Potter
Chairman

Mr John Willis CBE
Non-Executive Director/Chairman of Audit Committee

Mrs Diane Brown
Non-Executive Director

Mrs Christine Mayer CBE
Non-Executive Director

Mrs Rowena Burns (stood down 31st July 2017)
Non-Executive Director

Rowena's early career was spent with Greater Manchester Passenger Transport Authority and Manchester City Council working in a variety of transport and economic development roles, including the first phase of Manchester's Metrolink system. Rowena has had a number of roles with Manchester Airport Group, Bruntwood and Manchester Science Parks with a brief for acquisition, economic regulation and overall business strategy. Rowena was also a Non-Executive Director at Salford Royal and stood down at the end of July 2017.

Professor Chris Reilly
Non-Executive Director

Chris is a scientist and business leader with over 30 years' experience in medical research, life science consultancy and venture capital in the UK, USA and Sweden. Chris has a Ph.D in Biochemistry from the University of Georgia and performed his postdoctoral work in the Massachusetts Institute of Technology. Chris is also a Non-Executive Director at Salford Royal.

Dr Hamish Stedman
Non-Executive Director

Hamish was educated at St Andrews and Victoria Universities, qualifying as a Doctor in 1978. He has recently retired from his role as a General Practitioner in Swinton, and Chair of Salford CCG and the Association of Greater Manchester CCGs. Hamish continues as a part time medical officer at St Ann's Hospice in Little Hulton and Neighbourhood Primary Care Lead for Salford Primary Care Together. Hamish is also a Non-Executive Director at Salford Royal.

Mr Kieran Charleson (commenced 1st December 2017)
Non-Executive Director

Kieran is the North West Regional Director for BT Group and represents BT's interests from broadband to broadcast in the region. He has held UK and international leadership roles in the digital sector with IBM and BT over a 30 year period and has extensive experience in developing and leading strategic partnerships. He leads BT's UK engagement with the Federation of Small Businesses and the Institute of Directors. Kieran is also a Non-Executive Director at Salford Royal.

Executive Directors	Responsibilities	Board of Directors' Attendance	Group Committees in Common Attendance
Sir David Dalton	Chief Executive Officer/Group Chief Executive Officer	3/3	9/9
Mr Chris Brookes	Chief Medical Officer	N/A	8/9
Mrs Elaine Inglesby- Burke CBE	Executive Nurse Director/Chief Nursing Officer	2/3	7/9
Mr Ian Moston	Chief Financial Officer	N/A	9/9
Mr Raj Jain	Chief Strategy & Organisational Development Officer	N/A	8/9
Mrs Judith Adams	Chief Delivery Officer	N/A	8/9
Mr Steve Taylor	Chief Officer Bury & Rochdale Care Organisation	N/A	7/9
Donna McLaughlin	Chief Officer Oldham Care Organisation	N/A	6/9
Mrs Nicola Firth	Interim Chief Officer Oldham Care Organisation	N/A	1/1
Mr Damien Finn	Executive Director of Finance/Chief Officer North Manchester Care Organisation	3/3	8/9
Mr James Sumner	Chief Officer Salford Care Organisation	N/A	8/9
Professor Matthew Makin	Executive Medical Director/Medical Director North Manchester Care Organisation	3/3	N/A
Mr Jon Lenney	Executive Director of Workforce	NA	N/A

Non-Executive Directors	Responsibilities	Board of Directors' Attendance	Group Committees in Common Attendance
Mr James Potter	Chairman	3/3	9/9
Mr John Willis CBE	Vice-Chairman/Chairman of Audit Committee	3/3	8/9
Mrs Diane Brown	Non-Executive Director/Senior Independent Director	3/3	8/9
Mrs Rowena Burns	Non-Executive Director	N/A	3/4
Professor Chris Reilly	Non-Executive Director	N/A	9/9
Dr Hamish Stedman	Non-Executive Director	N/A	8/9
Mrs Christine Mayer CBE	Non-Executive Director	3/3	9/9
Mr Kieran Charleson	Non-Executive Director	N/A	1/2

Declaration of Interests of the Board of Directors

The Group CiC, including all members of the Board of Directors, undertakes an annual review of its Register of Declared Interests and compliance with the Fit and Proper Persons Requirements as applicable to all members of Group CiC, the Board of Directors and Care Organisation Leadership Teams. At each meeting of the Group CiC and the Board of Directors a standing agenda item requires all members to make known any interest in relation to the agenda or other matters, and any changes to their declared interests.

The Register of Declared Interests is made available to the public via the Group CiC papers and within the Declarations of Interests Register available on Pennine's website. Members of the public can also gain access by contacting the Group Secretary:

Mrs Jane Burns
Director of Corporate Services/Group Secretary
Group Headquarters
Salford Royal NHS Foundation Trust
Stott Lane
Salford
M6 8HD.

Tel: 0161 206 5185
Email: jane.burns@srft.nhs.uk

Committees of the Pennine Board of Directors

The Pennine Board of Directors has established the following committee:

- Group Committees in Common
- Executive Assurance and Risk Committee

The Group Committees in Common has established the following committees:

- Audit Committee
- Nominations, Remuneration and Terms of Service (NRTS) Committee
- Charitable Funds Committee
- Strategy and Investment Committee
- Group Executive Assurance and Risk Committee
- Group Executive Development Committee

Pennine Executive Assurance and Risk Committee

The Executive Assurance and Risk Committee was established as a standing committee of the Pennine Board with responsibility for the control of risk and provision of assurance to the Board with respect to the overall performance of the Trust. The disaggregation of Pennine into three Care Organisations (North Manchester, Oldham, Bury & Rochdale), commenced in March 2017, with leadership functions devolving to the Care Organisations. To ensure that the new Care Organisations had sufficient infrastructure to assume full management functions over their hospital site(s), including the provision of assurance and escalation of risks to the Group Executive, the Pennine Executive Assurance and Risk Committee continued to meet during 2017/18. Membership included all Executive Directors, senior members of Divisional and Care Organisation Management Teams and key corporate leaders. In March 2018, the Group CiC confirmed that a series of 'Conditions Precedent' which had to be satisfied before the Pennine executive-level governance structure could be removed, and full operational authority transferred to the Care Organisations, had been completed, with a small number of actions transferring to the appropriate Group Committees. To this end, the final meeting of the Pennine Executive Assurance and Risk Committee took place in March 2018.

Audit Committee

The Group CiC has established an Audit Committees in Common for Pennine and Salford Royal, known as the Audit Committee. Audit Committee plays a key role in supporting the Group CiC by critically reviewing and reporting on the adequacy and effectiveness of effective systems of integrated governance, risk management, and internal control that supports the achievement of Group objectives and its constituent Care Organisations. In carrying out this work, the Audit Committee primarily utilises the work of internal and external audit, established committees of within the Group Assurance Framework, specifically the Group Risk and Assurance. Audit Committee also obtains assurance from the views of other external agencies such as the Care Quality Commission.

Non-Executive Directors (with the exception of the Chairman) of the Group CiC are members of Audit Committee. Attendance during 2017/18 was as follows:

Mr John Willis	6/6
Mrs Diane Brown	3/6
Mrs Rowena Burns	0/3
Dr Chris Reilly	6/6
Dr Hamish Stedman	2/6
Mrs Christine Mayer	4/6
Mr Kieran Charleson	0/1

Support for the committee was provided by the Group Secretariat and meetings were attended by the Chief Finance Officer, Deputy Chief Finance Officer, Chief Medical Officer, Chief Nursing Officer, Group Secretary and Internal and External Audit Teams.

During 2017/18, the Trust's Internal Audit function was carried out by Mersey Internal Audit (MIAA). Internal Audit provides an independent assurance service to the Group CiC, Audit Committee and management, focused on reviewing the effectiveness and extent of compliance with the governance, risk management and control processes that the Group and Pennine has put in place. Audit Committee approved the Internal Audit and Anti-Fraud Work Plans for 2017/18 and received regular progress updates with respect to the work and findings of the respective plans.

Pennine's External Auditors regularly attend Audit Committee, providing an opportunity for the committee to assess their effectiveness. The Audit Plan for Pennine was presented to Audit Committee in January 2018, confirming the audit would be conducted with an understanding of the key challenges and opportunities Pennine was facing. The Audit Committee received assurance that the audit would consider the impact of key developments in the sector and take account of national audit requirements and ensure compliance with International Standards on Auditing (ISAs).There were no other significant facts or matters that may impact on the External Auditors independence drawn to Audit Committee's attention during 2017/18.

At its meeting in April 2017, the Audit Committee reviewed the first draft of the Annual Report, including the Annual Governance Statement, Quality Report and unaudited Accounts 2016/17.This was followed by further review and approval, prior to submission to NHS Improvement, at the meeting in May 2017. Audit Committee also received the External Auditors Findings Report (ISA 260) in May 2017.

As the year began, Audit Committee reviewed the opening Pennine Board Assurance Framework and confirmed that the strategic and operational risks identified were fully aligned to the Annual Plans submitted to NHSI. As Audit Committee's relationship with the Group Risk and Assurance Committee (GRAC) developed during the year, a number of matters were referred to and from committee meetings. Following a 'limited assurance' internal audit of Pennine's Medical Job Planning, and the agreement of management action, Audit Committee continued to monitor progress, and, in January 2018, when it was noted that timescales for completion of medical job planning had not been achieved, requested escalation of this matter to the GRAC. Audit Committee emphasised the importance of high quality medical job planning, appraisals and control processes for annual and study leave to support the delivery of the objectives of the Care Organisations and Pennine, and the control of agency costs. Further comprehensive review and discussion at GRAC, arrangements were made for Chief Officers to report progress to the Group CiC in January 2018, and provide assurance regarding this matter within the Statements of Assurance from April 2018.

In the review of internal audit and management assurance reports, Audit Committee identified significant and cross cutting issues with respect to the fragility of the IM&T infrastructure across Pennine. Further to this, the Strategy and Investment Committee, comprising the Chairman, all Non-Executive Directors and Executive Directors, reviewed and supported a priority investment case to stabilise and transform IM&T infrastructure for Pennine prior to request for approval by Group CiC.

The Audit Committee is authorised by the Group CiC to investigate any activity within its terms of reference and to seek any information it requires from staff. Senior managers from the NCA (including the Care Organisation Medical Directors, Chief Strategy & Organisational Development Officer, Director of Workforce, Head of Clinically Coded Data and Standards Assurance, Director People & Organisational

Development, Group Procurement Director) attended meetings during 2017/18 to provide a deeper level of insight into key issues within their respective areas of expertise.

In addition to reviewing key finance related matters, including losses and special payments reports and reviewing and approving write-off of non-NHS debtors, Audit Committee undertook a detailed mid-year financial review for Pennine in the form of an updated Going Concern Report, providing financial outlook until March 2019.

In October 2017, Non-Executive Directors embarked on a site visit programme across all services, wards and departments of the NCA; allowing Non-Executive Directors to triangulate information gathered during the site visits with that presented to the Group CiC and Audit Committee, for the purpose of gaining assurance and obtain feedback from staff and patients. The visits enable NEDs to further understand how the organisation works and the impact of Board-level decisions on clinical services.

During 2016, Pennine and Salford Royal aligned their selection processes for an External Auditor, awarding two organisational contracts to a single External Auditor firm. In December 2016, the Board of Directors approved the appointment of Grant Thornton as the External Auditor for Pennine for a period of three years (conducting the 2017/18, 2018/19 and 2019/20 audits), with an option for this to be extended by a further 1 year subject to mutual agreement.

In January 2018, Audit Committee reviewed and refreshed the robust policy in place for the engagement of the External Auditor for Non-Audit Work.

Nominations, Remuneration and Terms of Service (NRTS) Committee

The Group CiC has established a Nominations, Remuneration and Terms of Service Committees in Common for Pennine and Salford Royal, known as the Nominations, Remuneration and Terms of Service (NRTS) Committee to consider matters pertinent to the nomination, remuneration and associated terms of service for Executive Directors (including the Chief Executive), matters associated with the nomination of Non-Executive Directors and remuneration of senior managers/clinical leaders. Further information regarding the NRTS Committee can be found in the Remuneration Report.

Charitable Funds Committee

A Charitable Funds Committees in Common for Pennine and Salford Royal has been established with responsibility for the on-going management of charitable funds on behalf of the Corporate Trustees. The membership of the Charitable Funds Committee comprises all Non-Executive Directors.

Strategy and Investment Committee

The Strategy and Investment Committee provides independent and objective review of, and assurances, in relation to major strategic initiatives, including investments/divestments of activities which significantly broaden, diversify or reduce the NCA activity base, and ensure their alignment with the Group CiC approved strategy and risk framework.

Group Risk and Assurance Committee

The Group Risk and Assurance Committee has responsibility for providing assurance on the control of risk, including monitoring of all board level risks via the Board Assurance Framework, overseeing the Group's Single Oversight Framework which includes receiving the Care Organisation Statements of Assurance and review Care Organisation Assurance Frameworks/Risk Registers.

Group Executive Development Committee

The Group Executive Development Committee oversees the development and delivery of NCA's strategic ambitions, and takes appropriate action to mitigate risk.

Standing Committee Reporting Arrangements

The Group CiC receives report on the work of each of its standing committees following each meeting. A comprehensive reporting cycle has been established for the Group CiC and its subcommittees to ensure timely review of an appropriate range of matters.

Membership and Group Council of Governors

Membership is a key vehicle through which Pennine embraces patient and public engagement. Pennine's membership scheme provides opportunity for members and the public to share their experiences of services to help inform and influence service improvement and redesign. Engaging with members, patients and the local public ensures views of local people help improve the experience for patients, visitors and staff and their views are taken in to consideration when making plans for the year ahead.

The Pennine membership is made up of public and staff members.

Public Members

We have four public member constituencies. All members of the public who are 14 years old or over, living in one of the following constituencies can become a member:

- Bury & Rochdale
- North Manchester
- Oldham
- Rest of England and Wales

The table below highlights Pennine actual membership figures for 31st March 2018

Public Members	Actual 31st March 2018
Bury & Rochdale	6042
North Manchester	2419
Oldham	3474
Rest of England and Wales	449
Total	**12384**

Staff Members

We have three staff member constituencies reflective of the Care Organisations: Bury & Rochdale, Oldham and North Manchester

Staff Members	Actual 31 March 2018
Bury & Rochdale	2789
Oldham	3311
North Manchester	3236
Total	**9336**

Membership Recruitment

Recruitment of new members is an ongoing activity to ensure overall membership numbers are maintained, whilst focussing on those areas where membership is under represented i.e. young people. Over the last 12 months we have continued to visit schools and colleges across the boroughs to encourage students to join as members.

Membership Engagement

During 2017/18, Pennine communicated with members, patients and the public regularly using a range of communication channels and feedback mechanisms, these include:

- Members' Newsletter – Your hospitals, Your Pennine
- Pennine Website
- Medicine for Members – Talks and Tours
- Open Day and Annual Members' Meeting 2017
- Social Media

In October 2017, Pennine hosted its' Open Day and Annual Public Meeting. The Open Day was an opportunity for staff and services to showcase their work including; the Oasis Medical Dementia Unit, the Trust's award winning stroke service, liver disease, older people's services, volunteering and the infection control team providing free flu jabs. At the Annual Public Meeting members received an update on key strategic developments, the work undertaken to significantly improve patient safety and services following the CQC Inspection in 2016, and had a chance to ask questions to the Executive Team.

Medicine for Member Events

Over the past twelve months we have held over 20 'Medicine for Members' events on various health related topics including :

- Wolstenholme Intermediate Care Unit Talk & Tour
- 'Living With & Beyond Cancer'
- 'Snoring Sometimes Matters'– Sleep Apnoea Seminar
- 'Inflammatory Bowel Disease' Seminar
- Neuro-Rehabilitation Talk & Tour of the Floyd Unit
- 'Learning Disabilities & Autism Seminar

- Health & Wellbeing/Mindfulness Seminar
- Liver Disease Seminar
- Maggies Centre Talk and Tour
- Oasis Dementia Unit Talk & Tour
- Pressure Ulcer Talk Seminar
- Dinwoodie (Clinical Skills & Simulation Suite) Talk &Tour
- Interventional Radiology Open Day

These events were attended by over 500 members and people from the local communities.

In December 2017 we conducted an Annual Public and Members' Survey, which this year focused on our how we best communicate with members and finding out what matters most when using our services. With nearly 500 responses the results will help us to develop our new Group strategies and patient experience work going forward.

Group Council of Governors

In March 2017 Salford Royal's Council of Governors approved bold changes to its own composition; and agreed to establish a subcommittee of the Salford Royal Council of Governors; the Shadow Group Council of Governors. Bearing resemblance to the establishment of the Group CiC to which the Boards of Salford Royal and Pennine delegated their functions, the Shadow Group Council of Governors, (known as the Group Council of Governors) would include both Salford Royal Governors and Shadow Pennine Governors, elected from the Pennine membership, and would assist the Council of Governors in carrying out its functions.

Between August 2017 – October 2017 Salford Royal held elections for Governors and Shadow Governors across the NCA footprint.

Group Council of Governors

Constituency	Number of Positions Available	Number of Nominations Received
Public		
Salford	5	15
Bury and Rochdale (Shadow)	5	15
Oldham (Shadow)	3	6
North Manchester (Shadow)	2	2
Staff		
Salford – Clinical Support Services & Tertiary Medicine	1	2
Salford – Surgery and Neurosciences	1	1
Bury and Rochdale (Shadow)	2	2
Oldham (Shadow)	2	2
North Manchester (Shadow)	2	3

Following successful elections, the composition of the Group Council of Governors from 3rd October 2017 to 31st March 2018 was as follows

Public Elected Governors		
James Collins	Salford	3 years (2020)
David Pike (Lead Governor)	Salford	3 years (2020)
Chris Mullen	Salford	3 years (2020)
Gill Collins	Salford	2 years (2019)
Charlotte Layton	Salford	2 years (2019)
Sandra Breen	Rest of England and Wales	3 years (2019)
Jeredine Benjamin	Rest of England and Wales	3 years (2019)
Shadow Public Elected Governors		
Sylvia Edney	Bury and Rochdale	3 years (2020)
Marie Douglas	Bury and Rochdale	3 years (2020)
Terri Evans	Bury and Rochdale	3 years (2020)
Shaun Furlong	Bury and Rochdale	2 years (2019)
Luise Fitzwalter	Bury and Rochdale	2 years (2019)
Robert Scott	Oldham	3 years (2020)
Ivy Ashworth-Crees	Oldham	3 years (2020)
Fabiha Chowdhury	Oldham	3 years (2020)
Maurice Gorton	Oldham	2 years (2019)
Kevin Thomas	North Manchester	3 years (2020)
Mohammad Shafiq	North Manchester	2 years (2020)
Staff Elected Governors		
Deborah Seddon	Clinical Support and Tertiary Services	3 years (2020)
Nicola Kent	Corporate & General Services	3 years (2019)
Agnes Leopold-James	Salford Healthcare	3 years (2019)
Sheila Tose	Surgery and Neurosciences	3 years (2020)
Shadow Staff Elected Governors		
Margaret Sweetmore	Bury and Rochdale	3 years (2020)
Amanda Chesney	Bury and Rochdale	2 years (2019)
Julia Riley	Oldham	3 years (2020)
Georges Ng Man Kwong	Oldham	2 years (2019)
Mireia Cassou	North Manchester	3 years (2020)
Philippa Jones	North Manchester	2 years (2019)
Appointed Governors		
Nick Grey	University of Manchester	3 years (2019)
Cllr Richard Critchley	Salford City Council	3 years (2020)
Shadow Appointed Governors		
Brian Boag	Salford University	3 Years (2020)
Vacant	Local Authority Governor	3 Years (2020)
Vacant	Local Authority Governor	3 Years (2020)

The overriding role of the Council of Governors is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of members and of the public. A comprehensive induction and training and development programme for Governors commenced immediately to support all Governors in their new roles.

There are a number of easy ways for you to communicate with the Group Council of Governors

Email: membership@pat.nhs.uk or foundation@srft.nhs.uk

Tel: 01706 517302

Website: http://www.pat.nhs.uk/get-involved/council-of-governors.htm

Write to your Governor at:
Membership Department
Rochdale Infirmary
Whitehall Street
Rochdale
OL12 0NB

Group Council of Governors' Register of Interests

All Governors are required to comply with the Code of Conduct for Governors and declare any interests that may result in a potential conflict of interest in their role as Governor. The register of interest is publicly available via the Council of Governors' Meeting Minutes on Salford Royal's website. In addition, the register can be obtained via the Group Secretary at the following address

Group Headquarters
Salford Royal NHS Foundation Trust
Stott Lane
Salford
M6 8HS
Tel: 0161 2063133
Email: foundation@srft.nhs.uk

Personal Data

It is a requirement of the Department of Health and Social Care Group Accounting Manual to provide information on personal data related incidents where these have been formally reported to the information commissioner's office. During the period 1st April 2017 – 31 March 2018, there have been 2 personal data incidents formally reported to the Information Commissioner's Office; further information can be found in the Annual Governance Statement. The Trust is working within time constraints to have all systems and processes functioning at the correct level to support the General Data Protection Regulations which will become law on 25 May 2018.

Statement Regarding Information Relevant to External Audit

All Directors of Pennine, and members of the Group CiC, have undertaken to abide by the provisions of the Code of Conduct for Board Level Directors, this includes ensuring that each Director at the time that this Annual Report is approved:

- so far as each director is aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- each 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 Trust's auditor is aware of that information.

The provisions of the Code of Conduct also confirm, and directors have undertaken to have taken all the steps that they ought to have taken as a director in order to do the things mentioned above and:

- made such enquiries of his/her fellow directors and of the company's auditors for that purpose; and
- taken such steps (if any) for that purpose, as are required by his/her duty as a director of the company to exercise reasonable care, skill and diligence.

Modern Slavery Act 2015 – Transparency in Supply Chains

The Pennine Acute Hospitals NHS Trust is committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation.

We realise that slavery and human trafficking can occur in many forms, such as forced labour, domestic servitude, sex trafficking and workplace abuse.

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, we have a strict set of values that we use as guidance with regard to our activities. We therefore would expect that all suppliers to the Trust adhere to the same principles.

As part of our commitment, the Trust has reviewed our supply chains and have introduced a 'Supplier Code of Conduct' and have requested all existing and new suppliers to confirm that they are compliant with the Act. Where we use contracts awarded centrally, this is covered by the contract body placing the supplier on their contract / framework agreement.

The Trust's Procurement Procedures have been updated and we use the NHS standard terms and conditions of contract which take account of the Act.

Statement of the Chief Executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Sir David Dalton
Chief Executive
Date: 25 May 2018

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Date: 25 May 2018 **Chief Executive**

Date: 25 May 2018 **Finance Director**

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Pennine Acute Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Pennine Acute Hospitals NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Pennine Acute Hospitals NHS Trust (Pennine) has become part of an alliance established by Salford Royal NHS Foundation Trust (Salford Royal). The Northern Care Alliance NHS Group (NCA) was launched on 1st April 2017. Whilst Pennine and Salford Royal remain statutory bodies, the Boards of both organisations have delegated the exercise of significant functions to the Group Committees in Common (Group CiC). Group CiC comprises all members of the Salford Royal Board of Directors and the Chief Officers of the NCA's four care organisations: Oldham, Bury & Rochdale, North Manchester and Salford.

As the Chief Executive, I am responsible for overseeing risk management across all organisational, financial and clinical activities. I am the chairman of the Group Risk and Assurance Committee, which reports directly to Group CiC and has overarching responsibility for risk management including: the development and implementation of the Group's Assurance Framework and Risk Management Strategy; monitoring of all Group-level risks; overseeing the Group's Single Oversight Framework; and reviewing Care Organisation Assurance Framework/Risk Registers. An important enabler to fulfilling this responsibility has been the development of purposeful interaction between the Group Risk and Assurance Committee and the Group's Audit Committee. Audit Committee provides a key forum through which the Group's Non-Executive Directors bring independent judgement to bear on issues of risk management and performance. The constructive interface between Audit Committee and Group Risk and Assurance Committee supports the effectiveness of the Group's systems of internal control.

Each of the NCA's Care Organisations has a Chief Officer responsible for the effective and efficient use of resources, including the proactive identification and mitigation of risks to which the care organisation is exposed. Each Chief Officer is the chair of the Care Organisation's Assurance and Risk Committee (COARC), which has responsibility for providing leadership and ensuring appropriate oversight of the achievement of the Care Organisation's principle objectives through the effective mitigation of risk. The Oldham, Bury & Rochdale and North Manchester Care Organisations have all of the above arrangements in place.

Throughout 2017/18, a corporate governance structure was maintained for Pennine. The Pennine Executive Assurance and Risk Committee continued to have overarching responsibility for risk management supported by Executive Governance Committees. The Pennine Executive Assurance and Risk Committee reported directly to the Group Risk and Assurance Committee throughout this time. The developing Care Organisations at Oldham, Bury & Rochdale and North Manchester established initial performance review and assurance groups which reported upward to the executive governance committees ensuring risk

continued to be identified, managed and escalated where appropriate. The Pennine Transition Board introduced conditions precedent, against which the developing Care Organisations' leadership and governance structures were assessed. In March 2018, the Group CiC confirmed, following report from the Pennine Transition Board, that leadership and governance arrangements were fully established.

Pennine and Salford Royal have complementary risk management strategies in place, which are implemented via Group and Care Organisation governance structures. Pennine's Risk Management Strategy provides the framework for managing risk across the Oldham, Bury & Rochdale and North Manchester Care Organisations and at all levels within the Group. It is consistent with best practice and Department of Health guidance. The Strategy provides a clear, systematic approach to the management of risks to ensure that risk assessment is an integral part of all clinical, managerial and financial processes. Risk management is supported in the following ways; a central NCA Risk Management Team led by the Group Head of Patient Safety, a centralised Health and Safety Team with seeded support from Health and Safety Advisors and, for each Care Organisation, an Associate Director of Governance is in place supported by a team of Governance Managers for each clinical division.

Pennine's improved capacity to handle risk was evidenced via the CQC Well-led Inspection (March 2018) which concluded that 'services were developing effective systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected'. The NCA acknowledges that this process is at various stages of development across the services and will continue to diligently review risk management systems during 2018/19.

The NCA has developed a Training Needs Analysis which is implemented by the Oldham, Bury & Rochdale and North Manchester Care Organisations and focuses training programmes against highest risk activities across the organisations. Training is provided for risk assessment and incident investigation and delivered at appropriate levels in relation to job role and duties.

Where good practice is identified this is shared in line with the NCA Learning Framework in place. Good practice and lesson learning is disseminated via corporate and divisional governance systems, newsletters and patient stories that are received at all levels of committee. The Oldham, Bury & Rochdale and North Manchester Care Organisations have mechanisms to receive and act upon alerts and recommendations made by all relevant central bodies.

The Group CiC receives assurances from the Group Risk and Assurance Committee relating to the management of all serious untoward incidents, including Never Events, as well as receiving integrated Learning from Experience and patient Responsiveness reports.

The risk and control framework

Risk management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks via structured risk assessments. Identified risks are documented on risk registers. These risks are then analysed in order to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found whilst higher scoring risks are managed at progressively higher levels within the organisation. Achieving control of the higher scoring risks is given priority over lower scoring risks. Risk control measures are identified and implemented to reduce the potential for harm. The potential severity (consequence) and the likelihood of the risk occurring are scored along with the existing control measures. It is the sum of these scores which determine the level in the organisation at which the risk is reported and the monitoring of further actions to mitigate against the risk.

Each Care Organisation within the NCA has in place a Board Assurance Framework/Corporate Risk Register (BAF/CRR) which is overseen by each Care Organisations' COARC and directs management focus to the mitigation of the Care Organisations' most significant risks, and provides assurance that the key risks to which the Care Organisations are exposed are managed appropriately. The Oldham, Bury & Rochdale and North Manchester Care Organisation BAF/CRR, cumulatively make up the Pennine BAF/CRR, overseen by the Group Risk and Assurance Committee.

Pennine seeks to reduce risk in so far as possible, however it is understood that delivering healthcare carries inherent risks that cannot be eradicated completely. Pennine therefore pursues assurance that controls continue to be operated for risks that cannot be reduced any further. On this basis, risks are tolerated in line with an organisational risk appetite.

The NCA has a Group Assurance Framework, which is based on six key elements:

- Clearly defined principal objectives agreed with stakeholders together with clear lines of responsibility and accountability;
- Clearly defined principal risks to the achievement of these objectives together with assessment of their potential impact and likelihood;
- Key controls by which these risks can be managed, this includes involvement of stakeholders in agreeing controls where risks impact on them;
- Management and independent assurances that risks are being managed effectively;
- Board level reports identifying that risks are being reasonably managed and objectives being met together with gaps in assurances and gaps in risk control;
- Board level action plans which ensure the delivery of objectives, control of risk and improvements in assurances.

The workplan of committees within the Group Assurance Framework is linked so that the Group CiC is assured that there is an aligned independent and executive focus on strategic risk and assurance. Routine referral of issues exists between committees ensuring a respective understanding of risk and assurance concerns. The Internal Audit Assurance Framework Review 2017/18 confirmed that 'the organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.' Furthermore, the Group CiC has established and operates an oversight framework for each of its Care Organisations, called the Group Single Oversight Framework (Group SOF). The Group SOF provides assurance on delivery of the Care Organisation's Annual Plan objectives and supports quality and performance improvement. The five themes of the Group SOF reflect those of the NHS Improvement Framework:

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

The Group SOF segments Care Organisations, according to the scale of issues faced, and enables the Group CiC to determine the extent of support required by each Care Organisation. The Group SOF utilises an integrated reporting approach, including performance dashboards, board assurance frameworks, statements of assurance, annual plan reviews, well led reviews and CQC improvement plans.

During 2017/18, Pennine's first Quality Improvement Strategy was approved by the Group CiC. The strategy provided clear and ambitious quality goals, which were initially monitored through the Pennine Executive Quality and Patient Experience Committee and the Executive Clinical Effectiveness Committee. A quarterly Quality Improvement Progress Report, including Care Organisation Quality Improvement Dashboards, are reviewed by the Group CiC. At Care Organisation level, each Care Organisation now has in place clear quality governance arrangements through the assurance framework committee structure. This includes a monthly Quality and Clinical Effectiveness Committee which reviews a suite of Quality Dashboards that track performance against key quality indicators; standardised risk assessment (Quality and Safety Impact Assessment) of all productivity improvement workstreams, as part of the Better Care at Lower Cost Programme; and arrangements for staff, patients and members of the public to raise concerns with respect to the quality of care; reporting directly to the respective Care Organisation Assurance and Risk Committee.

The NCA has a Freedom to Speak Up (FTSU) Guardian to act in a genuinely independent and impartial capacity to support staff who raise concerns and will have access to the Chief Executive and the nominated non-executive director for 'Freedom to Speak Up'. This individual will be supported by a number of FTSU Care Organisations Guardians who work across the Care Organisations, ensuring staff have easy access to practical support. A recruitment process for the Care Organisation FTSU Guardians for Oldham, Bury &

Rochdale and North Manchester is currently underway. A quarterly report of all concerns raised and themes will be produced for the respective Care Organisations quality governance committees; summary information will be escalated to the COARC and the Group Risk and Assurance Committee via the Care Organisation Statements of Assurance. The NCA FTSU Guardian also meets with the nominated non-executive director on a quarterly basis.

An independent Well-Led Governance review of Salford Royal was conducted towards the end of 2016/17 and reported "There is a confident understanding at Board level of how services are performing in relation to quality. QI [Quality Improvement] is notable in terms of the breadth and depth of its embeddedness across the Trust." Potential improvement themes identified from the Well Led Governance review were shared with all Care Organisations across the NCA, and in September 2017, MIAA in partnership with AQuA, were commissioned to undertake developmental work with each Care Organisation. This included all Care Organisations completing a developmental self-assessment against the Well-Led Framework, followed by a workshop to provide access to external challenge and insight. The outcome of this work was reported to the Group Risk and Assurance Committee in April 2018, where proposals for Group and Care Organisation review of the Well Led Framework for Governance for 2018/19 were agreed. The Quality Report, within this Annual Report and Accounts, describe quality improvements and quality governance in more detail.

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

Pennine was assessed by the CQC in February 2016 with a rating of 'inadequate' applied in August 2016. Following this inspection, the Trust entered into arrangements with Salford Royal NHS Foundation Trust to provide leadership and management support, effective from 1 April 2016. An Improvement Plan was developed based on the findings identified within the CQC Report targeting specific fragile services including urgent care, maternity services, children's services and critical care.

The CQC Improvement Plan has been monitored internally on a weekly basis with clear leadership for each recommendation from within each of the Care Organisations. Assurance has been provided through the Trust's Assurance Framework with each recommendation applied to an assurance committee, chaired by a Group Executive lead. Externally assurance has been provided on progress against the Improvement Plan via the monthly Greater Manchester Improvement Board and the North East Sector Clinical Commissioning Groups, Clinical Quality Leads meeting.

Pennine was reassessed by the CQC between October 2017 and November 2017, with significant improvements made across all services, culminating in the Trust being rated 'Requires Improvement' with a number of services improving by two ratings. The development of Care Organisations and strong senior leadership at each of the hospital sites saw the Well Led Domain assessed as 'Good'

A new action plan has now been developed which will be monitored through each Care Organisation's assurance committee structure with risks identified and reported through the NCA assurance framework with the 'must do' requirements monitored and assurance provided at the Group CiC.

A process to provide regular assurance at Care Organisation and NCA level is currently under development, supported by a CQC annual review of the Well led domain and at least two core services.

Dedicated data quality teams pro-actively manage data quality within 'source' systems and provide appropriate training and guidance to the Care Organisation teams. Independent assurance regarding data quality is provided by regular, and independent, external audits and the Information Governance Toolkit self-assessment review by internal audit and independent auditors, for example MIAA and Capita, who review the Trust's data and data systems. Risks to data quality and data security are continuously assessed and added to the IM&T risk register, and score dependent, reviewed by the Group Executive Risk and Assurance Committee.

During 2017/18, the Group CiC ensured on-going assessment of in-year and future risks. Major risks related to:

- Planned income levels not being achieved and/or expenditure controls exceeded
- Delivery of Pennine's Better Care at Lower Cost programme

- Compliance with access standards: A&E Performance, Open/Incomplete Referral to Treatment, 62 Day Cancer, 6 Week Diagnostic Standard
- JAG Endoscopy Accreditation
- Effective systems and processes in place to assure patient tracking, booking and data quality
- Implementation of Lessons Learnt following the Diagnostic Review (Radiography, Missed Results, Follow Ups)
- Lessons Learnt effectively identified and acted upon
- Processes in place/followed for Deteriorating Patient and Sepsis
- Evidence based budgeted (staff) establishment levels in place and maintained
- Stabilisation and sustaining medical and nursing workforce to support the Urgent Care pathway
- Estate investment for North Manchester General Hospital
- System for digitalisation of clinical notes (Evolve) to deliver timely, accessible and reliable retrieval of clinical records
- Achieve coherent range of IM&T clinical systems and investment in 'not fit for purpose' IM&T infrastructure

The Group CiC oversees the management of all major risks, which are actively addressed by the Group Executive Risk and Assurance Committee. Key controls and assurances, and any identified gaps are continually reviewed and action plans developed and progressed accordingly. Outcomes are confirmed via this process and reported routinely to the Group CiC, via the Group CiC's Integrated Performance Dashboard. Audit Committee reviews the Board Assurance Framework/ Corporate Risk Register and commissions additional reviews where appropriate in order to provide necessary assurance to the Group CiC.

Significantly, Pennine has developed a Productivity Improvement Programme titled 'Better Care at Lower Cost' with robust project management arrangements via a central project management office (PMO) and oversight via the Productivity and Efficiency Board, chaired by the Chief Finance Officer and reported each month in detail to the Group CiC. This programme is fully aligned to the objectives of Pennine's financial and operational plan.

The Trust has assessed compliance with the NHS provider condition 4. Audit Committee reviewed the assessment in detail at its meeting on 24th May 2018 and confirmed that no material risks had been identified. The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

- The effectiveness of governance structures
- The responsibilities of Directors and subcommittees
- Reporting lines and accountabilities between the board, its subcommittees and the executive team;
- The submission of timely and accurate information to assess risks to compliance with the Trust's licence; and
- The degree and rigour of oversight the board has over the Trust's performance.

These conditions are detailed within the Corporate Governance Statement, the validity of which is assured via the Audit Committee.

Risk management is embedded in the activity of the organisation. The risk management systems are fully incorporated within the Group's Assurance Framework. Pennine's corporate risk register is integrated with the Board Assurance Framework thereby ensuring that risks are not only managed and communicated efficiently, but that the management of them is embedded in practice. Care Organisations proactively identify risks through a programme of risk assessment which are recorded on the Care Organisation's BAF/CRR. Care Organisations also retrospectively identify risk through the encouragement of adverse incident reporting, receipt and appropriate response to complaints, patient feedback and concerns raised by the coroner and through concerns identified through a claim.

Due to the devolved nature of risk management including the management and compliance of incident reporting and investigation at a local level, quality and quantity of incident management continues to improve and develop. The NCA and each Care Organisation advocate a transparent reporting culture, combined

with a fair blame culture which encourages openness and transparency.

Two major improvements within the last 12 months in incident management have been higher completion rates of incident investigations, allowing timely feedback to reporters encouraging them to report future incidents. The second improvement is the option to anonymously report an incident, which encourages reporting which may have previously gone unreported, including access to agency/locum staff to report incidents, these system improvements combined with the promotion of an open and honest culture has led to an increase of patient safety incident reporting at Pennine by 15% in the 6 months post launch of the Datix system compared to the 6 months previous.

There is a key focus within risk management on organisational learning to address key themes identified during mortality reviews, and incident investigations to enable continuous improvement to patient safety. The Care Organisations continue to develop systems and processes to capture learning at every opportunity, and sharing best practice across each Care Organisation.

When things do go wrong Pennine encourages its staff to report incidents whether there was any consequence resulting from the incident or not. Anonymous reporting is accepted to mitigate against any concerns the reporter of an incident may have. However, if the reporter of an incident does include who they are, then they receive automated feedback for every incident they report. This is to help demonstrate the value of reporting and that things have changed as a result, with the intent on encouraging staff to report more incidents.

Public stakeholders are involved in managing risks which impact on them. When serious incidents are investigated, members of Pennine speak and if possible meet with those who were affected. Relevant feedback from these discussions would be considered during the investigation and a copy of the final report is shared. This gives the opportunity for comment on the report to be considered and if appropriate included. A collective meeting of the Clinical Commissioning Groups (CCGs) covering the Pennine footprint receives a copy of all completed Serious Incident Investigation reports and members of the CCGs are invited to a Pennine-wide Serious Incident Assessment and Review Committee (SIARC), thereby ensuring public oversight of the investigation and learning process following patient safety incidents that have caused moderate harm.

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

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

The 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 financial plan is approved by the Group CiC, and the Pennine Board of Directors, and subsequently to NHS Improvement. The plan, relevant to each Care Organisation, including forward projections, is monitored in detail on a monthly basis by the Care Organisation Corporate Governance Finance Committee. Care Organisations' monthly Statement of Assurance to the Group Risk and Assurance Committee confirms the sufficiency of plans for the effective use of resources. Key performance indicators and financial sustainability metrics also reviewed monthly by the Group CiC.

Pennine's resources are managed within the framework set by the Group Governance Framework Manual, which includes Standing Financial Instructions. Financial governance arrangements are supported by internal and external audit to ensure economic,

efficient and effective use of resources and monitored through Audit Committee.

Information Governance

Information governance risks are managed as part of the processes described above and assessed using the Information Governance Tool kit. The risk register is updated with the currently identified information risks. In line with national requirements, Pennine's information risks are assessed using the HSCIC IG SIRI's (Information Governance Serious Incidents Requiring Investigation) assessment criteria and reported through to the Department of Health via the Information Governance (IG) Incident Reporting Tool. During 2017/18, two incidents were registered as Level 2 and reported through to the Information Commissioner's Office (ICO). The incidents related to inappropriate access to a patient record by a staff member and a record taken to a staff member's home without due authorisation. The ICO has not requested that Pennine takes any further action and the incidents are now closed.

Annual Quality Account

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.

For 2017/18, Pennine has opted to follow NHS Improvement's (non-mandatory) recommendation that NHS trusts should follow its requirements for foundation trusts. Therefore, Pennine has followed the 'Detailed Requirements for Quality Reports'. The Pennine Annual Quality Report 2017/18 has been developed in line with relevant national guidance and is supported internally through the Board Assurance Framework. All data and information within the Quality Report has been reviewed via the Care Organisation Quality and Clinical Effectiveness Governance Committees and supported through the comprehensive documented three year Quality Improvement Strategy. The Group CiC regularly reviews the Quality Improvement Dashboard and progress against identified projects.

The NCA has an identified Quality Improvement Department with relevantly skilled individuals to support the execution of the Quality Improvement Strategy across the organisation. Capability building in Quality Improvement techniques and skills has been and remains a key objective of the organisation. Staff at all levels are now exposed to collaborative working, clinical micro-systems or specific quality improvement educational programmes both internally and externally to ensure skills are developed and maintained.

The Quality Report 2017/18 has been reviewed through both internal and external audit processes and comments have been provided by local stakeholders including commissioners, patients and the local authority.

Following the CQC Inspection in 2016, a data quality improvement project to assure the quality and accuracy of elective waiting time data was initiated and monitored as part of the Pennine Improvement Plan. Significant progress has been made throughout 2017/18 to deliver against the aims of the project and assure the data quality of elective waiting times data and associated risk. Performance is continually assessed through key governance committees to ensure mandated standards are adhered to. Any issues that are highlighted within the data are reported through to the Data Quality Team for investigation and are acted on appropriately.

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 and the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust's Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its

principal objectives have been reviewed. Internal Audit provides me with an opinion about the effectiveness of the assurance framework and the internal controls reviewed as part of the internal audit plan. The Head of Internal Audit opinion for 2017/18 gave significant assurance on the system of internal control in place during the year. Work undertaken by internal audit is reviewed by the Assurance Framework's Committees and the Audit Committee. Where internal audit issued a limited assurance report the relevant Chief Officer and Care Organisation Director attended the Audit Committee to discuss the report and actions taken. The Board Assurance Framework/Corporate Risk Register is presented to the Group Executive Risk and Assurance Committee on a quarterly basis and all significant risks are detailed within the monthly Group Integrated Performance Dashboard presented to the Group CiC by the Chief Executive. This provides me and the Group CiC with evidence of the effectiveness of controls in place to manage risks to achieve the organisation's principal objectives.

My review is also informed by External Audit opinion, inspections carried out by the Care Quality Commission and other external inspections, accreditations and reviews.

The processes outlined below are well established and ensure the effectiveness of the systems of internal control through:

- Group Executive Risk and Assurance Committee review of the Board Assurance Framework, including risk registers and action plans;
- Group CiC oversight of all significant risks;
- Audit Committee scrutiny of controls in place;
- Review of serious untoward incidents and learning by the Assurance Framework committees, including those for risk management and clinical effectiveness;
- Internal audits of effectiveness of systems of internal control.

Conclusion

This Annual Governance Statement requires me to consider whether there are any significant internal control issues facing the Trust.

The Group CiC has extensive and effective governance assurance systems in operation. These systems enable the identification and control of risks reported through the Board Assurance Framework and Corporate Risk Register. Internal and external reviews, audits and inspections provide sufficient evidence to state that no significant internal control issues have been identified during 2017/18, and that these control systems are fit for purpose.

As set within the 2018/19 Internal Audit Plan, the Group's internal audit function will test compliance, across the three North East Sector Care Organisations, against the Group's Governance 'blue print' and the Group Governance Framework Manual to provide additional assurance that standardised governance structures are established and assurance information flows are effective.

Sir David Dalton
Chief Executive and Accountable Officer

Date: 25 May 2018

Remuneration and Staff Report

Remuneration Report

As part of the Northern Care Alliance's governance arrangements and as delegated by the Pennine Board of Directors, the Group Committees in Common established a Nominations, Remuneration and Terms of Service (NRTS) Committee (utilising a Committees in Common approach) at the beginning of 2017/18.

During 2017, the NRTS Committee applied a 1% increase to the basic salaries of Executive Directors and Senior Leaders for 2017/18, effective from 1 October 2017, where personal contribution has been assessed as 'successful' or above for the 2016/17 financial year. No bonus payments were awarded.

As described earlier in this year's Annual Report, Pennine Acute Hospitals NHS Trust has continued to receive managerial support from Salford Royal NHS Foundation Trust. The Chief Executive and Executive Nurse Director/Deputy Chief Executive have held formal executive responsibility at both organisations. To reflect these arrangements the salaries of the Chief Executive and Executive Nurse Director have been split and paid equitably by Pennine Acute Hospitals NHS Trust and Salford Royal NHS Foundation Trust.

The NRTS Committee ensures that Executive Directors' remuneration is set appropriately, taking in to account relevant market conditions, and that Executive Directors and Senior Managers are appropriately rewarded for their performance against personal goals and objectives that are aligned to the organisation's principal objectives. The NRTS Committee reports directly to Group Committees in Common and meets its responsibilities by:

- monitoring and evaluating the performance of the Chief Executive and Executive Directors/Group Chief Officers;
- determining appropriate remuneration, relative to individual and organisational performance;
- evaluating the balance of skills, knowledge and experience on the Board (Group Committees in Common) and approving descriptions of roles, and appointment processes, for the appointment of Executive Directors/Chief Officers;
- implementing and keeping under review local remuneration and performance-related pay/bonus arrangements for the most senior managers (sub-Executive Director level).

The NRTS Committee is chaired by Pennine's Chairman (who is also the Chairman of SRFT and the Northern Care Alliance NHS Group) and all Non-Executive Directors (of Pennine and the Northern Care Alliance NHS Group). Attendance during 2017/18 was as follows:

Mr James Potter	4/4
Mrs Diane Brown	4/4
Mr John Willis CBE	3/4
Mrs Christine Mayer CBE	3/4
Mrs Rowena Burns	1/2
Mr Kieran Charleson	1/1
Professor Chris Reilly	4/4
Dr Hamish Stedman	3/4

The Chief Executive attends the Committee in relation to discussions about Board composition, succession planning, remuneration and performance of Executive Directors. The Chief Executive is not present during discussions relating to his own performance, remuneration and terms of service. The Chief Strategy and Organisational Development Officer provides employment advice and guidance, and withdraws from the meeting when discussions about his/her own performance, remuneration and terms of service are held. The Director of Corporate Services /Group Secretary is the Committee Secretary.

The executive directors are employed on permanent contracts. The executive directors are required to give six months' notice of termination of employment.

There are no special guaranteed termination payments or compensation payments for early termination of executives. Executives are subject only to the same redundancy rights as all other employees of the Trust.

Details of remuneration of Board members being those individuals who are key to accountability and having authority or responsibility for directing or controlling major activities within the Trust are noted below. These have been determined as the Board members as they influence the decisions of the Trust as a whole rather than the decisions of individual directorates or departments.

Salary and Pension entitlements of senior managers

Introduction

The Chief Executive has determined, for the purpose of the Annual Report and Accounts, those officers who have authority and/or responsibility for directing or controlling the major activities of the Trust, i.e. who influence decisions of the Trust as a whole rather than individual Care Organisations or divisions. These officers include all members of the Board of Directors and Group Committees in Common (voting and non-voting).

	Status	Remuneration Proportion	
Executive Directors			
Sir D Dalton, Chief Executive Officer	Voting PAHT	50%	(60% 2016/17)
D Finn, Executive Director of Finance/Chief Officer, North Manchester Care Organisation	Voting PAHT	100%	
Prof M Makin, Executive Medical Director	Voting PAHT	100%	
E Inglesby-Burke CBE, Executive Director of Nursing	Voting PAHT	50%	(40% 2016/17)
Chairman and Non Executive Directors			
J Potter, Chairman	Voting PAHT		
C Mayer CBE, Non Executive Director	Voting PAHT		
J Willis CBE, Non Executive Director	Voting PAHT		
D Brown, Non Executive Director	Voting PAHT		

Footnote 1:
The delegation of the Board of Directors' powers to Group Committees in Common is described on page 142 of this Annual Report. All of the PAHT Board members are members of the Group Committees in Common, with the exception of Prof M Makin. The Group Committees in Common comprises all voting members of the Salford Royal NHS Foundation Trust Board of Directors and details of their remuneration for the 2017/18 financial year are included within the Salford Royal NHS Foundation Trust 2017/18 Annual Report. The following Care Organisation Chief Officers are also members of the Group Committees in Common:

S Taylor, Chief Officer, Bury & Rochdale Care Organisation

D McLaughlin, Chief Officer, Oldham Care Organisation

J Sumner, Chief Officer, Salford Care Organisation

Footnote 2:
Mr J Sumner received 100% of his remuneration from SRFT (as detailed within SRFT's annual report)

Footnote 3:
Sir David Dalton receives 50% of his remuneration from PAHT (as detailed above) and 50% of his remuneration from SRFT (as detailed within SRFT's annual report). In total the remuneration for Sir David Dalton for the 2017/18 financial year is £235,836

Footnote 4:
Mrs E Inglesby-Burke CBE receives 50% of her remuneration from PAHT (as detailed above) and 50% of her remuneration from SRFT (as detailed within SRFT's annual report). In total the remuneration for Mrs E Inglesby Burke CBE for the 2017/18 financial year is £146,786.

The following tables and the fair pay multiple, have been subject to external audit.

A) Remuneration

	2017-18						2016-17					
Name and Title	(a) Salary	(b) Taxable expense payments & taxable benefits total nearest £100	© Performance pay and bonuses	(d) Long term performance pay and bonuses	(e) All pension-related benefits	(f) TOTAL (a to e)	(a) Salary	(b) Taxable expense payments & taxable benefits total nearest £100	© Performance pay and bonuses	(d) Long term performance pay and bonuses	(e) All pension-related benefits	(f) TOTAL (a to e)
	(bands of £5000) £000	£ £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£ £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Sir D Dalton, Chief Executive Officer	115 -120	1,000			30 - 32.5	145 - 150	85 - 90	1,200			22.5 - 25	110 - 115
D Finn, Executive Director of Finance/Chief Officer, North Manchester Care Organisation	155 - 160				-	155 - 160	155 - 160				57.5 - 60	210 - 215
Prof M Makin, Executive Medical Director	175 - 180					175 - 180	170 - 175	7,000			-	175 - 180
E Inglesby-Burke CBE, Executive Director of Nursing (from 1 August 2016)	70 - 75	2,800			20 - 22.5	95 - 100	60 - 65	2,200			17.5 - 20	80 - 85
J Lenney, Executive Director of Workforce & OD (until 31 May 2017)	20 - 25	1,200			-	20 - 25	125 - 130	7,300			22.5 - 25	160 - 165
S Taylor, Chief Officer, Bury & Rochdale Care Organisation	120 - 125	300			75 - 77.5	195 - 200						
D McLaughlin, Chief Officer, Oldham Care Organisation	120 - 125	4,100			30 - 32.5	155 - 160						
J Potter, Chairman	35 - 40					35 - 40	35 - 40					35 - 40
C Mayer CBE, Non Executive Director	5 - 10					5 - 10	5 - 10					5 - 10
J Willis CBE, Non Executive Director (from 1 August 2016)	5 - 10					5 - 10	0 - 5					0 - 5
D Brown, Non Executive Director (from 1 October 2016)	5 - 10					5 - 10	0 - 5					0 - 5
2016-17 leavers/changes												
G Harris, Chief Nurse (until 31 July 2016)							50 - 55				10 - 12.5	60 - 65
H Mullen, Director of Operations (until 24 January 2017)							115 - 120				22.5 - 25	140 - 145
R Ahmad, Non Executive (until 31 July 2016)							0 - 5					0 - 5
W Cardiff, Non Executive (until 30 September 2016)							0 - 5					0 - 5
C Guereca, Non Executive Director (until 30 November 2016)							0 - 5					0 - 5
M Ollerenshaw, Non Executive Director (until 31 March 2017)							5 - 10					5 - 10
S Dixon, Non Executive Director (until 28 February 2017)							5 - 10					5 - 10

Column (e) is pension related benefits - this is the increase in year of the annual pension and lump sum that the individual would be entitled to from the NHS Pension scheme at 31 March or retirement less any employee contributions.

Prof M Makin and D Finn have opted out of the NHS pension scheme.

Taxable benefits relate to lease cars provided as part of a salary sacrifice scheme and/or mileage rates paid in excess of HMRC rates.

During 2017/18, Dr G Fairfield, former Chief Executive, received payment for loss of office of £153,333 (included in the exit packages note on page 181)

B) Pension Benefits

Name and title	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)	£000	£000	£000
Sir D Dalton, Chief Executive Officer	2.5 - 5	7.5 - 10	100 - 105	305 - 310	2,241	2,058	163
E Inglesby-Burke CBE, Executive Director of Nursing	0 - 2.5	5 - 7.5	70 - 75	220 - 225	1,664	1,534	114
J Lenney, Executive Director of Workforce & OD (until 31 May 2017)	-	-	45 - 50	145 - 150	980	925	46
S Taylor, Chief Officer, Bury & Rochdale Care Organisation	2.5 - 5	5 - 7.5	45 - 50	120 - 125	873	781	85
D McLaughlin, Chief Officer, Oldham Care Organisation	0 - 2.5	0 - 2.5	35 - 40	85 - 90	510	440	65

The above details for Sir D Dalton and E Inglesby-Burke are the full amounts and the same as in Salford's annual report. As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

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

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

Fair Pay Disclosure

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The mid-point banded remuneration of the highest paid director in Pennine in the financial year 2017-18 was £177.5k (2016-17, £177.5k). This was 7.5 times (2016-17, 7.4 times) the median remuneration of the workforce, which was £23.6k (2016-17, £23,9k).

In 2017-18, 7 (2016-17, 4) employees received remuneration in excess of the highest paid director. Remuneration ranged from £182.5k to £229k (2016-17 £183k to £187.5k).

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

Staff Report

At the end of 2017/18 Pennine employed 9786 people. Details of our workforce are provided below.

Average number of people employed by the Trust (WTE basis)

	2017/18			2016/17		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Medical and dental	743.23	459.94	283.28	739.14	458.64	280.5
Administration and estates	2442.64	2347.34	95.28	2372.76	2299.5	73.25
Healthcare assistants and other support staff	1606.92	1554.14	52.78	1465.49	1423.99	41.5
Nursing, midwifery and health visiting staff	2823.67	2746.74	76.93	2693.65	2646.89	46.75
Scientific, therapeutic and technical staff	992.39	966.13	26.26	944.49	927.43	17.01
Bank staff	514.70	0	0	452.71	0	0
Agency staff	522.29	0	0	679.85	0	0
Other (students)	13	5	7	13	6	7
Total	**9658.84**	**8079.29**	**541.53**	**9361.09**	**7762.45**	**466.01**

Inclusion and Equality

Pennine recognises that delivering on inclusion and equality is a key driver to achieving our mission to 'save lives and improve lives'. It gives us a real opportunity to place people at the centre of the work we undertake, recognising how actively involving individuals from diverse groups enables us to prioritise and address health and employment inequalities.

The Executive lead for inclusion and equality across the NCA is the Chief Strategy & Organisational Development Officer, however, the Trust's approach is that all staff and managers have responsibility. We continually work to embed robust systems that support everyone to deliver this agenda throughout their working lives. Pennine has outlined its commitment to this agenda through ensuring Inclusion and Equality training is mandatory for all staff.

Pennine is fully committed to meeting its requirements of the Equality Act 2010 and the Public Sector Equality Duty. The Trust's Annual Equality Reports, monitoring data/statistics and other relevant information can be viewed on the Trust website.This information enables Pennine to review and monitor outcomes for both its workforce and service user data by protected groups. It also includes the report and action plan on the Workforce Race Equality Standard (WRES).

The senior management is committed to ensure that we fully embed the Race Equality Standard into everyday business of the NCA. We will be enabling this through our vision on inclusion; to be the Centre of Excellence for inclusion – this will be incorporating local KPI's and metrics to support the development of staff to enable them to provide quality care for our patients.

From the Annual Equality Report, Pennine has reviewed and refreshed its equality objectives. This has enabled us to develop an evidence based approach to identifying key areas for improvement.

Pennine's Single Equality Scheme is also published on the website. This outlines and promotes our commitment to this agenda, ensuring that the organisation clearly defines it assurance, governance and engagement strategy.

In Year Achievements

Pennine's Recruitment Code of Practice reinforces our commitment to value diversity and remove unlawful discrimination. We are proud to have been nominated for the Diverse Company Award in the National Diversity Awards 2017, which led to Pennine being included for the first time on the Top 50 Inclusive Employers list at number 39.

Pennine was accredited with the Disability Confident Employer Status for a second year in 2017.

The Disability Confident Employer Scheme replaced the Disability Two Ticks scheme and is designed to help organisations show that they are disability friendly employers. This goes on to support the recruitment and retaining of disabled people and people with health conditions for their skills and talent. In 2018 the Equality, Diversity and Inclusion Team will be working with our 'workforce' colleagues to continue to raise awareness of the scheme and to meet Level Three.

Multi-faith Care After Death Group

The Multi-faith Care After Death Group consists of representatives from the local communities surrounding our localities. The group's membership largely consists of the Jewish and Muslim faiths, as these two groups highlighted particular issues in the delivery of end of life care for their communities. Pennine has been working with them for the past 6 months to resolve issues identified.

Accessible Information Standard

Pennine has implemented the Accessible Information Standard and continues to embed the standard across all services through the Accessible Information Standard (AIS) Action Plan. The Trust worked in partnership with other NHS and Adult Social Care providers and commissioners across the Pennine footprint to develop a Communication and Information Needs Passport for patients, service users, carers and parents.

We have worked hard to record, flag and meet the communication needs of patients and service users coming to Pennine and have been able to provide patient letters in the format required for example braille, easy read or large font.

Workforce Equality Standards

Research has demonstrated that the treatment and experience of Black and Minority Ethnic (BME) staff within the NHS is significantly worse than that of white staff. The publication of 'The Snowy White Peaks of the NHS' (2014) demonstrated that BME staff were absent from the leadership of many organisations, even those which had substantial numbers of BME staff and where the organisation provided services to communities with large numbers of BME patients. The report also showed that BME staff were treated less favorably in relation to promotion, grading, discipline, bullying and access to non-mandatory training.

Links between how NHS staff are treated and the quality of care to patients has also been well evidenced.

In April 2015 NHS England introduced the Workforce Race Equality Standard (WRES). The standard consists of 9 indicators and requires NHS organisations to close the gap between the BME and white staff experience for those indicators.

The WRES directly supports the Equality Delivery System (EDS2) goals 3 and 4: representative workforce and inclusive leadership including the Board and indirectly supports EDS2 Goals 1 and 2: Better Health Outcomes and Improved patient access and experience. The Trust is working towards implementing the EDS2.

The Care Quality Commission also consider the WRES in their assessments of how "well-led" NHS providers are from April 2016.

The standard will, for the first time, require organisations to demonstrate progress against a number of indicators of workforce race equality, including a specific indicator to address the low levels of BME Board representation. There are nine indicators. Four of the indicators are specifically on workforce data, four are based on data from the national staff survey indicators, and one considers Board composition. The standard highlights any differences between the experience and treatment of White staff and BME staff in the NHS with a view to closing those metrics. Indicator 9 requires organisations to ensure their Boards are broadly representative of the communities they serve.

The Equality, Diversity and Inclusion team have been working very closely with the Organisational Development team and developed a reciprocal mentoring scheme for BME staff members, with Board level sponsorship. We have had over 50 members of staff expressing an interest in the programme and are delivering the programme in two cohorts. The first cohort commenced in January 2017 and the second started in March 2017, with plans to roll out the third and fourth cohorts in 2018.

We have continued to promote leadership development opportunities for BME staff through the leadership academy such as the Stepping Up and Ready Now programmes and the Equality, Diversity and Inclusion team, along with the Organisational Development team, have worked together to develop an internal leadership programme which will commence in 2018.

The BME staff network held its first BME Conference in October 2017 as part of Black History Month.

Group Executive Directors and the Senior Leadership Teams within the Oldham, Bury & Rochdale and North Manchester Care Organisations are committed to ensuring that the WRES is fully embedded into the everyday business of Pennine. We are in the process of developing a roadmap for inclusion which will illustrate our vision to be a Centre of Excellence for inclusion reflecting and incorporating our values of providing respect for our staff and patients through empowering them through engagement and involvement. By proactively developing goals and objectives we will ensure continuous improvement, and providing clear transparent accountability keep the patient at the heart of everything that we do.

Training and Development

After listening to both service users and staff, Pennine developed and delivered a series of training and awareness sessions throughout the year to improve outcomes for diverse groups. These have enabled staff to have face to face conversations with a number of representatives from diverse groups and develop practical ways to support these individuals.

Future Priorities and Targets

Through the active engagement and data analysis we have developed a comprehensive Equality and Inclusion Performance Report and Action Plan. The plan is continually reviewed and updated through regular engagement with key stakeholder groups, current priorities are:

- Ensure that Pennine improves how it embeds equality analysis within its internal governance arrangements for Group CiC papers and service transformation/re-design, ensuring that due regard is paid to the public sector equality duty.
- Continue to develop systems to deliver on the Accessible Information Standard, including working with services and departments to apply for accreditation with Action on Hearing Loss for its 'Louder than Words' standard.
- Work towards improving the reporting of patient experience data by protected groups.
- Develop an umbrella policy to improve the support for patients from the transgender community to update their health records.
- Take action to ensure equality of outcomes in recruitment/selection and career development as outlined in the Workforce Race Equality Standard action plan, and prepare for the introduction of the Workforce Disability Equality Standard in 2018.
- Develop improved analysis of the staff survey results, with a focus on bullying & harassment/ discrimination by protected groups, to identify high impact actions.

Performance and monitoring of these targets will be undertaken by the Inclusion and Equality Group and key stakeholders through various engagement forums and the Equality Delivery System (EDS2).

Age Band	2017/18		2016/17	
	Headcount	%	Headcount	%
16-21	62	0.63	44	0.47
21-30	1688	17.25	1525	16.23
31-60	7348	75.09	7213	76.77
61-70	668	6.83	599	6.37
Over 70	20	0.20	15	0.16
Total	9786	100	9396	100
Ethnicity				
White British and Irish	7891	80.64	7692	81.86
Asian	916	9.36	842	8.96
White – Other	224	2.29	203	2.16
Black	290	2.96	224	2.38
Any other ethnic group	109	1.14	98	1.04
Mixed	127	1.30	110	1.17
Not specified	203	2.07	201	2.14
Chinese	26	0.27	26	0.28
Total	**9786**	**100**	**9396**	**100**
Female	7784	79.54	7461	79.41
Male	2002	20.46	1935	20.59
Total	9786	100	9396	100
No	4510	46.09	3727	39.66
Not declared	5015	51.25	5412	57.59
Yes	261	2.67	257	2.73
Total	**9786**	**100**	**9396**	**100**

	Male	Female
Board level Directors and Group Committees in Common	12	5
Senior Managers (excluding Hosted Services)	11	21
Other Employees	1989	7761
Total	**2012**	**7787**

Sickness Absence

It is our aim to reduce sickness to a target level of 4.6% by the end of 2017/18. During 2016/17 absence levels were 5.26% compared to the previous year's level of 5.79%. Within this figure, 2.86% related to short term absence whilst long term absence accounts for 2.40%.

Pennine has an established Health and Wellbeing Steering Group to oversee the Health and Wellbeing Strategy. As part of this strategy, Pennine has achieved the Workforce Wellbeing Charter accreditation, and now provides access to counselling, mental health advice and staff physiotherapy services as part of its Health and Wellbeing offering. Following extensive discussions with our trade union partners a policy to have all staff with a musculoskeletal issue referred to the physiotherapy service has been implemented. The Occupational Health Service provides a first response call to staff suffering with stress to support their return to work and ensure that they are supported and signposted to relevant services.

Sickness is reviewed with managers on a regular basis and Pennine has a number of supportive policies to assist staff to return to work or remain in employment. In March 2018 we introduced an electronic return to work form to capture the occurrence of return to work interviews. Such interviews are a key tool for managers to better understand absences and to enable them to work proactively with staff on ensuring appropriate health interventions are accessed. Pennine's values and disciplinary rules underpin our expectations for staff behaviour, whilst we are explicit on attendance in terms of established triggers for formal intervention due to absences.

Systems are in place to allow for a timely and professional review of long term sickness leave from Pennine, with referral to the Occupational Health Service. Managers are expected to make reasonable adjustments for staff to facilitate an early return to duty from long term sickness or to enable an employee who has acquired a disability to continue in work. Pennine recognises its duty to provide care to patients in an effective and economic manner and, where there is no reasonable prospect of a return to work, it may be appropriate to retire or dismiss employees who remain absent from work on an extended basis.

Staff Sickness Absence	2017/18	2016/17	2015/16	2014/15
Days lost – long term	102,930.34	101,324.28	109,416.05	69,711.63
Days lost – short term	57,753.7	52,924.86	50,692.80	30,052.15
Total days lost	160,684.05	154,249.14	160,108.85	99,763.78
Total staff years	8621.85	8228.53	8012.51	7947.21
Average working days lost	18.64	18.75	19.98	12.55
Total staff employed in period (headcount)	9420	9084	8627	8611
Total staff employed in period with no absence (headcount)	2764	2825	2720	2781
Percentage staff with no sick leave	29.34	31.10	31.53	32.30

	2017/18	2016/17	2015/16	2014/15	2013/14
01 April	4.69%	5.46%	5.72%	4.64%	5.33%
02 May	4.84%	5.01%	5.74%	4.89%	4.99%
03 June	4.94%	4.93%	5.61%	5.18%	4.82%
04 July	5.24%	5.32%	5.76%	5.23%	4.73%
05 August	5.22%	4.92%	5.48%	5.17%	5.00%
06 September	5.17%	4.70%	5.32%	5.78%	5.14%
07 October	5.47%	5.18%	5.93%	6.25%	5.28%
08 November	5.42%	5.60%	5.85%	6.08%	5.67%
09 December	5.77%	5.84%	6.08%	6.31%	5.70%
10 January	6.15%	5.86%	6.16%	6.61%	5.55%
11 February	5.02%	5.21%	5.95%	6.02%	5.33%
12 March	5.04%	5.14%	5.86%	5.55%	5.16%

Engaging with our People

Pennine has a specific engagement programme - The Pioneers' Programme which aims to embed staff engagement at team level and provides the tools and techniques to allow bottom-up improvement initiatives designed and delivered by local teams.

Pennine systematically provides employees with information on matters of concern to them as employees:

- Staff are invited to attend the monthly Team Brief receiving a briefing on key issues and developments; messages and information are then cascaded outwards to their wider teams;
- Pennine have a weekly e-newsletter;
- Regular and relevant information is posted for staff on Pennine's intranet, including a Performance Section;
- Pennine holds 1000 Voices events across its sites, with direct involvement from the Care Organisation leadership teams;
- Care Organisation Director drop in surgeries also take place providing the opportunity to find out more about the issues that matter most to our people.

In addition, Pennine has an agreed Organisational Change Policy with trade union colleagues which sets out a framework to consult and manage organisational change within Pennine. Pennine's formal consultation processes include managers meeting on a regular basis with trade union representatives. There are regular meetings of the Central Joint Negotiating Committee, the Joint Local Negotiation Committee and the Health and Safety Committee.

Values Based Appraisals

Pennine's Values Based Appraisal system ensures each person's goals and priorities are supporting their teams, and the Trust's priorities, ensuring everyone knows the part they play in the Trust delivering its services. Under the appraisal system all members of staff are encouraged to have regular conversations with their manager about both 'what' they are achieving and 'how' they are achieving it.

Apprenticeships

The government has pledged to deliver 3 million apprenticeship starts. The key to achieving this target was the introduction of the Apprenticeship Levy and the Public Sector targets. At Pennine, apprenticeships are delivered by the People Management Team within the Learning and Organisational Development Department, and are externally sourced from expert providers including Higher Education Institutions.

The Apprenticeship Levy came into force in May 2017. On an annual basis, Pennine pays approximately £1.8m into an account which can be used to pay for apprenticeship training. In addition to this the government contributes a 10% top up on a monthly basis. The levy is being used to fund a variety of apprenticeships from Level 2 Hospitality to Degree level Management Apprenticeships. This levy will also be used to fund the new Trainee Nurse Associate Programmes.

The Enterprise Act (2016) states that 2.3% of the workforce should be apprenticeship starts (based on headcount). The figures will be based upon a 3 year average between 2017 and 2020. Based upon the current headcount, Pennine would need 651 apprenticeship starts over this 3 year period, or 217 new apprenticeship starts each year. At the end of Year 1, Pennine expects to have achieved 174 apprenticeship starts, with over 250 projected for Years 2 and 3, anticipating that the Public Sector target will be met.

Trade Union Facility Time

From 1st April 2017 public sector organisations are required to report on trade union facility time. Facility time is paid time off for union representatives to carry out trade union activities.

Table 1

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full time equivalent employee number
56	9080.18

Table 2

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	28
1%-50%	25
51% - 99%	1
100%	2

Table 3

Percentage of pay bill spent on facility time

	Figures (£)
Provide the total cost of facility time	164,689.22
Total pay bill	440,248,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time/total pay bill) x 100	0.03%

Table 4

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period/total paid facility time hours) x 100	20%

Helping our people stay healthy and safe

The Health and Safety Committees established within the Care Organisations meet regularly to provide a forum for managers and trade unions to work together to promote health and safety and improve the working environment.

The below table describes the top 5 Health and Safety incidents reported during 2017/18

Category	Total
Abuse verbal	327
Assault physical	250
Sharp/needlestick injury	153
Fall, slip, trip	138
Moving and handling	105

Countering Fraud

Pennine has an established Anti-Fraud Service provided at a local level in-house by a professionally accredited and certified Counter Fraud practitioner, with support from Mersey Internal Audit Agency (MIAA), who undertakes a variety of activities in accordance with the Standards for Providers for Fraud, Bribery and Corruption. Pennine is committed in embedding an anti-crime culture throughout the organisation and this is supported in full by the Group CiC and monitored on a regular basis by the Audit Committee. Pennine's commitment to protecting valuable public funds from the risks of fraud, bribery and corruption is unwavering and we continue to invest significantly in our efforts to proactively counter criminal activity.

A number of key tasks were undertaken this year to combat fraud, bribery and corruption in accordance with the agreed Counter Fraud Response Plan/Policy and Communications Strategy; including ongoing awareness through presentations, articles, newsletters and joint events with Greater Manchester Police. This approach contributes towards creating and embedding a transparent anti-fraud culture and best probity practice across the organisation and has seen over the last 12 months over 3,000 staff receiving anti-fraud training. Local and national proactive exercises aimed at identifying potential or apparent risks of fraud, bribery and corruption have been conducted; review of policies procedures to ensure that appropriate counter fraud, bribery and corruption measures are included; and finally investigations where suspected or apparent fraudulent activity has been identified and redress of monies sought where appropriate.

Staff Survey

Pennine's approach to staff engagement is described throughout this Annual Report. Specific mechanisms are in place to monitor and learn from staff feedback which includes participation in the national NHS Staff Survey. The 2017 staff survey was undertaken between October and December 2017 with the results being published by NHS England on 7th March 2018.

Pennine used the mixed mode method providing the majority of staff with the opportunity to complete the survey online, with paper surveys provided where access to emails was limited. The Picker Survey was sent to all staff across different divisions, directorates and professions; 9237 staff in total. The response rate to this survey was 33% with over 3000 staff completing the survey.

Pennine compares favourably against other trusts in two particular areas: percentage of staff feeling unwell due to work related stress in the last 12 months; and percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months. The survey also reported a significant increase in satisfaction with staff having opportunities for flexible working, staff working extra hours and staff reporting errors, near misses or incidents witnessed in the last month. The key area of staff motivation at work has also increased marginally from last year's survey; we will be working to keep this momentum going.

Staff reported deterioration in the quality of appraisals and this will be an area of focus for 2018, as will strengthening clinical and site leadership and increasing frontline staffing numbers.

Overall the staff engagement scores have increased from 3.64 % to 3.71% in the 2017 survey. Staff experience has improved overall in five key areas;

- Percentage of staff reporting good communication between senior management and staff from 25% to 31%.
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months we have seen a 3% decrease, from 16% to 13%.

- Effective use of patient/service user feedback which has increased from 3.52% to 3.63%
- Staff confidence and security in reporting unsafe clinical practice from 3.51% to 3.60%
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents – from 3.55% to 3.63%

Encouragingly, the staff group engagement score for our adult general nursing workforce and Health Care Assistant/Nursing Assistants (which make up the largest proportion of the Trust's workforce) has increased significantly from 3.72 to 3.80. This shows that in the face of the huge amount of pressure our nursing workforce are under, more of our frontline clinical staff have confidence in the future, feel better engaged and can see they are being listened to and supported.

Following the results of the 2015 survey, a number of actions were implemented from April 2016 onwards. These were aimed at further improving staff engagement and we can see from the 2017 survey that these have had a positive impact on staff which in turn benefits patients and patient care. Work will continue on the above and further actions agreed from this year's results throughout 2018.

National Staff Survey Results

	2016/2017		2017/2018		Trust Improvement / Deterioration
	Trust	National	Trust	National	
Response Rate	45	44	33	43	Trust Deterioration

Top Ranking Scores	2016/2017		2017/2018		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	
* KF29 % staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)	90%	90%	91%	91%	Trust Improvement
* KF17 % staff feeling unwell due to work related stress in the last 12 months (the lower the score the better)	38%	35%	37%	38%	Trust Improvement
KF22. % staff experiencing physical violence from patients, relatives or the public in last 12 months (The lower the score the better)	16%	11%	13%	14%	Trust Improvement
KF15 % Percentage of staff satisfied with the opportunities for flexible working patterns (the higher the score the better)	48%	40%	51%	51%	Trust Improvement
KF16 % staff working extra hours (the lower the score the better)	70%	72%	71%	71%	Trust Improvement

Bottom Ranking Scores	2016/2017		2017/2018		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	
KF19 Organisation and management interest in and action on health and wellbeing	3.38	3.61	3.41	3.63	(the higher the score the better)
KF10. Support from immediate manager	3.61	3.73	3.65	3.76	(the higher the score the better)
*KF12 Quality of appraisals	2.89	3.11	2.91	3.11	(the higher the score the better)
KF27 % of staff / colleagues reporting most recent experience of harassment, bullying or abuse	43	45	42	47	(the higher the score the better)
KF30 Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.55	3.72	3.63	3.73	(the higher the score the better)

Where staff experience has improved	Trust 2016/2017	Trust 2017/2018	
KF6 % of staff reporting good communication between senior management and staff	25%	31%	(the higher the score the better)
KF22 % staff experiencing physical violence from patients, relatives or the public in the last 12 months	16%	13%	(the lower the score the better)
KF32 Effective use of patient / service user feedback	3.52	3.63	(the higher the score the better)
KF31 staff confidence and security in reporting unsafe clinical practice	3.51	3.60	(the higher the score the better)
KF30 Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.55	3.63	(the higher the score the better)

In response to the National Staff Survey 2017, Divisional and NCA wide action plans are in development. Pennine has initiated specific staff engagement programmes such as the Pioneer Programme, which has proven to increase the staff engagement scores and activity. This model will be rolled out across the Trust. Pennine also undertakes an extended quarterly 'Pulse check' survey and Family and Friends survey to reduce reliance on the National Staff Survey and monitor staff satisfaction across the course of the year.

Expenditure on consultancy

Expenditure on consultancy during 2017/18 was £236k. This related to a review of corporate functions to facilitate economies of scale as part of the NCA performed by PA Consulting and a review of theatre productivity by Four Eyes Insight.

Off-payroll engagements

Pennine limits the use of off-payroll arrangements for highly paid staff. Care Organisation Director approval is required in all cases, where the appointment of medical staff is to be made on a locum basis, approval is required from the relevant Divisional Managing Director or Divisional Chair and appointments are only made where they are compliant with the IR35 regulations.

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2018	0
Of which	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	1
Of which	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency/assurance purposes during the year	1
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements.	0

Exit Packages

During 2017/18, Pennine Acute agreed exit packages as follows:

Exit Package cost band (including any special payment element)	Number of compulsory redundancies Whole numbers only	Cost of compulsory redundancies £s	Number of other departures agreed Whole numbers only	Cost of other departures agreed £s	Total number of exit packages by cost band	Total cost of exit packages £s	Number of departures where special payments have been made Whole numbers only	Cost of special payment element include in the exit packages £s
< £10,000	0	0	18	63,742	18	63,742	18	-
£10,000 - £25,000	1	13,876	2	37,000	3	50,876	2	-
£25,001 - £50,000	0	0	0	0	0	0	0	-
£50,001 - £100,000	0	0	0	0	0	0	0	-
£100,001 - £150,000	0	0	0	0	0	0	0	-
£150,001 - £200,000	1	153,333	0	0	1	153,333	0	-
>£200,000	0	0	0	0	0	0	0	-
Totals	**2**	**167,209**	**20**	**100,742**	**22**	**267,951**	**20**	**-**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are the full costs of departures agreed in the year. Where the Pennine Acute Hospitals NHS Trust has agreed early retirements, the additional costs are met by the Pennine Acute Hospitals NHS Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table. This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	(2016/17 – 0) 2017/18 – 0	(2016/17 0) 2017/18 0
Mutually agreed resignations (MARS) contractual costs	(2016/17 – 1) 2017/18 – 0	(2016/17 – 19) 2017/18 – 0
Early retirements in the efficiency of the service contractual costs	(2016/17 – 0) 2017/18 – 0	(2016/17 – 0) 2017/18 – 0
Contractual payments in lieu of notice	(2016/17 – 24) 2017/18 – 20	(2016/17 – 122) 2017/18 – 101
Exit payments following Employment Tribunals or court orders	(2016/17 – 0) 2017/18 – 0	(2016/17 – 0) 2017/18 – 0
Non-contractual payments requiring HMT approval	(2016/17 – 0) 2017/18 – 0	(2016/17 – 0) 2017/18 – 0
Of which		
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	(2016/17 – 0) 2017/18 – 0	(2016/17 – 0) 2017/18 – 0

Sir David Dalton
Chief Executive
Date: 25 May 2018

Independent Auditors Report

Independent auditor's report to the Directors of The Pennine Acute Hospitals NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of The Pennine Acute Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including the accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.1 in the financial statements, which indicates that the Trust has incurred a deficit

of £30.4 million (NHS financial performance) during the year ended 31 March 2018 and received £28.2 million of revenue support loans from the Department of Health and Social Care (DHSC) during this period to support the payment of staff and suppliers.

The Directors have approved an open ended resolution to apply for further revenue support loans as and when necessary. The Trust received a further revenue support loan of £18.4m in April 2018, however, DHSC (as the ultimate body responsible for NHS Trusts) has not, as at the date of our report, confirmed any further revenue support loans.

These events or conditions, along with the other matters explained in note 1.1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report other than the financial

statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except that on 14 May 2018 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to The Pennine Acute Hospitals NHS Trust's breach of its break even duty for the three year period ending 31 March 2018.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matters described in the basis for qualified conclusion section of our report, we are satisfied that, in all significant respects, The Pennine Acute Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust incurred a deficit of £30.4 million (NHS financial performance) in 2017/18, compared to a planned deficit of £11 million and had to rely on £28m of revenue support loans in the year to support the payment of staff and suppliers. Key reasons for this were that:
  - The Trust failed to qualify for planned £10m Sustainability and Transformation Fund income due to not achieving its financial control and other performance targets including A&E 4 hour waiting time
  - Medical agency staff costs of £29m were £16m greater than the planned amount of £13m
- The Trust does not have a plan to achieve its statutory financial target to break even taking one year with another in 2018/19 and will require further revenue support loans in 2018/19.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures.

These matters are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable

delivery of strategic priorities and maintain statutory functions

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of The Pennine Acute Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Sarah Howard

Sarah Howard
Partner
for and on behalf of Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB
25 May 2018

Annual Accounts

Foreword to the Accounts

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care.

Statement of Comprehensive Income for the year ended 31 March 2018

	NOTE	2017-18 £000	2016-17 £000
Income			
Income from patient care activities	5	**597,515**	566,817
Other operating income	6	**64,413**	76,922
Total Income		**661,928**	643,739
Staff Costs		**(440,185)**	(409,418)
Other Costs		**(242,947)**	(228,149)
Operating expenses	8	**(683,132)**	(637,567)
Operating surplus/(deficit)		**(21,204)**	6,172
Finance costs:			
Investment income	12	**84**	93
Other gains and (losses)	13	**(28)**	532
Finance costs	14	**(2,034)**	(2,177)
Surplus/(deficit) for the financial year		**(23,182)**	4,620
Public dividend capital dividends payable		**(8,115)**	(7,735)
Retained surplus/(deficit) for the year		**(31,297)**	(3,115)
Other comprehensive income			
Will not be reclassified to income or expenditure:			
Impairments and reversals taken to the revaluation reserve		**0**	0
Net gains on revaluations taken to the revaluation reserve		**35,459**	26,280
Total comprehensive income for the year		**4,162**	23,165
The notes on pages 5 to 30 form part of these accounts.			
Reported NHS financial performance position			
Retained surplus/(deficit) for the year		**(31,297)**	(3,115)
Impairments		**700**	654
Donated Assets adjustment (difference between value of assets received and depreciation)		**182**	49
Reported NHS financial performance position - surplus/(deficit)		**(30,415)***	(2,412)

* **Note:** In 2017/18, trust other operating income includes £13.7m Sustainability & Transformation Fund (STF) income (2016/17 £28.1m). Without this income, the Trust would have incurred a £46.1m deficit (2016/17 £30.5m deficit).

A Trust's Reported NHS financial performance position is derived from its Retained surplus/(Deficit), but adjusted for the following that are not part of the Trust's financial performance:-

- Impairments to Property, plant and equipment.
- The net effect of donated assets. The value of donated assets received in the year is credited to other operating income. Depreciation on donated assets is charged to operating expenses. Where the value of donated assets received in any year is different from the ongoing cost of depreciation (either more or less) it results in an adjustment for financial performance purposes.

Statement of financial position as at 31 March 2018

	NOTE	2017-18 £000	2016-17 £000
Non-current assets			
Property, plant and equipment	15	**385,010**	351,096
Intangible assets	15	**6,542**	8,413
Trade and other receivables	19	**3,849**	4,041
Total non-current assets		**395,401**	363,550
Current assets			
Inventories	18	**7,211**	6,774
Trade and other receivables	19	**47,698**	45,296
Cash and cash equivalents	20	**11,391**	18,388
Total current assets		**66,300**	70,458
Total assets		**461,701**	434,008
Current liabilities			
Trade and other payables/other liabilities	21	**(75,684)**	(75,546)
Borrowings	22	**(3,234)**	(3,249)
Provisions	25	**(2,456)**	(4,370)
Total current liabilities		**(81,374)**	(83,165)
Net current assets/(liabilities)		**(15,074)**	(12,707)
Total assets less current liabilities		**380,327**	350,843
Non-current liabilities			
Borrowings	22	**(79,712)**	(54,712)
Provisions	25	**(9,549)**	(10,153)
Total assets employed		**291,066**	285,978
Financed by taxpayers' equity:			
Public dividend capital		**211,283**	210,357
Retained earnings		**(65,357)**	(38,112)
Revaluation reserve		**145,140**	113,733
Total taxpayers' equity		**291,066**	285,978

Sir David Dalton
Chief Executive
Date: 25 May 2018

Statement of changes in taxpayers' equity for the year ended 31 March 2018

	Public dividend capital (PDC) £000	I&E Reserve £000	Reval'n reserve £000	Total £000
Balance at 31 March 2016	**210,316**	**(39,760)**	**92,216**	**262,772**
Changes in taxpayers' equity for 2016-17				
Retained surplus/(deficit) for the year		(3,115)		(3,115)
Public Dividend Capital received	41			41
Public Dividend Capital repaid	0			0
Transfers between reserves		4,763	(4,763)	0
Upward revaluation of land			0	0
Upward revaluation of buildings/dwellings			26,280	26,280
Balance at 31 March 2017	**210,357**	**(38,112)**	**113,733**	**285,978**
Changes in taxpayers' equity for 2017-18				
Retained surplus/(deficit) for the year		(31,297)		(31,297)
Public Dividend Capital received	926			926
Public Dividend Capital repaid	0			0
Transfers between reserves		4,052	(4,052)	0
Upward revaluation of land			0	0
Upward revaluation of buildings/dwellings			35,459	35,459
Balance at 31 March 2018	**211,283**	**(65,357)**	**145,140**	**291,066**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income & Expenditure (I&E) reserve

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

Statement of Cash Flows for the year ended 31 March 2018

	NOTE	2017-18 £000	2016-17 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**(21,204)**	6,172
Depreciation and amortisation (non cash)		**22,557**	23,806
Impairments and reversals (non cash)		**700**	654
Donated Assets received credited to income (non cash)		**(119)**	(278)
(Increase)/decrease in inventories		**(437)**	776
(Increase)/decrease in trade and other receivables		**(2,210)**	(14,751)
Increase/(decrease) in trade and other payables/other liabilities		**(3,062)**	8,315
Provisions utilised		**(933)**	(835)
Increase/(decrease) in non cash provisions		**(1,610)**	(740)
Net cash inflow/(outflow) from operating activities	a	**(6,318)**	23,119
Cash flows from investing activities			
Interest received		**84**	93
(Payments) for property, plant, equipment and intangibles		**(16,993)**	(18,097)
Proceeds from disposal of plant, property and equipment		**163**	2,548
Net cash inflow/(outflow) from investing activities	b	**(16,746)**	(15,456)
Net cash inflow/(outflow) before financing	a+b	**(23,064)**	7,663
Cash flows from financing activities			
Public dividend capital received		**926**	41
Public dividend capital repaid		**0**	0
Capital Investment Loans repayments to the DHSC		**(3,249)**	(3,239)
Revenue Support Loans received from DHSC		**28,234**	
Interest paid		**(1,961)**	(2,037)
Dividends paid		**(7,883)**	(7,257)
Net cash inflow/(outflow) from financing	c	**16,067**	(12,492)
Net increase/(decrease) in cash and cash equivalents	a+b+c	**(6,997)**	(4,829)
Cash/cash equivalents at the start of the financial year		**18,388**	23,217
Cash/cash equivalents at the end of the financial year	20	**11,391**	18,388

Notes to the Accounts

1.0 Accounting Policies

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1 Accounting convention, going concern

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

The accounts have been prepared on a going concern basis for accounting purposes in line with Department of Health & Social Care (DHSC) guidance. In the Summer of 2017, NHS Improvement committed to undertake the necessary work to determine the most appropriate long term solution for Pennine Acute during this summer. This work has been completed taking into account the views of Pennine Acute's commissioners. NHS Improvement has determined that the preferred long term solution for Pennine Acute is for the North Manchester part of the Trust to be acquired by Manchester University NHS Foundation Trust and for the remainder of the Trust to be acquired by Salford Royal NHS Foundation Trust. All organisations are in the process of developing the case for this organisational change for submission to NHS Improvement.

The Trust incurred a £30.4m deficit (NHS financial performance) in 2017/18 and received £28.2m in revenue support loans from DHSC to support the payment of staff and suppliers. In January 2018, the Trust Board authorised an open ended resolution to apply for further revenue support loans as and when necessary in view of the fragile financial position of the Trust. A further revenue support loan of £18.4m was received in April 2018. These events and conditions indicate that a material uncertainty exists that may cast significant doubt over the Trust's ability to continue as a going concern. To date however, the Trust Board has not been refused revenue support funding and is confident that DHSC (as the ultimate body responsible for NHS Trusts) will continue to support the Trust until such time as a long term solution is put into effect.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Charitable Funds

Following Treasury's agreement to apply IAS 27 Consolidated and Separate Financial Statements to NHS Charities from 1 April 2013 (superseded by IFRS 10), the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity, *The Pennine Acute Hospitals and Other Related Charities (Registration number 1050197),* it effectively has the power to exercise control so as to obtain economic benefits. However, the transactions are immaterial in the context to the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties note.

A separate annual report and accounts is prepared as required by the Charity Commission. This is published on the Charity Commission website and Trust website.

1.4 Critical accounting judgements and key sources of estimation uncertainty

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.

Management has applied accounting policies as outlined in note 1.0 according to the Group Accounting Manual and has not made any critical judgements about the application of accounting policies that could have a significant effect on the amounts recognised in the financial statements.

There are no key assumptions, other than asset values and lives (see note 1.8), concerning the future or 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.

Other less significant areas of judgement and estimation techniques (e.g. depreciation) have been disclosed in the Trust's accounting policies and in the notes to the financial statements, as required by IFRS.

1.5 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is from commissioners for healthcare services. Income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

1.6.1 Short-term employee benefits

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

1.6.2 Retirement benefit costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of 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.or 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 expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme

A small number of employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. These employees transferred to the Trust as part of service changes in September 2015. The Trust joined the Greater Manchester Local Government Pension Scheme for administrative purposes with the former employer (Rochdale MBC as sponsor). As such, the scheme is a "closed" scheme ie there are no new entrants and the Trust follows the

lead of Rochdale MBC (sponsor). Pension contributions are charged to expenditure and no account is taken of the assets or liabilities of the scheme, this is the responsibility of Rochdale MBC as sponsor. The amounts involved are insignificant.

1.7 Expenditure on other goods and services

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

1.8 Property, plant and equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or

Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, 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

Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.8.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings was estimated for an exact replacement of the asset in its present location. After that date HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

A revaluation of land and buildings was performed during 2015/16 by the District Valuer with an effective date of 30 September 2015 (previous revaluation 30 September 2011). Indexation is applied, if necessary, in intervening years. Subsequently, at the 31 March 2016 and 31 March 2017, building values were adjusted at the year end to reflect changes in the building cost index and associated location factor since the valuation. At the 31 March 2017 the index/factor had increased by 11% since the 31 March 2016 and buildings values increased as a result. At the 31 March 2018 the index/factor had increased by 14% and building values further increased as a result.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Plant and machinery, fixtures and other equipment is written off over their remaining useful lives or carried at their depreciated historic cost as this is not considered to be materially different from current value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.8.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

1.9.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

Freehold land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets.

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments (eg the Department of Health) may not exceed the limits that they have been set. AME budgets are set by Treasury and may be reviewed with departments in the run up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.11 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is only recognised where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Government Grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is only recognised where conditions attached to the grant preclude immediate recognition of the gain.

1.13 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.14 Leases

Leases are classified and accounted for as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee and the value of the asset is greater than £50,000. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value, or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight line basis over the lease term.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using either the first-in first-out (manually recorded inventories) or weighted average (computerised inventories) cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of inventories.

Manually recorded inventories are counted once a year. Computerised inventories are the subject of rolling counts during the year. Certain inventories on wards and departments (including sterile supplies) are covered by a materials management topping up system. The level of materials management inventories held by wards and departments are estimated using a formula. Likewise, the value of ward/department drug inventories are estimated using a formula. Other ward and department inventories with a value less than £10,500 (per ward/department) are not included in the inventories balance.

1.16 Cash and cash equivalents

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

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

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 Clinical negligence costs

NHS Resolution (formerly NHS Litigation Authority - NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all

clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 25.

1.19 Non-clinical risk pooling

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

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.21 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

ther than trade receivables and other receivables (relating to the injury cost recovery scheme) the Trust does not have any other financial assets.

1.22 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Other than payables, borrowings and provisions the Trust does not have any other financial liabilities.

1.23 Value Added Tax

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

1.24 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise. The Trust has very few foreign currency transactions.

1.25 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in

them. Details of third party assets are given in note 31 to the accounts.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in NHS trusts. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, trusts. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by trusts, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Government Banking Service (GBS). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.27 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, excluding provisions for future losses and including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.28 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

2 Accounting Standards issued but not yet adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- I FRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

3. Operating Segments

All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the Trust's income originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the delivery or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish the delivery of healthcare. The activities which earn income and incur expenses are, therefore, of one broad combined nature and, therefore, on this basis one segment of 'healthcare' is deemed appropriate.

The operating results of the Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with divisional budgets and their cost improvement positions. The statement of financial positions (balance sheet), statement of comprehensive income (I&E), cash flow statement and cash flow forecasts are considered for the whole Trust in total only. The Board as chief operating decision maker, therefore, only considers one segment of healthcare in its decision making process.

The single segment of 'healthcare' has been identified as consistent with the core principles of IFRS8 which is to enable users of financial statements to evaluate the nature and financial effects of business activities and economic environments.

4. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

	Car Parking Charges		Catering		DWP Assessments	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Income	**2,915**	3,031	**2,735**	2,551	**1,985**	2,495
Full cost	**2,701**	2,591	**2,356**	2,308	**2,288**	2,625
Surplus/(deficit)	**214**	440	**379**	243	**(303)**	(130)

	Occupational Health		Laundry	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Income	**645**	1,102	**1,468**	1,308
Full cost	**622**	1,072	**1,424**	1,269
Surplus/(deficit)	**23**	30	**44**	39

Income of £9,748k has been included in note 6 'other operating income' and full cost of £9,391k has been included in note 8.1 within the relevant expense headings.

5. Income from patient care activities

5.1 Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Acute Services		
Elective income	**77,421**	83,997
Non-elective income	**195,502**	171,100
First outpatient income	**36,189**	34,164
Follow up outpatient income	**28,959**	35,673
A&E income	**34,970**	29,203
High cost drugs income from commissioners (excluding pass-through costs)	**33,646**	35,254
Other NHS clinical income	**127,031**	120,294
Acute Services total	**533,718**	509,685
Community services		
Income from CCGs and NHS England	**35,422**	30,430
Income from other sources (e.g. local authorities)	**5,705**	5,597
Community services total	**41,127**	36,027
Other services		
Private patient income	**44**	34
Other clinical income	**22,626**	21,071
Total income from patient care activities	**597,515**	566,817

5.2 Income from patient care activities (by source)

	2017/18 £000	2016/17 £000
NHS England	**96,098**	93,342
Clinical Commissioning Groups (CCGs)	**489,394**	461,032
Foundation Trusts	**618**	1,314
Local authorities	**6,114**	6,409
Department of Health & Social care	**211**	0
Sub Total - Main Commissioners	**592,435**	562,097
Non NHS : Private patients	**44**	34
Overseas patients (non-reciprocal)	**971**	715
Injury costs recovery	**3,060**	3,415
Other	**1,005**	556
	597,515	566,817

Injury cost recovery income is subject to a provision for impairment of receivables of 4% to reflect expected rates of collection based on information relevant to the Trust.

6. Other operating income

	2017/18 £000	2016/17 £000
Education, training and research	**18,482**	18,920
Donated assets included in property, plant and equipment (SOFP)	**119**	278
Non-patient care services to other bodies	**12,277**	13,146
Sustainability & Transformation Fund income	**15,720**	28,135
Income generation (see note 4)	**9,748**	10,487
Other income	**8,067**	5,956
	64,413	76,922

7. Overseas visitors (relating to patients charged directly by the trust)

	2017/18 £000	2016/17 £000
Income recognised this year	**971**	715
Cash payments received in-year	**62**	44
Amounts added to provision for impairment of receivables	**618**	333
Amounts written off in-year	**0**	345

8. Operating expenses

8.1 Operating expenses

	2017/18 £000	2016/17 £000
Services from NHS and DHSC bodies	**10,181**	10,573
Services from non-NHS and non-DHSC bodies	**7,721**	5,095
Staff and executive directors costs	**440,185**	409,418
Remuneration of non-executive directors	**63**	79
Supplies and services - clinical (excluding drugs costs)	**48,463**	44,066
Supplies and services - general	**16,634**	16,143
Drug costs (drugs inventory consumed/ purchase of non-inventory drugs)	**55,868**	53,082
Inventories write down	**47**	67
Consultancy services	**236**	332
Establishment	**9,763**	10,467
Premises	**20,411**	18,161
Business Rates	**3,831**	3,463
Transport	**1,267**	1,011
Depreciation	**19,727**	20,929
Amortisation	**2,830**	2,877
Net impairments of property, plant and equipment	**700**	654
Increase/(decrease) in provision for impairment of receivables	**556**	425
Change in provisions discount rate(s)	**84**	916
Audit fees payable to the external auditor:		
audit services- statutory audit	**90**	125
other auditor remuneration (external auditor only - quality accounts)	**8**	11
Internal Audit fees	**134**	133
Clinical negligence premium	**28,961**	26,328
Legal Fees	**896**	1,153
Insurance	**696**	834
Education and Training	**1,164**	1,239
Security Services	**1,911**	1,650
Interpreter Fees	**380**	431
Clinical waste	**473**	452
Professional Fees (other external contracts)	**3,517**	3,411
Other	**6,335**	4,042
Total Operating Expenses	**683,132**	637,567

8.2 Limitation on auditors liability

There is £2m limitation on auditor's liability for external audit work carried out for 2017/18.

8.3 Research and Development (R&D)

Note 8.1 above includes R&D costs of £307k for 2017/18 spread across various expenditure lines (£252k for 2016/17).

9. Operating leases

9.1 As lessee

	2017/18 £000	2016/17 £000
Payments recognised as an expense		
Minimum lease payments	**2,252**	2,560
Total future minimum lease payments		
Payable:		
Not later than one year	**1,988**	2,091
Between one and five years	**3,738**	1,853
After 5 years	**0**	0
Total	**5,726**	3,944

9.2 As lessor

The Trust does not have any significant operating leases as lessor

10. Employee benefits

	2017/18 £000	2016/17 £000
Salaries and wages	**296,743**	304,411
Social Security Costs	**30,856**	29,264
Apprenticeship levy	**1,570**	0
Employer contributions to NHS Pension scheme/other	**37,971**	35,929
Termination benefits	**268**	179
Temporary staff (external bank, agency, contract)	**73,195**	40,053
Total staff costs	**440,603**	409,836
Of the total above:		
Charged to capital	**418**	418
Employee benefits charged to revenue	**440,185**	409,418
	440,603	409,836

10.1 Ill Health Retirements

	2017/18	2016/17
No. of persons retired on ill health grounds	**5**	9
Total additional pension liabilities accrued in year £000s	**464**	655

10.2 Pension costs

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

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 2012.

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

11. Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance

	2017-18		2016-17	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	**122,195**	**403,763**	139,488	352,652
Total Non NHS trade invoices paid within target	**108,717**	**376,024**	131,984	346,904
Percentage of Non-NHS trade invoices paid within target	**89%**	**93%**	95%	98%
Total NHS trade invoices paid in the year	**3,823**	**27,418**	5,052	44,757
Total NHS trade invoices paid within target	**3,374**	**24,586**	4,946	43,791
Percentage of NHS trade invoices paid within target	**88%**	**90%**	98%	98%

The Better Payment Practice Code 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.

In addition to the Better Payment Practice Policy, the Trust signed up to the Prompt Payment Code (PPC) in March 2010. The Prompt Payment Code is a payment initiative developed in 2009 by Government with The Institute of Credit Management (ICM) to "tackle the crucial issue of late payment and help small businesses." Details of the code can be found at www.promptpaymentcode.org.uk.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998 / Public Contract Regulations 2015

	2017-18 £000	2016-17 £000
Late payment charges	**32**	0

12. Investment income

	2017-18 £000	2016-17 £000
Interest income: Bank accounts	**84**	93

13. Other gains and losses

	2017-18 £000	2016-17 £000
Gain/(loss) on disposal of property, plant and equipment	**(28)**	532

14. Finance Costs

	2017-18 £000	2016-17 £000
Interest on capital investment loans	**1,929**	2,037
Interest on revenue support loans	**48**	0
Interest on late payment of commercial debt	**32**	0
Unwinding of discount factor (provisions)	**25**	140
Total	**2,034**	2,177

15A Property, plant and equipment (PPE)/Intangibles

2017-18	Land	Buildings excluding dwellings	Dwellings	AUC and POA*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total PPE		Intangibles Computer Software - purchased
	£000	£000	£000	£000	£000	£000	£000	£000	£000		£000
Cost or valuation at 1 April 2017	46,092	278,428	640	2,903	95,752	260	17,493	3,559	445,127		22,253
Additions purchased		7,286		1,128	7,690		2,654	195	18,953		959
Additions donated					119				119		
Reclassifications		2,903		(2,903)					0		
Disposals	(20)		(92)		(3,262)	(46)			(3,420)		
Revaluation/indexation		35,323	136						35,459		
Impairments									0		
At 31 March 2018	**46,072**	**323,940**	**684**	**1,128**	**100,299**	**214**	**20,147**	**3,754**	**496,238**		**23,212**
Depreciation ** at 1 April 2017		13,583	29		65,993	176	12,254	1,996	94,031		13,840
Disposals			(6)		(3,178)	(46)			(3,230)		
Revaluation/indexation									0		
Impairments		700							700		
Charged during the year		10,687	15		6,892	33	1,757	343	19,727		2,830
Depreciation at 31 March 2018	**0**	**24,970**	**38**		**69,707**	**163**	**14,011**	**2,339**	**111,228**		**16,670**
Net book value											
Purchased	44,822	297,297	646	1,128	29,797	43	6,099	1,414	381,246		6,542
Donated	1,250	1,673			795	8	37	1	3,764		
Government granted									0		0
Total at 31 March 2018	**46,072**	**298,970**	**646**	**1,128**	**30,592**	**51**	**6,136**	**1,415**	**385,010**		**6,542**
Asset financing											
Owned	46,072	298,970	646	1,128	30,592	51	6,136	1,415	385,010		6,542
Finance leased									0		0
Private finance initiative									0		0
Total 31 March 2018	**46,072**	**298,970**	**646**	**1,128**	**30,592**	**51**	**6,136**	**1,415**	**385,010**		**6,542**

15.1 Revaluation reserve balance for property, plant & equipment

	Land	Buildings excluding dwellings	Dwellings	AUC and POA*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total PPE
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	24,186	85,967	386	n/a	3,092	10	0	92	113,733
Movements		31,590	61	n/a	(240)	(1)		(3)	31,407
At 31 March 2018	**24,186**	**117,557**	**447**	**n/a**	**2,852**	**9**	**0**	**89**	**145,140**

* AUC - assets under construction, POA - payments on account. ** amortisation for intangible assets

The net book value of PPE disposals during the year was £190k (Cost £3,420k less depreciation £3,230k).

15B Property, plant and equipment (PPE)/Intangibles

2016-17	Land	Buildings excluding dwellings	Dwellings	AUC and POA*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total PPE		Intangibles Computer Software - purchased
	£000	£000	£000	£000	£000	£000	£000	£000	£000		£000
Cost or valuation at 1 April 2016	47,877	247,961	676	248	96,107	252	28,858	3,271	425,250		20,893
Additions purchased		3,642		2,699	8,423		546	295	15,605		1,699
Additions donated		198			39		41		278		0
Reclassifications		276		(44)	(236)	8	30	(7)	27		(27)
Disposals	(1,785)		(99)		(8,581)		(11,982)		(22,447)		(312)
Revaluation/indexation		26,351	63						26,414		0
Impairments									0		0
At 31 March 2017	**46,092**	**278,428**	**640**	**2,903**	**95,752**	**260**	**17,493**	**3,559**	**445,127**		**22,253**
Depreciation ** at 1 April 2016	0	3,377	10		66,321	135	21,254	1,648	92,745		11,275
Disposals					(8,449)		(11,982)		(20,431)		(312)
Revaluation/indexation		132	2						134		0
Impairments		654							654		0
Charged during the year		9,420	17		8,121	41	2,982	348	20,929		2,877
Depreciation at 31 March 2017	**0**	**13,583**	**29**		**65,993**	**176**	**12,254**	**1,996**	**94,031**		**13,840**
Net book value											
Purchased	44,842	263,274	611	2,903	28,894	72	5,197	1,561	347,354		8,410
Donated	1,250	1,571			865	12	42	2	3,742		3
Government granted									0		0
Total at 31 March 2017	**46,092**	**264,845**	**611**	**2,903**	**29,759**	**84**	**5,239**	**1,563**	**351,096**		**8,413**
Asset financing											
Owned	46,092	264,845	611	2,903	29,759	84	5,239	1,563	351,096		8,413
Finance leased									0		0
Private finance initiative									0		0
Total 31 March 2017	**46,092**	**264,845**	**611**	**2,903**	**29,759**	**84**	**5,239**	**1,563**	**351,096**		**8,413**

15.1 Revaluation reserve balance for property, plant & equipment

	Land	Buildings excluding dwellings	Dwellings	AUC and POA*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total PPE
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2016	24,877	63,389	344	n/a	3,501	10	0	95	92,216
Movements	(691)	22,578	42	n/a	(409)			(3)	21,517
At 31 March 2017	**24,186**	**85,967**	**386**	**n/a**	**3,092**	**10**	**0**	**92**	**113,733**

* AUC - assets under construction, POA - payments on account. ** amortisation for intangible assets

The net book value of PPE disposals during the year was £190k (Cost £3,420k less depreciation £3,230k).

15.1 Property, plant and equipment (cont.)

Donated Assets

During the year the Trust received medical equipment from the charity with a total value of £119k

Asset Revaluations

A revaluation of land and buildings was performed during 2015/16 by the District Valuer with an effective date of 30 September 2015 (previous revaluation 30 September 2011). Indexation is applied, if necessary, in intervening years. Subsequently, at the 31 March 2016 and 31 March 2017 building values were adjusted at the year end to reflect changes in the building cost index and associated location factor since the DV valuation. At the 31 March 2017 the index/factor had increased by 11% since the 31 March 2016 and building values increased as a result. At the 31 March 2018 the index/factor had increased by 14% and building values further increased as a result.

Asset Lives

There have been no changes during the year in the lives applied to the Trust assets

Life applied	Min	Max
Buildings exc Dwellings	5	51
Dwellings	25	46
Plant & Machinery	3	15
Transport Equipment	5	10
Information Technology	5	8
Furniture and Fittings	5	15

There has been no compensation from third parties for assets impaired included in the Trust's surplus.

The Trust has no temporary idle assets

The gross carrying amount of fully depreciated assets (plant & machinery) still in use is £61.7m (2016-17 £52.7m).

15.2 Intangible assets

There have been no revaluations to intangible assets during the year and there are no revaluation balances held for intangibles.

For all purchased software the Trust applies a finite life of between 5 and 9 years.

The Trust still has fully amortised purchased software in use with a replacement cost of £11.4m (2016-17 £7.5m)

16. Impairments

The District Valuer has reviewed newly contructed buildings/enhancements. This resulted in an impairment charge of £0.7m to operating expenses. Such impairments are managed overall by the Department of Health & Social Care on an annual basis as part of Annually Managed Expenditure totals (AME).

17. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	**1,085**	6,428
Intangible Assets		359

18. Inventories

18.1 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	**1,941**	1,846
Consumables	**5,035**	4,743
Energy	**235**	185
Total	**7,211**	6,774

18.2 Inventories recognised in expenses

	31 March 2018 £000	31 March 2017 £000
Inventories recognised as an expense in the period	**38,226**	34,166
Write-down of inventories (including losses)	**47**	67

19. Trade and other receivables

19.1 Trade and other receivables

	Current 31 March 2018 £000	Non-current 31 March 2018 £000	Current 31 March 2017 £000	Non-current 31 March 2017 £000
Trade receivables	**27,577**	**5,401**	21,571	5,471
Accrued income & prepayments	**15,373**		21,035	
Provision for the impairment of receivables	**(2,033)**	**(1,552)**	(1,711)	(1,430)
VAT	**2,173**		899	
Other receivables	**4,608**		3,502	
Total	**47,698**	**3,849**	45,296	4,041
Of which receivables from NHS and DHSC group:	**28,572**		29,579	

The vast majority of trade is with Clinical Commissioning Groups (CCGs) and NHS England (Specialised Commissioning), as commissioners for NHS patient care services. As CCGs and NHS England are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

The Trust is the lead employer for doctors in training on behalf of the North West Deanery. The Trust is responsible for the employment and payment of over 2000 doctors in training under the lead employer contract with an annual value of approximately £172m (16/17 £177m). The costs are recharged to the relevant NHS organisations (25) throughout the North West (including Pennine Acute). Only the costs and associated numbers of the Deanery doctors in training to Pennine Acute (approximately 10%) are shown in Pennine Acute's expenditure account and workforce numbers.

19.2 Receivables past their due date but not impaired

	31 March 2018 £000	31 March 2017 £000
By up to three months	**7,754**	3,982
By three to six months	**3,895**	1,385
By more than six months	**10,276**	2,985
Total	**21,925**	8,352

19.3 Provision for impairment of receivables

	31 March 2018 £000	31 March 2017 £000
Balance at 1 April	**(3,141)**	(3,090)
Amount written off during the year	**112**	374
Amount recovered during the year	**62**	139
(Increase)/decrease in receivables impaired	**(618)**	(564)
Balance at 31 March	**(3,585)**	(3,141)

The provision mainly relates to overseas visitors and injury cost recovery receivables

20. Cash and cash equivalents

	31 March 2018 £000	31 March 2017 £000
Balance at 1 April	**18,388**	23,217
Net change in year	**(6,997)**	(4,829)
Balance at 31 March	**11,391**	18,388
Made up of		
Cash with Government Banking Services	**11,366**	18,361
Cash in hand	**25**	27
Cash/cash equivalents in statement of financial position	**11,391**	18,388
Cash/cash equivalents as in statement of cash flows	**11,391**	18,388

21. Trade and other payables

	Current	
	31 March 2018 £000	31 March 2017 £000
Trade payables	**9,887**	6,564
Capital payables	**7,111**	4,192
Accruals	**44,496**	38,428
Social security costs	**(280)**	6,486
Income Tax (on behalf of employees)	**375**	6,027
NHS Pension contributions	**7,153**	6,676
PDC dividend payable	**484**	252
Other	**839**	286
Total	**70,065**	68,911
Of which payables to NHS and DHSC group:	**12,460**	5,608

A proportion of the tax, social security and NHS pension payables in total relates to the Trust's contract as lead employer for doctors in training for the North West Deanery (see also note 19.1)

21.1 Other Liabilities (deferred income)

	Current	
	31 March 2018 £000	31 March 2017 £000
Deferred income at 31 March	**5,619**	6,635

22. Borrowings

	Current		Non-current	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Loans from:				
Department of Health (capital investment)	**3,234**	3,249	**51,478**	54,712
Department of Health (revenue support loans)	**0**	0	**28,234**	0
Finance lease liabilities	**0**	0	**0**	0
Total	**3,234**	3,249	**79,712**	54,712
Total current and non current	**82,946**	57,961		

In 2009-10, the Trust secured a loan of £42.050m over 25 years from the Department of Health & Social Care (DHSC) to support the Womens & Children development at North Manchester General Hospital and the additional capacity development (above Radiotherapy) at the Royal Oldham Hospital. This was drawn down in 2009-10 and 2010-11. In 2011-12 the Trust secured a loan of £36m to support Womens & Children development at the Royal Oldham Hospital. £18m of this loan was drawn down in 2011-12, £15m drawn in 2012/13 and £3m drawn in 2013/14.

In 2017-18 the Trust's financial deficit meant that a series of revenue support loans were necessary from DHSC in the latter part of the year. Further revenue support loans will be necessary for the foreseeable future.

Loans - repayment of principal falling due in:

	DHSC Capital £000	DHSC Revenue £000
0-1 years	3,234	0
1-2 years	6,468	28,234
3-5 years	9,702	0
> 5 years	35,308	0
	54,712	**28,234**

24. Finance lease obligations

The Trust does not have any material finance lease obligations as lessor or lessee.

The Trust granted the Christie NHS Foundation Trust a 40 year lease for the Oldham satellite centre for use of part of the building located on land owned by Pennine Acute Hospitals NHS Trust. This was paid for up front and in full in March 2010. The Christie include the value of their part of the building in their accounts. No value is included in the accounts of Pennine Acute Hospitals.

25. Provisions

	Current 31 March 2018 £000	Non-current 31 March 2018 £000	Current 31 March 2017 £000	Non-current 31 March 2017 £000
Pensions relating to other staff	**246**	**2,411**	416	2,289
Legal claims	**122**	**244**	194	194
Restructurings	**112**	**1,765**	140	1,995
Redundancy	**320**	**0**	2,618	0
Other	**1,656**	**5,129**	1,002	5,675
Total	**2,456**	**9,549**	4,370	10,153

	Pensions relating to other staff £000	Employers & Public Liability Legal Claims £000	Restructurings £000	Redundancy £000	Other £000	Total £000
At 1 April 2017	2,705	388	2,135	2,618	6,677	14,523
Arising during the year	195	192	21	160	590	1,158
Used during the year	(249)	(114)	(112)	(192)	(435)	(1,102)
Reversed unused		(100)	(172)	(2,266)	(145)	(2,683)
Change of discount rate					84	84
Unwinding of discount	6		5		14	25
At 31 March 2018	**2,657**	**366**	**1,877**	**320**	**6,785**	**12,005**
Expected timing of cash flows:						
Within one year	246	122	112	320	1,656	2,456
Between one and five years	985	244	447		1,186	2,862
After five years	1,426		1,318		3,943	6,687

Pensions relating to other staff refer to pre 1995 early retirements. The restructurings provision relates to the costs of restructuring associated with the creation of Pennine Acute Hospitals NHS Trust from the four predecessor Trusts in April 2002 (Bury, Rochdale, Oldham and North Manchester). Other provisions relate mainly to permanent injury benefits payable, contract issues and changes to pay.

£375m is included in the provisions of the NHS Resolution (formerly NHS Litigation Authority NHSLA) in respect of clinical negligence liabilities of the Trust (31/03/17 £301m).

26. Contingencies

26.1 Contingent liabilities

	2017/18 £000	2016/17 £000
The Trust's liability to third parties (public and employers) under the scheme operated by NHS Resolution (formerly NHS Litigation Authority)	**(209)**	(235)

26.2 Contingent assets

The Trust does not have any contingent assets.

27 Events after the reporting period

There are no events after the reporting period to report.

28 Financial instruments

28.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with commissioners for example, Clinical Commissioning Groups and NHS England and the way those commissioners are financed, an NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of directors. Trust treasury activity is subject to audit by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. In addition, the Trust currently borrows from government to support it's working capital position while it is experiencing an I&E deficit using the revenue loan facility. Interest on any revenue loans is currently charged at 1.5% for the duration of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

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

Liquidity risk

The Trust's operating costs are incurred under contracts with NHS England and Clinical Commissioning Groups (CCGs), which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internal funds or within its prudential borrowing assessment via NHS Improvement. Revenue support loans are available from the Department of Health & Social Care whilst the Trust is in deficit. The Trust is not, therefore, exposed to significant liquidity risks.

28.2 Carrying values of financial assets

	Loans and receivables £000	Total book value £000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	**34,864**	**34,864**
Cash and cash equivalents at bank and in hand	**11,391**	**11,391**
Total at 31 March 2018	**46,255**	**46,255**
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	34,023	34,023
Cash and cash equivalents at bank and in hand	18,388	18,388
Total at 31 March 2017	52,411	52,411

Items not included above are:	2017/18 £000	2016/17 £000
Prepayments	**7,461**	7,171
Injury Cost Recovery	**7,049**	7,241
VAT receivable	**2,173**	889
	16,683	15,301

28.3 Carrying value of financial liabilities

	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	**82,946**	**82,946**
Trade and other payables excluding non financial liabilities	**69,486**	**69,486**
Provisions under contract	**12,005**	**12,005**
Total at 31 March 2018	**164,437**	**164,437**
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	57,961	57,961
Trade and other payables excluding non financial liabilities	56,146	56,146
Provisions under contract	14,523	14,523
Total at 31 March 2017	128,630	128,630

Items not included above are:	2017/18 £000	2016/17 £000
Deferred income	**5,619**	6,635
Social security and other taxes payable	**95**	12,513
PDC dividend	**484**	252
	6,198	19,400

28.4 Maturity of financial liablilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	**75,176**	63,765
In more than one year but not more than two years	**36,133**	8,286
In more than two years but not more than five years	**11,133**	11,520
In more than five years	**41,995**	45,059
	164,437	128,630

28.5 Fair values of financial assets at 31 March 2018

The fair value of all assets and liabilities is reported as being equal to their book value which the Trust considers to be materially the same as the fair value.

29. Financial performance targets

29.1 Breakeven Performance

	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Turnover	569,840	567,664	582,684	591,544	643,739	659,928
Retained surplus/(deficit) for the year	(25,416)	(7,384)	(6,727)	(22,493)	(3,115)	(31,297)
Adjustments for Impairments	25,273	7,057	6,533	2,750	654	700
Adjustments for donated assets	168	380	208	(205)	49	182
Break-even in-year position	25	53	14	(19,948)	(2,412)	(30,415)
Break-even cumulative position	6,694	6,747	6,761	(13,187)	(15,599)	(46,014)
Materiality test (i.e. is it equal to or less than 0.5%):	%	%	%	%	%	%
In-year position as a %tage of turnover	0.0	0.0	0.0	(3.4)	(0.4)	(4.6)
Cumulative as a %tage of turnover	1.2	1.2	1.2	(2.2)	(2.4)	(7.0)

The Trust achieved a small surplus in 2012-13, 2013-14 , 2014-15 and deficit in 2015-16, 2016-17 and 2017-18.

29.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on 3.5% of the actual (rather than forecast) average relevant net assets and, therefore, the actual capital cost absorption rate is automatically 3.5%.

29.3 External financing

The Trust is given an external financing limit which it is not permitted to overshoot.

	2017/18 £000	2016/17 £000
External financing limit	**33,025**	14,974
Cash flow financing	**32,908**	1,631
Other capital receipts	**0**	0
External financing requirement	**32,908**	1,631
Undershoot/(overshoot)	**117**	13,343

29.4 Capital Resource Limit

The Trust is given a capital resource limit which it is not permitted to overshoot.

	2017/18 £000	2016/17 £000
Gross capital expenditure	**20,031**	17,582
Less: book value of assets disposed of	**(190)**	(2,016)
Less: donations towards the acquisition of non-current assets	**(119)**	(278)
Charge against the capital resource limit	**19,722**	15,288
Capital resource limit	**21,073**	23,722
(Over)/Undershoot against the capital resource limit	**1,351**	8,434

30. Related party transactions

During the year no Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with The Pennine Acute Hospitals NHS Trust.

The Department of Health & Social Care is regarded as a related party. During the year The Pennine Acute Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The main transactions and balances in each category are shown below:

Related Party	Expenditure £000s	Income £000s	Receivables £000s	Payables £000s
NHS Heywood, Middleton and Rochdale CCG		145,530		571
NHS Oldham CCG		127,020	1,507	
NHS Manchester CCG		99,092	1,114	
NHS Bury CCG		94,464		750
NHS England - NW Specialised Commissioning Hub		77,267	3,512	
Health Education England		18,699	737	
NHS England - Core (incl 1718 STF)		18,606	7,080	
NHS England - Greater Manchester Local Office		14,468	1,998	
NHS East Lancashire CCG		6,933		345
NHS Salford CCG		6,929		
NHS Tameside and Glossop CCG		3,506		285
Greater Manchester Mental Health NHS FT		3,433		
Pennine Care NHS Foundation Trust		2,926		
Total Income >£2m		**618,873**		
NHS Resolution (NHS Litigation)	29,542			
DHSC (PDC dividend)	8,115			454
Salford Royal NHS Foundation Trust	5,861			2,289
Manchester University NHS FT	3,532		4,082	2,287
Community Health Partnerships	1,363			2,070
The Christie NHS Foundation Trust	1,086		771	
NHS Property Services	717			316
Pennine Care NHS Foundation Trust	572		2,998	1,105
Care Quality Commission	332			
Bolton NHS Foundation Trust	292		544	
Wrightington, Wigan and Leigh NHS FT	283			
East Lancashire Hospitals NHS Trust				286

There are 13 entities from whom the Trust has received income in excess of £2m per entity. The total of £618m represents 94% of the Trust revenue for 2017/18. In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with HMRC, Bury/Oldham/Rochdale MBCs and Manchester Council. Included within expenditure with the Salford Royal NHS Foundation Trust is the cost of the management charge agreed between Salford and Pennine Acute as part of Salford's management oversight of Pennine Acute.

Pennine Acute Hospitals Charity

The Trust has also received donations from a number of charitable funds, which include the Pennine Acute Hospitals Charity. The Pennine Acute Trust Board is the corporate trustee of the charity. The financial information of the charity is not consolidated within the Trust's accounts (see accounting policies note 1.4). The majority of expenditure relates to the Pennine Acute Hospitals NHS Trust. A summary of the key unaudited financials of the Pennine Acute Hospitals Charity (registered number 1050197) is shown below:

	2017/18 £000s	2016/17 £000s
Statement of Financial Activities (SOFA)		
Total Income	237	1,236
Total Expenditure	(354)	(241)
Gains/(losses) on revaluation of investments	(88)	193
Net movement in funds	**(205)**	1,188
Statement of Financial Position (SOFP)		
Investments	3,104	3,221
Cash	542	486
Receivables	41	189
Payables	(54)	(58)
Net Assets/Liabilities	**3,633**	3,838

31. Third party assets

The Trust held £11k cash and cash equivalents at 31 March 2018 (£6k at 31 March 2017) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

32. Losses and special payments

The total number of losses in 2017-18 and their total value was as follows:

	Total Value of Cases £000	**Total No of Cases No**
Losses	180	194
Special Payments	221	182
Total losses and special payments	401	376

The total number of losses in 2016-17 and their total value was as follows:

	Total Value of Cases £000	**Total No of Cases No**
Losses	526	192
Special Payments	202	195
Total losses and special payments	728	387

Contacting the Trust

The Trust welcomes feedback from patients about its services. There are a number of different ways in which you can contact us or give us your views.

If you have an issue which you wish to raise about your care then you should initially discuss this with the ward or departmental staff in the area you are being cared for. Local staff are usually best placed to be able to answer questions about your own care, or those of your relatives.

We recognise that in some circumstances patients or relatives may prefer to discuss the matter with someone not directly involved in their care. In those circumstances you can also contact the Patient Advice and Liaison Service (PALS) on 0161 604 5897. You can also email: pals@pat.nhs.uk

Twitter

You can follow the Trust and its news and events on Twitter @pennineacutenhs

Report Publication

The Annual Report, Quality Report and Annual Accounts are published on line at www.pat.nhs.uk. A printed copy is available free of charge, and in different formats, by contacting the Communications Department on Tel. 0161 918 4284 or email enquiries@pat.nhs.uk

The Pennine Acute Hospitals NHS
NHS Trust

Saving *lives*,
Improving *lives*

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